HSE Psychosocial Response to the Covid-19 Pandemic

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Foreword

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The Covid-19 pandemic's disruption to daily life has caused psychological, emotional and social impacts for many individuals, families and communities across the country. There are also certain groups in our society who have faced more significant challenges during this pandemic such as, children and adolescents, older adults, people with disabilities, those bereaved during the pandemic and people living in residential care settings. In particular, it is important to recognise that healthcare workers across all sectors have been faced with significant personal, family and work stresses.

As the crisis has progressed, statutory, voluntary and community services mobilised to provide supports and services to their different communities. Similarly, the HSE was able to quickly respond to the mental and social wellbeing needs of people (often referred to as psychosocial needs), through mobilising existing services and emergency management psychosocial response plans across the country. We also moved quickly to create new accessible and timely supports, particularly free online services to augment existing services.

With support and time, the majority of people will effectively manage any psychological difficulties they may experience in the short-to-medium term. However for some people, without appropriate supports, significant psychological and social problems may arise, resulting in longer-lasting distress.

This report was commissioned to examine how the HSE, working with its partners, can both mitigate against this situation and sustainably support the mental health and psychosocial wellbeing of the public and healthcare workers. This support will be needed for the duration of the pandemic and over the longer "post emergency" term.

This report and its findings were developed through a process of widespread national consultation across all areas of the health sector, and by harnessing international and local evidence and research. Our aim was to examine our strengths and prioritise key areas for improvement.

Based on this work, the National Psychosocial Response to Covid-19 Framework, outlined in this report, was developed. It provides a layered care approach to addressing the psychosocial consequences of Covid-19, from a societal level and then through the levels of need of the population across the life span. The framework's structure enables us to effectively integrate the wide range of wellbeing and mental health supports available or those that could be offered. In addition, with its focus on early detection and prevention, the framework provides a positive platform for the future of wellbeing and mental health services.

Importantly, the report's recommendations integrate and build on existing response practices and policies, and capitalise on our capabilities and expertise across Community and Acute services on an Inter-agency and Inter-disciplinary basis and in line with Slaintecare.

I would like to acknowledge and thank all staff who are providing a psychosocial response to the public and our fellow healthcare workers. I would also like to thank all those who provided their input and expertise, which was invaluable in helping to shape this report. In particular, I would like to give a special thanks to the National Psychosocial Response steering and working groups, and to their chair Dr Cathal Morgan.

I am confident that through this framework we can address the ongoing psychosocial challenges posed by Covid-19 for the Irish people and build our resilience, so that we can respond in an integrated and timely way to any emergent challenges over the coming months.

Anne O'Connor

HSE Chief Operations Officer

Executive Summary



Executive summary

This report was commissioned by the Chief Operations Officer as chair of the HSE's Integrated National Operations Hub (INOH), to address the need for a national health sector psychosocial plan to be produced in response to the Covid-19 pandemic.

Psychosocial refers to the full spectrum of psychological, emotional, social, relationship, behavioural and cognitive experiences of people. A psychosocial approach in this context refers to the process of planning and delivering a coordinated range of health and social care responses to these experiences during a time of major emergency, such as a pandemic.

To develop a psychosocial plan and ensure broad representation with active engagement across the health sector and beyond, a steering group was established. This steering group was supported by three working groups and an expert advisory group. These groups working together provided operational and service delivery expertise, along with a broad range of disciplinary perspectives.

The primary purpose of the steering group was the necessity to bring together different strands of existing services already engaged in responding to psychosocial aspects of Covid-19, to ensure that the response was comprehensive, and could be sustained not just in the acute phase, but also in the medium and perhaps longer-term.

It was also considered essential to design flexibility into this response, so that the HSE could respond to new challenges in a robust and timely manner, with agility, effectiveness and efficiency. The steering group developed a structure to facilitate and add value to existing work by re-aligning services and promoting an integrated cohesiveness that addressed the needs of the public and all types of health and social care workers, while recognising the needs of specific priority groups.

The steering group commissioned detailed literature reviews of prior research on the psychosocial aspects of epidemic-like situations and of the more recent Covid-19 literature. An extensive mapping of psychosocial services and supports in the first few months of responding to Covid-19 was also undertaken to identify the coverage, strengths and gaps in our response. The steering group was also informed by the HSE's Psychosocial and Mental Health Needs Following Major Emergencies: A guidance document (2014), which was produced to improve local emergency responses to a major incident.

Although that guide was produced to respond to different types of scenarios, it also assisted in guiding the initial stages of our response to Covid-19. This report therefore builds on those 2014 recommendations within the Covid-19 context of a prolonged national public health emergency and incorporates our early learning from the response to Covid-19.

Integrating these different sources of information and expertise, the steering group developed a framework to integrate the plethora of different responses that were already being, or could be, offered to address the psychosocial consequences of Covid-19. That approach recognised that the majority of the public will cope well with the personal, family, work and societal stresses that may be associated with Covid-19, but that some people will require different levels of support to help them to cope effectively.

The framework resembles an inverted pyramid, with the largest number of people being supported at the broadest width of that pyramid, as follows:

Level 1

Societal wellbeing, resilience and safety, in relation to the nature of the information and community support initiatives that strengthen a sense of positive identify and protection, along with clear directions to other supports.

Level 2

Self-help, which provides the tools and information for personal support for people who are interested and able to avail of it.

Level 3

People-to-people support, which can be provided personally or through a range of virtual and digital modes – this being a particular feature of the response to Covid-19, due to the need for social distancing and infection control procedures. Many of these supports have been provided outside of conventional health services.

Level 4

Primary care and voluntary care services, where more conventional and structured services are provided for the general public and through employee assistance programmes for healthcare workers.

Level 5

Specialist mental health services in community settings.

Level 6

Severe and enduring needs, which may include residential settings. These latter two levels, while relevant to a small minority, include services for people who had pre-existing mental health problems prior to the pandemic, or those who developed significant mental health problems during the course of the pandemic.

There are also other groups who may face particular types of challenges during or after the pandemic, including; children and adolescents, the working-age population, older adults, people with disabilities, family carers, those bereaved during the pandemic, people living in residential care setting and those with drug and alcohol use problems, as well as others often marginalised from mainstream society, such as ethnic minorities, homeless people and asylum seekers.

Healthcare workers have had a special role in responding to and attempting to contain the Covid-19 pandemic. While the health of any occupational group is important in its own right, it has been strategically important to ensure that under difficult circumstances, the mental health and psychosocial wellbeing of all health and social care workers, across all sectors within Ireland, has been supported. This includes HSE employees, those employed in Section 38 or 39 agencies, people volunteering with a health service or psychosocial service provider, or a community service provider, along with anyone providing direct or support services on a health sector site and private healthcare practitioners. This ranges across caterers and cleaners, therapists, doctors and nurses, administrative and technical staff and those who are themselves providing psychosocial support and services to others. The psychosocial support needs of healthcare workers will vary across the course of the pandemic, and a proactive, clear and cohesive approach by management is important in addressing these needs.

The HSE has benefited greatly from well-prepared and strong psychosocial response leadership across its nine regional Community Health Organisations and the lessons learned in response to Covid-19 are now being used to identify key competencies for leading and co-leading both our ongoing and future responses to public health emergencies.

The steering group recommends focusing on a number of key action areas necessary to effectively manage the psychosocial challenges and opportunities arising from the Covid-19 pandemic. This will also enhance preparation in responding effectively to similar future

public health emergencies. Described in detail in this report, the eight action areas recommend that all necessary resources are promptly put in place to:

1. Establish a public health emergency psychosocial response programme with a board to oversee and coordinate implementation of the psychosocial framework described in this document.

2. Re-align existing services to ensure that sufficient appropriate and effective services and supports are available to the public and ring-fence and protect resources that support staff to ensure a sustainable and timely response across all phases of public health emergencies.

3. Identify and tailor psychosocial services and supports to the needs of different priority groups so that they can be assured of equitable access.

4. Ensure appropriate services and supports are available for all workers in health and social care settings, and that their efforts are recognised and appreciated.

5. Embrace recent technological developments that allow services and supports to be delivered online, through digital or telephone means.

6. Establish a research, evaluation and monitoring system that can learn in real time and feed back into the implementation and modification of the psychosocial framework.

7. Promote engagement with and effective communications between members of the public and healthcare workers. This includes providing an appealing and meaningful platform through which the work of the board and programme can be easily identified, understood and appreciated.

8. Prepare to respond to future public health emergencies.

The steering group was very impressed by the commitment and work undertaken by a range of health and social care workers, those from other service sectors, community organisations, volunteers, private and independent organisations as they rose to the unique psychosocial challenges that the Covid-19 pandemic has presented.

In writing this report, the steering group recognised the importance of ensuring a strong systemic response, both within health and across related sectors, without which social inequalities may further disadvantage those already marginalised within society. A systemic approach enhances our ability to succeed in preventing, mitigating and addressing viral outbreaks, other types of public health emergencies and our psychosocial response to them. Our recommendations therefore build on existing population, health and social care staff supports and they are aligned with HSE policies and governance structures.

The success of the psychosocial framework proposed in this report should be regularly evaluated in terms of its readiness, including its ability to provide timely, appropriate, accessible, effective and efficient interventions and supports, through interacting layers of psychosocial responses. The perception from both the public and healthcare workers that this framework is capable, meaningful and clear, will in itself promote greater confidence and resilience in how we respond to Covid-19 as a community.

The psychosocial framework anticipates and welcomes new initiatives, supporting and adopting them through an integrated and comprehensive response, to ensure that all sections of society will benefit. While much has been achieved to date, the continuing challenges presented by Covid-19 also presents opportunities to learn from delivering services in new ways that will augment conventional services in the longer-term, especially in community settings.

Summary of Recommendations



Summary of recommendations

The following section summarises the eight action areas for implementation and their associated recommendations. Please note a baseline implementation plan based on the recommendations below will be provided to the next phase's overseeing body, to support the embedding and sustaining of the recommended changes.

Action area 1:
Oversight and governance structures

1. Maintain the current national psychosocial response project structures, such as the steering, working and expert advisory groups, until the new National Health Sector Psychosocial Programme Board (NHSPPB) is established (See **Section 8.3**).

2. Establish the NHSPPB. Its overall responsibility will be to oversee the effective implementation of the health sector psychosocial plan, represent psychosocial responses at a national level and to drive and support actions, ongoing communication and monitoring.

3. Establish the role of the regional psychosocial lead as a full-time post, responsible for: Overseeing the roll out of psychosocial responses, chairing the Health Service Psychosocial Management Team (HSPMT) driving integration with the acute services, targeting priority areas most impacted by Covid-19 and supporting the implementation of the recommendations of the agreed framework.

4. Identify a group psychosocial co-ordinator for each hospital group. The role of the co-ordinator will be to oversee the delivery of the group's psychosocial responses across each of the group's hospitals, targeting priority areas most impacted by Covid-19, representing the group at a regional level and integrating acute and community psychosocial supports.

5. Where needed maintain and or establish Health Service Psychosocial Management Teams (HSPMTs) to enhance the task of addressing the wider societal needs of the Covid-19 pandemic and its anticipated prolonged effects.

Action area 2:
Re-alignment of existing services towards the implementation of the proposed psychosocial framework

6. The Covid-19 psychosocial response framework based on a layered care approach will form the basis for strategic and operational planning, resourcing and funding for the health sector's psychosocial response.

7. Re-configure and ring-fence funding for a psychosocial response based on the proposed psychosocial framework and to fund elevated robust psychosocial responses to Covid-19 for: 1) Direct community and workforce provision, 2) Extending of provision, 3) Oversight and co-ordination of services, 4) Direct psychosocial interventions, and 5) Research and additional provisions.

Action area 3:
Priority groups

8. Planning processes to remain informed and aware of the specific needs arising within particular settings and population groups, in line with evidence arising nationally and internationally with respect to the impact of COVID-19 for priority groups, as follows: 1) Older adults, 2) Family carers, 3) Bereavement care, 4) People with disabilities, 5) People using mental health services, 6) Children and young people, 7) Marginalised groups.

9. Planned responses for the public, under the psychosocial framework to reflect best practice, quality and align to existing strategy and policy as appropriate.

Action area 4:
Healthcare workers

10. Develop and agree regional and national partnerships between the regional psychosocial leads and Employee Assistance Programme (EAP) and or Workplace Health and Wellbeing Units (WHWUs) for the duration of the current and future public health emergencies.

11. Develop an employee recognition programme framework in recognition of the efforts of healthcare workers (HCWs) during a national public health emergency.

12. Establish consultation fora to inform and guide best practice for staff, psychosocial resources and processes for all health sector organisations (including Section 38 and 39 agencies and the private sector).

13. Investment recommended by the national board should focus on longer-term staff health and psychosocial support, including preventive measures for public health sector staff.

14. Sustain and develop psychosocial awareness and expertise and build on existing psychosocial materials and initiatives to address the emerging training and educational needs of healthcare staff.

15. Health sector organisations should provide interventions and support in line with the changing psychosocial needs of HCWs across the different phases of the pandemic, informed by relevant research evidence.

Action area 5:
Technology and innovation

16. Psychosocial service delivery models should incorporate online and phone-based supports and services in keeping with the work of the National Telehealth Steering Group (NTSG).

17. Delivery should support, interact with and promote the HSE National Health Library and Knowledge Service and its work on preparing and collating a wide range of evidence summaries to guide the health sector response to Covid-19.

Action area 6:
Research, evaluation and monitoring

18. The national board to establish and maintain an evaluation and monitoring system which contributes to and informs both the national board and regional HSPMTs to ensure the psychosocial response is evidence-informed and needs-based.

19. Commission and prioritise psychosocial research into our learning from the Covid-19 experience and continue to review and disseminate clinical and non-clinical based national and international evidence.

Action area 7:
Communications and engagement

20. National communications initiatives to update and resource the national psychosocial communications plan, to support the implementation of both local and national communications with specific focus on: 1) Online communications, 2) Clear and joined up signposting, 3) HCWs, and 4) the general public.

Action area 8:
Future preparedness for national public health emergencies

21. The Covid-19 psychosocial response and associated recommendations should form the basis of preparedness for and the response to future national public health emergencies.

Acknowledgements



Acknowledgments

Acknowledgement and thanks are due to the members of the National Health Sector Psychosocial Response, steering, working and expert advisory groups for their input, guidance and advice in the development of the psychosocial framework and the production of this guidance document.

Acknowledgement and thanks go particularly to the CHO psychosocial leads, CHO bereavement support leads, the CHO mapping liaisons and pilot group, hospital group psychosocial responders, HSE National Library and Knowledge Service, HSElive staff, and the national communications team and press office, whose input and support is noted with thanks.

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Section 1

Section 1: Introduction

1.1 Background

Covid-19 was first identified in December 2019 in Wuhan[1], China, from where it rapidly spread to other countries. By 30 January 2020, the World Health Organization (WHO) declared Covid-19 to be a 'Public Health Emergency of International Concern' and by 11 March 2020, a pandemic. Subsequently, Ireland responded by closing all schools, colleges and crèches on 12 March, and implemented further measures as announced by the government on 27 March.[2]

The Covid-19 pandemic has caused an unparalleled health emergency across our society and is having ongoing psychological and social wellbeing impacts on individuals, communities and Irish healthcare workers (HCWs)[3]. In particular, these effects have been amplified by the high mortality rates in acute hospitals and long-term stay settings, such as residential and nursing homes.

At the start of this pandemic, the WHO issued advisory notes on the significant psychological and social impact of public health emergencies and epidemics on individuals and communities[4]. During the Covid-19 crisis individuals and communities across the country experienced a range of responses, including worry, anxiety, isolation, grief, anger and fear, but also positive experiences such as enjoying a slower pace of life, more family time, more autonomy from work, and no commute to work, as a direct and indirect result of the pandemic's disruption to daily life. These reactions are seen as understandable and appropriate for people faced with uncertainty and change caused by an emergency situation.

The impact of emergencies such as Covid-19 can be felt, to varying degrees, across all population groups. Research shows that individuals will respond and cope in different ways, depending on multiple factors, but with reassurance, practical support and time, the majority of people will cope well, predicting that 85 per cent of the general population will effectively manage any psychological difficulties they may experience in the short-to- medium term (Durcan et al, 2020; Allan et al, 2020).

Literature published on this impact also highlights that for some people significant psychological and social problems may arise, resulting in longer-lasting distress (Durcan et al, 2020; Allan et al, 2020), which, without appropriate support, can lead to mental health problems such as depression, post-traumatic stress disorder, anxiety and addiction. Such impact may also cause personal relationship, family, domestic or work difficulties.

At the beginning of the Covid-19 crisis and knowing its potential impact on our wellbeing, the HSE enacted a comprehensive psychosocial response at a national level and across the acute hospitals and local Community Healthcare Organisations (CHOs).

At a national level current services and innovations were aligned and scaled up to provide supportive interventions that incorporated emotional care and practical help such as Tele-Health, Occupational Health, Employee Assistance Programme (EAP), Health and Safety and National HR.

1 The WHO became aware of a cluster of cases of 'pneumonia of unknown cause', in Wuhan, China in December 2019. In January 2020 it was determined that this cluster was caused by a novel corona, which was named Covid-19 in February 2020. See Timeline of WHO's response to COVID-19 (June 2020) at **https://www.who.int/news-room/detail/29-06-2020-covidtimeline**

2 **https://merrionstreet.ie/en/News-Room/News/Speech_of_Taoiseach_Leo_Varadkar_27_March_2020.html**

3 The term 'Healthcare Worker (HCW)' is used in this document to refer to health and social care workers who work in a range of acute, residential and community settings.

4 World Health Organization (2020), Mental health and psychosocial considerations during the COVID-19 outbreak, 18 March 2020 (No. WHO/2019-nCoV/MentalHealth/2020.1), World Health Organization.

At CHO level, local psychosocial response teams were activated. The CHO psychosocial[5] response was required to meet the varying psychological and social needs of the general public, from child to older adults, who were impacted directly and indirectly by Covid-19. HSE priorities at CHO level in the early phase of Covid-19 included psychosocial supports for HSE staff, nursing home management and staff in HSE residential units for older persons and private nursing homes[6].

Across the HSE Acute Hospital network, psychosocial responses were mobilised to support staff and members of the public. For staff, some of these psychosocial initiatives focused on peer-to-peer support, team and adverse event supports. For the general public these initiatives focused on providing bereavement services for patients and families, promoting connection and virtual communication between isolated patients and families, and psychosocial support around distress caused by isolation and visiting restrictions.

It is important to note that the psychosocial response to Covid-19 was across the full spectrum of society, from small local community groups to large national voluntary organisations. Many of these groups spontaneously adapted and innovated, to provide a wide array of psychosocial and wellbeing services for different sections of our society.

As the acute health crisis continues, the psychosocial impact of the pandemic may become more apparent, with increases in demand for varying levels of accessible psychosocial supports emerging over the coming months. The WHO (2020) highlight that an individual's ability to cope with potential levels of distress may be immediate or indeed felt at different time intervals over the course of the pandemic and at the post-pandemic phase.

1.2 National Health Sector Psychosocial Response Project

To actively prepare for the potentially detrimental psychological and social wellbeing effects of the outbreak, a formal project group under the HSE's Covid-19's Integrated National Operations Hub (INOH), was established, under the auspices of the Chief Operations Officer, Ms Anne O'Connor. This project group was tasked with the development of the National Health Sector Psychosocial Plan in response to Covid-19.

This group was chaired by Dr Cathal Morgan (Head of Operations – Disability Services, Community Operations), and from the beginning, the group designed into its ongoing processes three supporting project structures to ensure active representation and engagement across the health sector:

- **The steering group** – whose role was to initiate and oversee the project.
- **Three working groups** – two of these working groups were focused on providing cross sectoral expertise and input for each of the two main target groups as outlined below. The third working group was to provide research and technical support and advice for both the other working groups and the steering group.
- **An expert advisory group (EAG)** – whose role was to provide broader cross-sectoral, priority group and inter-disciplinary advice on the project's approach and direction.

The overall aim of each of these groups was to bring together the different strands of existing services and structures across the health sector, to ensure that there was an integrated strategic framework in place to effectively plan the health sector's psychosocial response to Covid-19 for both the medium and longer term.

5 As defined in Section 2, paragraph 1.
6 See Bereavement Guidance document and report on CHO Psychosocial leads for examples.

Specifically, the project was focused on the psychosocial response needs for:

- **The public** – members of the public who may have been exposed to a range of psychological distress due to Covid-19, and the individual and societal challenges it presents. In particular, at risk groups such as older persons and the bereaved etc.
- **Healthcare workers (HCW)** – the mental health and psychosocial wellbeing of all health and social care staff across the HSE and related service providers. It is recognised that all workers employed across health and social care sectors are involved in the systemic response to crisis situations. It is likely therefore that some staff may have experienced significant distress as they deal with both the individual and or organisational challenges presented by Covid-19.

1.3 About this report

This report provides guidance and direction for HSE leadership, staff and associated partners on an integrated national health sector framework, which will enable sustainable support for the psychological and social wellbeing needs of individuals, families, communities and HCWs, arising from the pandemic, including during the recovery phase. It ensures that the critical psychosocial part of the country's response to the pandemic is promoted, supported and embedded within all Covid-19 planning and on-the-ground delivery.

It also builds on the foundation provided by the HSE's Psychosocial and Mental Health Needs Following Major Emergencies: A guidance document (2014). That document was developed to guide local emergency response to a major incident, while this report updates the previous report's recommendations, but within the context of a national public health emergency, which Covid-19 has proven to be.

To develop this framework and its recommendations, the project group consulted with a wide range of individuals, groups and organisations who provided the relevant and necessary perspective required for the framework and recommendations. These outreach activities included:

- Building in as part of the project's structures and processes, cross-sectoral engagement and active involvement of subject matter experts.
- Conducting a review of current psychosocial structures and governance arrangements at CHO level.
- Working with local CHO liaisons to conduct a comprehensive mapping and analysis of current and Covid-19-related psychosocial interventions at a CHO level.
- Conducting a comprehensive national mapping and analysis of current and Covid-19- related psychosocial interventions across national organisations, professional bodies and care groups.
- Working with the EAG on gaining their cross-sectoral perspectives on the system's learning from the effects of Covid-19 to date.
- Reaching out to national and international research bodies and or teams and the national library service to review relevant research.

See **Appendix 1** for a list of organisations and areas of expertise that were involved in either the mapping and or consultation stages.

1.3.1 Report structure

To comprehensively address the report's remit, it has been divided up into eight key sections, as follows:

- **Section 1** –context, vision and objectives.
- **Section 2** – a description of the psychosocial impact of a pandemic.
- **Section 3** – a summary of the current research evidence specifically related to the Covid-19 pandemic.

- **Section 4** – an overview of the project team's specific learning to date in terms of the current health sector's applicable polices, structures and system experience, in response to the Covid-19 pandemic.
- **Section 5** – the national psychosocial response guidance principles and framework.
- **Section 6** – responding to the needs of the general public.
- **Section 7** – responding to the needs of healthcare workers.
- **Section 8** – supporting recommendations for the implementation of the framework.

1.4 Vision and framework objectives

To guide strategic and operational planning, the HSE will deploy an inclusive, system-wide approach across all services, both HSE and non-HSE, community, acute and long-term residential care settings, to implement an integrated and coordinated psychosocial response framework.

The HSE will also build on the 2014 guidance document, to ensure as far as possible, that all individuals, families, HCWs and communities experiencing or at risk of experiencing psychosocial, emotional, social and or mental health impacts from the pandemic will receive a continuum of supports from health, social care and primary care community services, along with other community service providers who understand the issues and who recognise and respond appropriately to the needs of those impacted.

Section 5 of this report outlines the guiding principles of the framework, but the specific objectives of this framework and its recommendations are to:

Focus on the impact and psychosocial responses related to the Covid-19 pandemic.

Build on the HSE's Psychosocial and Mental Health Needs Following Major Emergencies: A guidance document (2014), but not stand it down. This report is specifically related to the Covid-19 crisis and future similar national public health emergencies. The 2014 document addresses localised major emergencies and is still applicable.

Provide HSE leadership, local management, partner organisations and related teams with clear direction and recommendations on how psychosocial supports can be maintained and improved over the medium and longer term for:

- the public in general
- all healthcare workers from all occupations employed in services

Provide a framework on how to consolidate existing policies, structures, and mobilise ongoing psychosocial work into a whole system response. The framework will build on this work and experience, which has served the country well to date, and will support further improvements. It will not replicate, replace or slow down current work.

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Provide a framework and recommendations which outline how all areas within the healthcare sector, both HSE and non-HSE can work together, promoting connectivity and providing national and local integrated psychosocial responses.

Assess and recommend the nature and extent of resources required to implement an effective population-wide response to a pandemic or similar situation.

Recommend an effective and efficient response that provides a multi-faceted psychosocial approach, delivered through a range of procedures and service providers.

Foster a culture of hope, resilience and community connectedness.

Pay particular attention to the needs of priority groups, who may need immediate support, such as older people, families and healthcare workers directly impacted by bereavement during the pandemic.

Ensure that the needs of marginalised groups (such as homeless people, people with disabilities, people in direct provision) are taken into account, so that they receive the same level of access to quality services and supports made available to other people.

Provide oversight of current activities and interventions that are responding to the psychosocial needs of priority groups, and ensure the greatest effectiveness in using these resources.

Support existing community and acute staff who are currently delivering psychosocial supports.

Support HCWs and the public with a model of care that builds on the positives achieved during Covid-19; with all areas working together, increasing innovative measures and adapting current practices and structures which contribute to the longer-term strengthening of health services.

Deploy new technologies and telehealth advances that contribute to the longer-term strengthening of health services.

Align recommendations to the planning priorities under national policy (such as SlainteCare, Healthy Ireland, Sharing the Vision: A Mental Health Policy for Everyone, Connecting for Life: Ireland's National Strategy for the Reduction of Suicide and Self Harm) and HSE agreed priorities under the Corporate Plan 2020–2025.

Prepare for future pandemics or other national public health emergencies based on experiences to date, focusing on mobilisation during the first weeks of a new pandemic occurring.

Note: This report does not supersede any existing governance structure or legislative and regulatory requirements. It should be considered to act alongside them and support their correct implementation, providing additional guidance and information relevant to combating Covid-19. It is critical to note that obligations arising for employers under the relevant Health & Safety Act(s), employee welfare regimes and relevant service arrangements between the HSE as funder and service provider remain in place and supersede all guidance provided here.

Section 2

Section 2: Psychosocial responses to pandemics

This section provides an insight into the multiple factors involved in understanding the psychosocial impacts of a pandemic at a population level, and consequently the factors that need to be considered in developing an effective national Covid-19 psychosocial response.

2.1 What does 'psychosocial' mean?

Psychosocial includes the full spectrum of psychological, emotional, social, relationship, behavioural and cognitive experiences of people. A psychosocial approach refers to the process of planning and delivering a coordinated range of health and social care responses to these experiences during a time of major emergency, such as a pandemic[7]. Psychosocial planning is seen as an essential response to appropriately manage the consequences of a major emergency (WHO, 2020).

The United Nations Inter-Agency Standing Committee (IASC) Guidelines propose that the term mental health and psychosocial support (MHPSS) may be used 'to describe any type of local or outside support that aims to protect or promote psychosocial wellbeing and or prevent or treat mental disorder.' This term is now widely used and accepted by practitioners in the field. This definition reflects a pragmatic approach to collaboration between a wide range of actors working in this field, approaching mental health and psychosocial issues from different perspectives.

As stated in the introduction to the IASC Guidelines, 'the composite term mental health and psychosocial support (MHPSS) serves to unite as broad a group of actors as possible and underscores the need for diverse, complementary approaches in providing appropriate supports.'

Psychosocial factors are involved in how individuals respond to threatening situations, both in terms of how they seek to cope with the actual threats, and the consequence that such threats have on their own wellbeing. In the case of a pandemic, the psychosocial response at population level may shape not only the spread of the disease, but also the occurrence of individual emotional distress (Taylor, 2019). Indeed the broader psychosocial response can also influence the extent to which social order, or social disorder and division, impact on the consequences of the threat.

Some of the different reasons why we need to develop a psychosocial approach in emergencies such as pandemic situations include:

- The highest attainable standards of mental and physical health in any given situation need to be maintained, and our health service has to plan to ensure that this is provided during a pandemic, especially if the pandemic is prolonged.
- Maintaining the psychosocial wellbeing of citizens enables them to continue to perform well in personal, family and community relationships, or in their job roles (including healthcare workers), as well as preserving behaviours that protect from infection.
- The impact of major emergencies such as a pandemic on mental health, and potentially on levels of self-harm and suicide also needs to be considered. Overall levels of alcohol consumption, domestic violence, loss of employment and financial stressors may increase with the potential to worsen existing

7 These definitions are based on the 2014 HSE Guidance document Psychosocial and Mental Health Needs Following Major Emergencies, prepared by a multi-agency group for the HSE National Vision for Change Working Group.

difficulties or create new difficulties for people. Clear and effective psychosocial responses have the potential to avoid these negative outcomes (Gunnell et al, 2020).

2.1.1 Stress and stressors

The experience of stress involves a number of interacting elements. The HSE Policy for the Prevention and Management of Stress in the workplace 2018 defines stress as 'a mental and physical condition which results from pressure or demands that strain or exceed persons capacity or perceived capacity to cope'. Major and minor events may all act as stressors. Whether they actually result in the personal experience of stress is determined by a range of mediators, such as how people think about the stressor (cognitive appraisal), their personal coping styles and resources, and social support. If the perceived demands exceed the perceived capacity of these mediators, then a stress response is experienced. This would involve some or all of the possible emotional, cognitive, behavioural and physical elements.

Psychosocial factors can significantly influence the impact of mediators on levels of stress response. At low levels, stress can be beneficial, motivating people to change certain behaviours, enhance their performance or focus more on addressing the source of the stress. At higher levels stress can be debilitating, resulting in both acute and prolonged psychological, social and physical problems (Taylor, 2019).

2.1.2 Trauma and resilience

In the context of traumatic events, the majority of the population maintain healthy functioning or resilience (Bonanno et al., 2011). Traumatic events vary in terms of type, severity, and duration, but even at the more severe end of stress exposure, post-traumatic stress disorder (PTSD) is typically observed in only 5 per cent to 10 per cent of exposed individuals. In the case of bereavement, commonly around 10 per cent to 15 per cent of people exhibit complicated grief reactions.

There are a number of common trajectories of response to potentially traumatic events. Resilience is associated with transient reactivity (symptoms), little impairment and healthy functioning (being able to fulfil common commitments and routines). Most people respond to even the most extreme stressors with minimal disruptions in overall functioning.

Another trajectory is Recovery, which is associated with elevated reactivity and some degree of functional impairment (for instance, difficulties meeting some role obligations), with a gradual return to normal levels of functioning. It is important to note that resilience and recovery are specific (independent) trajectories, and can occur in response to a wide range of acute stressors.

Chronic distress, is associated with a significant elevation in reactivity and functional impairment, possibly persisting for years after an event. Delayed distress is associated with moderate to elevated reactivity soon after the event, but this tends not to be of sudden onset but rather gradually worsens over time. Less common, but sometimes observed trajectories include continuous distress, associated with impairments that predate a traumatic event, and distress-improvement, where elevated levels of distress prior to the event are actually subsequently reduced (Bonanno et al, 2011).

Those factors most associated with resilience across stressors are personality (such as high perceived control, low emotional negativity, low levels of rumination and higher levels of self-enhancement behaviours), demographic factors (older, well educated, and males performing better), exposure level (the nearer the exposure the greater the distress), social support (higher levels of perceived support from family, friends or community are associated with more resilience) and

economic factors (such as a loss of resources due to unemployment being associated with reduced resilience) (Bonnano et al., 2011).

Prior exposure to stressful events which resulted in negative emotional reactions are associated with negative reactions to subsequent events, but prior positive coping may also be associated with good coping in response to future stressful events. People can build their resilience and learn new skills at any stage in their life, even in the aftermath of a pandemic. A positive world view prior to an event and a propensity to easily display positive emotions (for example, love, interest, gratitude) are also associated with resilience.

2.2 Epidemic and pandemic situations

The 2014 Psychosocial and Mental Health Needs Following Major Emergencies – A guidance document, made recommendations about implementing the development of local psychosocial response plans for community healthcare areas. The 2014 guidance document was primarily developed to help ensure an immediate and effective response to acute, discrete and short-lived disaster scenarios. While that guidance document strongly informed the initial HSE response to Covid-19, the characteristics of a pandemic present some additional and distinct challenges for psychosocial planning.

The last two decades have seen a number of viral epidemics, such as severe acute respiratory syndrome (SARS) (2003), H1N1 influenza (2009), Middle East respiratory syndrome (2012), and most recently Ebola virus disease (2014). These have all presented psychosocial as well as viral challenges. Based on the research from these experiences and other major public health emergences, and building on the 2014 guidance document, there are three groups to consider with regard to psychosocial responses: healthcare workers, the general population and those personally infected by the virus.

2.3 Priority groups to consider in pandemic situations

As stated in 2.2, based on research from public health emergencies, there are three groups in particular that should be considered closely in psychosocial planning – healthcare workers, the general population and people directly impacted, such as those infected by a virus. These groups are considered briefly below. Other population groups, particularly marginalised groups, will be considered later in this report, with specific reference to Covid-19.

2.3.1 Healthcare workers

In supporting the psychosocial wellbeing of healthcare workers, it is important to be aware of both risk and protective factors, which influence the potential impact of Covid-19 on staff. Risk factors are associated with a higher likelihood of negative outcomes, while protective factors reduce the impact of a risk factor or are associated with a lower likelihood of negative outcomes. Risk and protective factors exist at individual, community, work and societal levels.

Irish healthcare workers face a number of interacting personal and work-related risk factors, and the impact of Covid-19 may affect their role with their colleagues in a number of ways:

- Having increased direct and indirect contact with the public
- Remaining in role while others are redeployed
- Cocooning
- Being asked to work from home
- Having increased or new responsibilities (managers) and increased workloads (senior managers)
- Losing a colleague and or service-user to Covid-19
- Working with at-risk groups (including nursing homes, homeless services, Travelling Community and direct provision)
- Working in high pressure acute and community settings under changed working conditions.

Kisely et al's (2020) review of thirty-eight empirical studies from a range of countries assessed the psychological wellbeing of healthcare workers responding to these situations.

Socio-demographic factors most associated with psychological distress included being; a woman, younger and a parent of dependent children. The fear of infecting, or having an infected family member, and having to undertake prolonged isolation was also linked to greater distress, as was having greater fear of infection, prior physical or mental health problems or a history of substance-abuse.

Those who had been in more direct contact with infected patients, those less experienced, and those working part-time, were more affected. Those who had been in direct contact with infected patients were almost twice as likely to experience acute stress or post-traumatic stress, compared to staff not directly in contact with infected patients.

In general, nurses reported more psychological distress than doctors. Factors associated with reduced distress included better staff training, better education, stronger perceptions of organisational support, peer support and clear communication, compensation for extra work and provision of appropriate protective clothing.

Healthcare workers have been identified as being at risk of 'moral injury' as a consequence of the Covid-19 pandemic. Moral injury is defined as the profound psychological distress which results from actions, or the lack of them, which violate one's moral or ethical code, such as having to choose which patient to save as a priority.

Potentially morally injurious events can lead to negative thoughts about oneself or others as well as deep feelings of shame, guilt or disgust. In turn, these can contribute to the development of mental health problems, including depression, PTSD and anxiety[7].

2.3.2 General population

Psychological distress can manifest in many ways including sadness, anxiety, hopelessness and frustration (WHO, Mental Health Emergencies). While many people may be challenged by Covid-19, the majority will cope effectively with it in the short-to-medium term. But a proportion of people are expected to experience longer lasting mental distress (Durcan et al, 2020; Allan et al, 2020) with mental health problems such as anxiety, depression, post-traumatic distress disorder and complex grief reactions occurring for some people (Holmes et al.2020).

Lee et al (2006) studied the psychological impact of SARS. The residents in high SARS-prevalent regions exhibited more intrusion, avoidance, and hyper-arousal, and a greater degree of overall post-traumatic disturbance, regardless of age. However, the likelihood of those experiences reaching clinically significant levels of probable PTSD was significantly higher in older people. The authors also stress the importance of mental health aftercare in the post-epidemic period of disease epidemics.

By contrast, Lau et al (2008) also investigating SARS in Hong Kong reported that while older people who lived in severely infected districts reported significantly lower levels of subjective wellbeing, those levels remained within the normative range. Interestingly, they suggest that a major mitigating factor was an increased sense of community-connectedness that arose from the response to SARS. This indicates how an epidemic may have impacts on individuals, the broader community and at societal level.

Muldoon et al (2019) have highlighted the important role that strong social identity can play in helping people to manage traumatic situations. Furthermore, the development of new positive social identities – such as a community's response to a viral pandemic – can in itself be a meaningful source of resilience.

2.3.3 People infected during a viral epidemic

For those who have been infected during an epidemic, the majority will not require formal support from mental health services. However, a minority may develop mental health problems either during the infection period, or afterwards. A review of over 2,000 studies on this topic by Rogers et al (2020), found that during an acute viral illness, some patients reported confusion, depressed mood, anxiety, impaired memory and insomnia. In the post-viral illness stage, depressed mood, insomnia, anxiety, irritability, memory impairment and fatigue were also reported in a minority of cases. The meta-analysis indicated that in the post-illness stage the point-prevalence of post-traumatic stress disorder was 32·2 per cent, depression was 14·9 per cent and that of anxiety disorders was 14·8 per cent, although these may have been co-occurring.

2.4 Technology-enabled support and access to services

Another characteristic difference and challenge presented by a pandemic is that, internationally, access to psychosocial services is unevenly distributed. Furthermore, the WHO, IASC and this report's recommended psychosocial response framework all advocate for psychosocial supports which go beyond individuals and are orientated to communities and society at large. In this context, the European Public Health Association has been encouraging digital health systems (Sharp, 2019) and this is in keeping with the 'stay left, shift left' prevention-focused philosophy of eHealth Ireland (ehealthireland.ie).

There is also a significant body of evidence regarding the efficacy of online mental health interventions (such as Tuerk et al. 2018 and Berryhill et al. 2019). These interventions can range from psychoeducation, to self-help, peer support and online therapies, all built on accessible, reliable public health information and clear signposting.

The development of a layered psychosocial response framework in the context of either pandemic or disaster response scenarios should be informed by recent developments in empirically derived dimensional models of mental health (Kotov, et al 2017) and by trauma informed approaches (Johnstone et al, 2018). Inchausti et al (2020) caution that in crisis situations there may be an oversupply of potentially non-evidence based psychological interventions, highlighting the importance of the planning, coordination and oversight functions of psychosocial responses.

Section 3

Section 3: Research evidence from the Covid-19 pandemic and other public health emergencies

The HSE National Health Library and Knowledge Services Evidence Team began preparing evidence summaries related to all aspects of the treatment, management and response to the physical and psychosocial impacts of Covid-19 since the beginning of the crisis. Whether responding to expressed clinical need or in collaboration with a broad range of health and social care professionals, topics for review have been identified on an ongoing basis and draft evidence summaries have been reviewed by subject matter experts prior to publication. While the evidence summaries draw on the best available research from across the world, particular attention is paid to Irish research and the Irish context.

Key evidence emerging from eleven separate research reports is highlighted in this section to inform the recommendations of this report. The research report titles are listed in **Table 1**. Where appropriate, additional research highlighted by members of the project steering group has also been referenced (see **3.5**).

Table 1: Evidence summaries prepared by the HSE National Library Team
How effective are early psychological interventions in preventing posttraumatic stress disorder in health workers exposed to traumatic scenarios in the context of the current Covid-19 pandemic? [v2.1]
Is there any evidence relating to effective psychological or psychosocial interventions for the general public and those recovering from Covid-19? [v1.0]
What psychological supports are required to assist health workers during the Covid-19 pandemic? [v2.0]
What is the psychological impact of Covid-19 on patients recovering from the disease who need rehabilitation? [v1.0]
What is the impact of the Covid-19 pandemic on suicide rates? What impact does social isolation have on the incidence of suicide and self-harm?
What impact is cocooning and the increased level of anxiety due to Covid-19having on the mental health of those identified as at-risk due to a chronic disease [immunocompromised]? What interventions have been identified and deemed efficacious? [v1.0]
What is the role of social work and family liaison during global pandemics [such as Covid-19]?
What are the palliative care considerations for Covid-19 patients at end-of-life?
What is the impact of the coronavirus pandemic on the mental health of nursing home residents?
How can telehealth best support Health and Social Care Professionals' response to the Covid-19 patient?
What are effective psychosocial responses based on regional or national response plans during, and following, public health emergencies? (in editing phase as of 31 July 2020)

3.1 Evidence for psychosocial response plans and interventions

Some important themes emerged from an evidence summary which reviewed the effectiveness of regional and national psychosocial response plans similar to the present framework (Clark and Delaunois, 2020). Specifically, international literature underlines the importance of prioritising the needs of groups within the population which are likely to be impacted most (Taylor et al, 2020 and Yoon et al 2016 in Clark and Delaunois, 2020). The theme of information has also been identified as critical to the psychosocial wellbeing of the population. This relates both to 'misinformation' (as propagated on social media) and to the importance of reliable and trustworthy public health messaging. One author suggests that having knowledge, or perceiving oneself to have knowledge, leads to increased happiness and a stronger sense of control (Yang and Ma, 2020 in Clark and Delaunois, 2020).

The key recommendations from current guidance and research (based on Clark, H. et al 2020 and Reynolds J. et al 2020) around mitigating Covid-19 related anxiety include:

- regulating exposure to print and broadcast news media
- maintaining a strong social network by connecting with others in safe ways such as online, by phone or in person while adhering to public health advice
- looking after one's body and avoiding unhealthy coping strategies such as excessive use of alcohol
- focusing on self-care techniques, including mindfulness.

Those with clinically significant difficulties with mood, anxiety, post-traumatic stress disorder or other psychological difficulties should be referred to local psychological therapy services or specialist psychological services in physical health, critical care or trauma, where available. Those with significant cognitive difficulties should be referred to specialist neuro-rehabilitation or neuropsychology services. These supports would be in addition to the psychosocial support provided by family caregivers and broader social support networks.

Interventions that may help individuals cope with mild psychiatric symptoms related to the Covid-19 pandemic, include limiting one's intake of print and broadcast news about the pandemic as well as maintaining routines and structured activities such as exercise. Healthcare workers in particular may benefit from private, on-demand access to mental health professionals who can address sources of anxiety, distress and other emotions related to caring for patients. Healthcare workers will also have access to internal employee assistance supports and services. Individuals with moderate to severe symptoms can be treated by their primary care provider or referred to a mental health specialist.

Ho et al. (2020) advocate the need to have a nationwide psychological intervention plan, and suggest six initiatives that should be incorporated:

- identification of high-risk groups
- improved screening of psychiatric conditions
- nature and content of psychological intervention
- more support for healthcare workers
- accurate dissemination of health and related information to the public
- integration of hospital and community resources.

While adopting this guidance on psychological interventions to alleviate anxiety and related psychological difficulties during a pandemic, research evidence has also been reported on the modes of intervention. In particular, a summary of evidence supporting the use of telehealth by health and social professionals highlighted some key successes.

The 'In a nutshell' section of the evidence summary reported the following:

> *'This pandemic has triggered an unprecedented demand for digital health technology solutions and has revealed successful solutions such as screening and tracking; prioritising the use and allocation of resources; designing targeted responses; and exploring alternatives to face-to-face triage and visits.'*

Advantages of telehealth include the ability to rapidly deploy large numbers of providers, facilitate triage so that frontline providers are not overwhelmed with new presentations, supply clinical services when local clinics or hospitals are damaged or unable to meet demand and decrease the risk of communicable diseases which are transmitted by person-to-person contact.

Although concerns exist around privacy, safety and technical issues, studies have shown that both patients and staff are satisfied with the outcomes of using such technology (Reynolds, Barrett and Leen, 2020). However, more research is needed as some individuals will opt out of using technology-delivered services, as has been found during the Covid-19 emergency when some mental health service users opted to wait for face-to-face services to be available. This highlights the importance of direct human contact in addressing mental health concerns and may also highlight variation in availability of and comfort in using technology. Further limitations to the use of telehealth have also been identified. Some consultations, particularly for physical health conditions, require physical examinations and diagnostics which cannot be done remotely. Telehealth solutions are also unlikely to be suitable in the assessment of and intervention with children with developmental needs.

3.2 The psychosocial impact on people with or recovering from Covid-19

The following is from the evidence summary completed by Reynolds J. and Leen B., 2020, titled 'What is the psychological impact of Covid-19 on patients recovering from the disease who need rehabilitation?' and from the report by Clark, H. et al 2020 and Reynolds J. et al 2020 titled 'Is there any evidence relating to effective psychological or psychosocial interventions for the general public and those recovering from Covid-19?'.

There is limited data on the psychosocial impact of Covid-19 on patients recovering from the disease. Available studies so far list reduced sleep quality, depression, anxiety and post-traumatic stress disorder (PTSD) as the main symptoms. Evidence from previous SARS and MERS epidemics support this pattern, as do studies looking at survivors of critical illness. Follow-up data in these patient groups reported symptoms of anxiety, depression and PTSD, ranging from 15 per cent to 44 per cent (Sheehy, 2020 in Reynolds and Leen, 2020). One recent multi-centre Chinese study found self-reported PTSD symptoms in 96 per cent of recovered Covid-19 patients (Bo Ho et al, 2020 in Reynolds and Leen, 2020).

During Covid-19, a small number of randomised controlled trials have been undertaken on an internet-based intervention for depression and anxiety; progressive muscle relaxation for anxiety and sleep quality; and effects of respiratory rehabilitation on psychological function in older person patients. These studies showed positive results, but patient numbers were small, and benefits were mild. Recommendations are to anticipate a high prevalence of depression, anxiety, and PTSD symptoms, while particular attention should be paid to the needs of those with pre-morbid psychiatric illness, healthcare workers, and those who have been treated in intensive care (Liu et al, 2020 and Wei et al, 2020 both referenced in 'Reynolds and Leen 2020').

All patients with significant psychological, cognitive, functional or physical difficulties following hospitalisation for severe Covid-19 should be given access to a structured, multidisciplinary rehabilitation package. This should be provided in an integrated way by physiotherapists, occupational therapists, practitioner psychologists, nurse specialists, doctors and other multidisciplinary team members such as speech and language therapists and dieticians where relevant (British Psychological Society, 2020 in Clark et al, 2020).

3.3 The psychosocial impact of Covid-19 on vulnerable groups and people in difficult circumstances

A number of evidence summaries were completed which addressed the psychosocial impact of Covid-19 on vulnerable groups, including people with chronic health conditions who may be immunocompromised and are cocooning; people receiving palliative care and their families; adults residing in nursing homes. It should be noted that the gathering of evidence relating to the impact of Covid-19 on priority groups will be ongoing and the information reported here is not intended as definitive, but merely reflects the evidence available to date. A more detailed discussion of specific populations and priority groups is included in Section 6 of this report.

The necessity to remain in quarantine or to cocoon to protect physical health has been highlighted as having a significant negative impact on psychological wellbeing. Research points to quarantine and social isolation as contributors to frustration, boredom, low mood and depression, while anxiety, sleep disturbance and stress are also common among people with chronic health conditions during pandemics (Lynch et al, 2020).

The particular stresses of delivering effective palliative care in the context of a pandemic have been highlighted by the WHO and in literature from countries most affected by Covid-19 to date. The WHO reported the similarities between the principles of humanitarianism and palliative care relating to the relief of suffering; respect for the dignity of all people; support for basic needs and accompaniment, even during the most difficult of times. Guidance from the General Medical Council in the United Kingdom acknowledges the need for adaptability and for doctors to work outside specific areas of training and expertise in ensuring the delivery of palliative care in exceptional circumstances. A paper on palliative care is reported in the evidence summary (Ryan and Leen, 2020), asserting that governments must urgently recognise the essential contribution of hospice and palliative care to the Covid-19 pandemic, and ensure these services are integrated into the healthcare system response. It should be noted that this emerging evidence will complement the existing guidance in the Irish context on palliative care, including the model of care developed on adult palliative care services (HSE and College of Physicians – Adult Palliative Care Services Model of Care for Ireland 2019).

The HSE evidence summary exploring mental health impacts on older nursing home residents (Madden and Leen, 2020) describes an extremely challenging dynamic. Pre-existing concerns for older people such as loneliness and a sense of abandonment have been exacerbated by the lack of personal interaction and familiar human contact for residents experiencing dementia. The situation has been described as follows in the evidence summary:

> *'An attempt has been made to replace direct contacts with the use of technology; however, such provision has limited effectiveness on residents with dementia who need social contact or a nearby voice. In some cases, serious discomfort manifests itself as delirium superimposed on dementia; in particular, a hypokinetic type, with consequent refusal of food and difficulty getting out of bed. Older residents who are cognitively intact also breathe the atmosphere of anxiety and anguish.'*

This set of circumstances is made worse by public discourse highlighting the vulnerabilities of older people in nursing homes and characterising the residents as helpless. This development has been described as stigmatising and ageist, leading to a further sense of isolation amongst older people.

While the HSE Library Service evidence summaries have explored the impact of the pandemic on vulnerable groups in some detail, an alternative socio-economic perspective on the unequal distribution of psychosocial stressors has been articulated well by the **Mental Health Foundation (MHF)** in the United Kingdom (online article, accessed 24 July 2020). According to the MHF:

> *'Divergence of experience presents a big policy challenge as there are many different groups, areas, impacts and experiences to consider. This huge variety of individual and group identities is difficult to capture in research and it is challenging to produce nuanced policy recommendations that recognise all these different experiences and their effects. A recovery response needs to take a holistic approach that addresses social, systemic and structural inequalities rather than placing the onus on the individual.'*

This perspective underlines the importance of 'Level 1' of the planned framework and the need to take account of, and address, the uneven distribution of stress and harm caused by Covid-19 across different population groups.

3.4 The impact on healthcare workers and supports required

According to the most recently published evidence, the risk to the mental health of health workers in the current pandemic has been clearly identified in the literature (such as Cao et al, 2020 and Choudhury et al, 2020 in Clark, Ryan and Leen, 2020). Specific risk factors within the healthcare workforce seem to include:

- female gender
- younger age groups
- direct experience of working with patients infected with Covid-19.

However, the evidence in relation to levels of professional experience seems to be mixed, with some research identifying newly-qualified clinicians as particularly vulnerable (Shen et al, 2020) while other studies suggest that with greater experience comes greater knowledge of the severity of the disease and, with that, heightened anxiety (Clark, Ryan and Leen, 2020).

While most of the literature agrees that those on the frontline in direct contact with Covid-19 patients experience the greatest levels of stress and anxiety, several studies have demonstrated that non-frontline healthcare workers also need psychological support and that their needs will differ from those of the general public. Among the main risk factors for stress and anxiety are shortage of personal protective equipment (PPE) and other vital equipment; concerns about family members; physical deprivation, such as lack of food and rest; poor sleep quality; too much or too little information and experience of bereavement.

According to a meta-analysis of the prevalence of common and stress-related mental disorders in healthcare workers based in pandemic-affected hospitals, Allan et al (2020) found that Post Traumatic Stress Symptoms (PTSS) in the acute phase were at an estimated prevalence of 23.4 per cent and at twelve months plus, the estimate was 11.9 per cent. For general psychiatric/mental health cases, prevalence rates during the acute phase were 34.1 per cent; at 6–12 months 17.9 per cent and 12 months plus prevalence rates were at 29.3 per cent. The

study concluded that the course of disorders in the aftermath of the immediate phase of a pandemic is poorly understood. Despite some evidence for natural recovery, PTSS remained elevated compared to the general population at 12 months (Allan et al 2020).

The project steering group also highlighted that workplace stress in healthcare settings can result in physiological changes such as increased heart rate and/or sleep difficulties, cognitive difficulties such as attention or memory recall, behavioural changes such as risk-taking and or an increase in unhealthy habits such as over-eating, as well as 'spiritual difficulties' (Halpern and Vermeulen, 2017). In addition, 'moral injury' (Williamson et al 2020) can occur for HCWs if they find themselves in a situation whereby they are unable to provide services at the level which meets their professional and or ethical standards, such as a lack of suitable resources such as PPE/ICU equipment or if they are overwhelmed by inadequate staffing levels and compassion fatigue.

Although there is a paucity of evidence about psychological interventions for healthcare workers in the current crisis, more studies are emerging which identify possible strategies for alleviating the psychological distress in the short and longer term (Clark, Ryan and Leen, 2020). These strategies include online interventions, self-care, mindfulness and resilience training, brief interventions and psychological first aid. The importance of social support from the rest of the team and management support is also emphasised, as well as the need for preventive measures, such as regular screening and the development of an organisational strategy.

While much of the focus on factors influencing stress for healthcare workers is about individual characteristics and outcomes, the importance of workplace culture and broader health system issues of wellbeing and stress should be an important focus in our overall psychosocial response.

3.5 Covid-19 psychological and social research – evidence from Ireland

3.5.1 Psychological research

While a significant number and range of original research studies have been undertaken relevant to the mental health impact of the pandemic, the Covid-19 Psychological Research Consortium (C19PRC) population-based surveys provide a broad 'sense-check' on mental health needs.

The C19PRC is a group of mental health researchers from the United Kingdom and Ireland who are conducting projects to understand the mental health effects of the Covid-19 pandemic. Phase 1 data collection took place between 31 March and 5 April 2020. At Phase 1, responses were collected from 1,041 Irish participants who were selected using stratified quota sampling techniques to ensure that the sample was representative of the general adult population in Ireland in terms of sex, age and geographical distribution (Hyland et al 2020).

At Phase 2, responses were collected from 506 individuals who participated at Phase 1, constituting a follow-up rate of 49 per cent. These responses were collected between 30 April and 14 May 2020. Data were also collected from 526 new participants in Phase 2 which ultimately involved a total of 1,036 participants.

Among the key findings, the C19PRC have reported no statistically significant changes in the rates of depression, general anxiety, and PTSD amongst respondents followed up in phase 2. Furthermore, there was no statistically significant change in the proportion of people who screened positive for any one of these three common mental health disorders. These results may be counter to public discourse on an anticipated increase in mental health difficulties and it may be too early to fully understand the public mental health impact of the pandemic. Further phases of this survey, along with other relevant research and the continuous monitoring of service demand will guide ongoing planning of our psychosocial response.

3.5.2 Social research

If there is a degree of reassurance that can be noted from the C19PRC data about the likely prevalence of mental health difficulties, at least in the short term, data from the Central Statistics Office (CSO) Social Impact of Covid-19 Survey highlights some areas for concern. Findings from that research, carried out in April 2020, note a decrease in overall life satisfaction across all age groups, with the 18–34 years age group experiencing the highest decrease. Nearly a quarter of respondents indicated feeling lonely at least some of the time, and a third felt depressed or downhearted.

Concern about household stress from confinement affected three quarters of those living in multiple person households, with one in every five of those aged 70 and over very concerned and 6 per cent of people reporting concern about violence in the home. An increase in alcohol consumption was evident, with one in five reporting an increase, particularly amongst those who felt very nervous, downhearted or depressed or lonely at least some of the time over the previous four weeks, and those experiencing stress from household confinement indicating higher consumption. Tobacco use also increased, again higher amongst those who felt nervous, downhearted or depressed. Junk food consumption, watching television and less exercise activity were also evident, with those aged 70 and older reporting that their frequency of exercising had decreased since Covid-19 restrictions were introduced.

The impact on unemployment due to the pandemic was also clear, with almost half (49.1 per cent) of those newly unemployed since the end of March (those employed between January and March but not employed in April 2020) rating their overall life satisfaction as low, compared to 26.8 per cent of those employed and engaged in work duties.

While these data are concerning, aspects of the national response to Covid-19 addressed many of the issues highlighted as they occurred. For example, the pandemic unemployment payment has been a very important and practical economic measure that is likely to have mitigated at least some of the likely negative psychosocial impact of living through the pandemic. As with the need for ongoing monitoring of psychological impact, the social impact of Covid-19 should be monitored to help inform ongoing psychosocial response efforts.

Section 4

Section 4: Current policies, psychosocial structures and system learning from Covid-19

The development of a health sector psychosocial response framework should be informed by current policy, initial psychosocial responses and lessons learned. The framework should also be in keeping with relevant national guidelines and key legislation. This section outlines the current context of the health sector psychosocial response and the experiences to date that need to be factored into medium-to-long-term planning.

4.1 Policy, guidelines and legislative context

This report recognises the importance of a whole population approach to planning future psychosocial responses and as such it resonates with Sharing the Vision: A Mental Health Policy for Everyone (2020). The population-wide, integrated policy approach of Sharing the Vision will provide a platform for the delivery of key supports and services that cut across different levels of need and serve different populations. While the policy context of psychosocial responses can be wide-ranging, and go beyond the health sector, it is those policies which emphasise collaboration and integration that most closely align with and provide a mandate for the type of psychosocial response detailed in this document. Other such policies include, but are not confined to:

- Connecting for Life, Ireland's National Strategy to Reduce Suicide (2015)
- Sláintecare Report: Committee on the Future of Healthcare (2017)
- Healthy Ireland: A framework for Improved Health and Wellbeing (2013)

Furthermore, this framework and the implementation of its recommendations will take into account significant changes in legislation relevant to healthcare and the delivery of services and supports to people. The Assisted Decision-Making (Capacity) Act (2015) is now in the commencement phase and the spirit of the Act promotes the importance of a person's will and preference over and above a more paternalistic approach to healthcare acting 'in the best interests' of an individual. A range of decision-making supports is provided for in the Act and full implementation of the Act, overseen by the Decision-Support Service, will complement the practical implementation of the revised HSE National Consent Policy (v1.3, 2019). The will and preferences of all individuals must be taken into account in the delivery of supports at all levels of this framework and in the delivery of health and social care services generally.

In addition to national policy and relevant legislative frameworks, there are important HSE guidance documents which will continue to direct our response to support the general population during public health emergencies. When Covid-19 arrived, the initial psychosocial response was very much guided by Psychosocial and Mental Health Needs Following Major Emergencies: A guidance document (2014). The psychosocial structures and services in Ireland, detailed in this document, are outlined below.

More recently, the Health Protection Surveillance Centre (HPSC) has developed a repository of guidance relevant to Covid-19, providing in-depth information and advice on the management of the pandemic for healthcare settings, non-healthcare settings (such as workplaces) and from the perspective of a range of government departments.

For healthcare staff safety and wellbeing, there are robust policies and a legislative framework which ensures that psychosocial wellbeing is addressed in the wider context of health and safety. Specifically, under health and safety law, all workplaces should have a current operational safety statement in place, outlining hazards and risks in the workplace environment and setting out the means to control those risks, and these

statements should include psychosocial risks (Safety, Health and Welfare at Work Act, 2005).

With further reference to the Safety, Health and Welfare at Work Act (2005), risk management in addressing psychosocial need is a key focus and a legal requirement for all employers. Each employer has an obligation to ensure that, as far as is reasonably practicable, the health of employees is not endangered in the course of their work. The HSA and States Claims Agency (SCA) promotes the process of risk assessment and control measures so that employers can be assured that their management systems ensure the demands placed on employees are reasonable. They also endorse the use of the Work Positive Critical Incident (WPCI) framework as a method for risk identification and the development of a focused response. The themes of governance, risk assessment and safety management are set out in detail in Appendix 2.

The key HSE policies relevant to the future management of our response to public health emergencies include the following:

- **Health Services People Strategy 2019–2024**
- **Healthy Ireland Framework for Improving Health and Wellbeing (Healthy Ireland Framework 2013–2025)**
- **HSE Policy for the Prevention and Management of Stress in the Workplace 2018**
- **HSE Corporate Safety Statement 2020**

HSE Health and Wellbeing is also currently leading on the development of a national mental health promotion strategy which will complement many of the psychosocial initiatives outlined in this framework.

Finally, in recognition of the ethical imperatives guiding the national response to Covid-19, the Department of Health has published an Ethical Framework for Decision-Making in a Pandemic (Department of Health, 2020). That framework highlights seven key principles including reciprocity, which, with reference to healthcare staff, patients, and those working in difficult circumstances 'requires that society supports those who face a disproportionate burden in protecting the public good, and takes steps to minimise the risks and burdens as far as possible' (Department of Health, p.7, 2020).

4.2 Psychosocial structures and responses in the initial stages of Covid-19

In order to understand the current psychosocial structures and the supports available across Ireland, a review was undertaken by the project team across each of the Community Healthcare Organisations (CHOs). Based on semi-structured telephone interviews with the Psychosocial Leads (Principal Psychologists) of each of the CHOs, the review sought to determine:

- A complete picture of the current national psychosocial response
- Whether the structures and governance outlined in the 2014 HSE guidance document were used in response to the Covid-19 emergency
- Learning and needs identified, to inform planning for future psychosocial responses as required.

The following sections summarise the review's findings on local psychosocial structures, services and learning.

4.2.1 Local psychosocial structures

All CHOs had the structures in place as recommended in the 2014 guidance document. However, there was significant regional variation in how well established or formally embedded these structures were across the country. This regional variability might be because no additional resources were allocated towards the implementation of the 2014 plan.

It was reported that certain areas had experience of implementing the guidance published in 2014 on psychosocial responding in the aftermath of flooding, fires and other critical incidents. That experience meant that certain CHOs had some level of preparedness in responding to the impact of Covid-19, but as was stated,

the existing guidance was not designed with an infectious disease pandemic in mind and therefore the response had to be changed.

The importance of supporting healthcare workers has been a distinctive feature of the Covid-19 emergency and CHOs responded by ensuring the employee assistance programmes and mental health staff were represented on local psychosocial response teams. During the Covid-19 emergency the psychology manager and or principal psychologist continued as designated chair of the local Health Service Psychosocial Management Teams (HSPMTs) which co-ordinated the psychosocial response. That role of psychosocial lead was taken on as an extra duty and over a relatively short period involved significant scaling up of support and in-reach to primary care, disability and mental health services.

While there was variability across areas, local psychosocial teams usually included:

- Psychologist (usually the principal psychology manager)
- National Counselling Service representative
- Social worker
- Representative from Human Resources
- Employee assistance programme representative.

Some CHO psychosocial response teams included a mental health service user representative. While such representation was not something that had been recommended in the 2014 guidance document, those areas which included it reported such inclusion as being beneficial.

Apart from ACMTs and Health Service Psychosocial Management Teams (HSPMTs), some CHO areas also worked with Partner Agency Psychosocial Groups (PAPGs) – mainly in an informal way. It is worth noting that only one area has a fully established PAPG. Where it was reported that CHOs were working with partner agencies, this engagement was typically based on emerging need, building on already established local knowledge and relationships. Frequently mentioned partner agencies included: National Educational Psychological Service (NEPS), Social Inclusion, Healthy Ireland, County Councils and Túsla. Recommendations for future structures, learning from experience to date, will be set out in detail in Section 8.

4.2.2 Services

Within the structures outlined above, a range of supports and interventions were introduced in the early phase of the Covid-19 pandemic, initially with a focus on the needs of the healthcare sector and later extending to the general public. Please note, Appendix 4 provides full detail of the services offered based on the mapping exercise to identify supports and services conducted by the steering group during the development of the framework. The following paragraphs provide an overview of the services that were most prominent in the early stages of the pandemic.

Key supports offered to staff included the psychosocial support phone line and a psychosocial call-back email service in each of the CHOs. Those supports were complemented by training for managers in psychological first aid and the delivery of staff workshops on relevant themes, including resilience and stress reduction.

In addition to the PFA training and other new initiatives, the existing staff support services (EAP and Occupational Health) within the HSE delivered direct psychosocial interventions to HSE staff. In the roll-out of psychosocial supports, communications emerged as a key theme during Covid-19 as online channels of engagement were increasingly used (such as short videos with tips on protecting mental health, uploaded to YouTube). Along with 'broadcast' emails, printed posters and flyers promoting available supports were used to reach healthcare staff working in hospitals and other health service delivery settings.

An important dimension of the delivery of psychosocial supports to the public in some areas was the focus on supporting those existing mental health service users whose mental health difficulties were made significantly

worse by the impact of Covid-19. At least some of this service delivery was supported by the innovative use of technology to reach and engage with people when the delivery of face to face support was challenging.

CHO psychosocial teams also developed public bespoke supports for nursing homes, call-centres, new mothers, acute hospitals and vulnerable groups. Materials were provided to service users in disability services, children, adolescents, adults and parents and or carers. Telephone drop-in supports were also provided to the families of children in disability services.

4.2.3 Learning from CHO psychosocial lead interviews

Important insights were provided in the review of the current psychosocial structures and supports through the semi-structured interviews with the CHO psychosocial leads. In summary, it was reported that:

- The 2014 framework for responding to major emergencies related to very different scenarios compared with a global pandemic. That framework related to more local incidents occurring at a more definable time.

- The local and national dynamic in terms of readiness to respond and provide direction had to be worked out in real time. A national position on this is required for any future emergency situation.

- Psychosocial responses were seen as secondary to initial and immediate safety concerns. It was recognised that this is a normal reaction, with safety and immediate physical health needs having to be met in any crisis situation before emotional and psychological needs are even recognised by those impacted.

- Nationally communications and media were focused in the early phase of the pandemic on immediate public health and safety concerns. Psychosocial leads experienced difficulties in promoting psychosocial messaging at a national level during that phase.

- Resources for a psychosocial response were drawn from within existing staff, some of whom continued to perform their core duties on top of supporting the response, while others were redeployed to support non-psychosocial operational aspects of the response, for example at Covid-19 test centres.

- Positive feedback included the availability of psychosocial leads in each of the CHOs who individually and as a group took responsibility and assumed a leadership role in developing a response.

Recommendations about a future response to a major public health incident or similar emergency will be detailed in **Section 8**.

The recommendations from the initial review of current structures may be highlighted briefly as:

- Preparation for the next emergency begins now.
- Messaging and communication about psychosocial impact must be agreed, to highlight the nature of impact and the importance of prevention to lessen future problems, such as absenteeism related to burnout.
- Existing psychosocial human resources should be protected, and the net should be widened to resource future psychosocial responding, such as across the wider voluntary and community sector.
- Knowledge of priority groups is increasing and attention must be paid to support redeployed staff, people with mental health difficulties, people with disabilities, people living in residential settings, children, adolescents and healthcare workers – especially those who may be in frontline roles but are from minority backgrounds and may not have English as a first language.
- There should be a plan to more effectively manage and support partner organisations in the community and voluntary sectors.

4.3 Telehealth and the use of online and or phone services

In parallel with the work of the Health Sector Psychosocial Response project, the National Telehealth Steering Group within the INOH developed a four-level model of online mental health support, building on ongoing work which commenced in 2018 through a service improvement project on online mental health supports. A range of staff phone and online support was also further developed, and this will be considered separately below.

The model of support submitted to the National Telehealth Steering Group identified existing resources and services to be scaled up based on need, and proposed the development of additional supports, broadening the increasing tendency to use technology in day-to-day activities. These supports will be widely available to the general public and to the wider health sector, as well as HSE staff who may wish to access them instead of or in addition to the organisation's employee assistance services.

The four-level model of online support for the general population identified the following:

1. **Mental health information** – to provide reassurance, guidance and signposting through platforms such as yourmentalhealth.ie, HSELanD (the HSE's e-learning platform) and platforms that can host webinars.
2. **Self-help resources** – which can help people to manage their mental health needs and stay well (for example through Silvercloud Health and through quality-assured mobile apps).
3. **Support** – through scheduled, moderated online peer support groups and through the confidential messaging service #text50808 which activated a 'frontline' campaign.
4. **Services** – including video-based online counselling through existing provider MyMind to complement existing employee assistance programme services.

In addition to the above supports which are available to the general public, the HSE Employee Assistance Programme (EAP) developed a dynamic range of supports to ensure ease of access for healthcare staff. Specifically, at the beginning of the Covid-19 period, the EAP team adapted and enhanced their services through introducing new platforms to enable virtual sessions, such as video sessions and structured telephone support.

This enabled EAP to deliver both individual and group online support to HSE staff in counselling, psychosocial support, consultation to managers on staff wellbeing issues, and Critical Incident Stress Management Response (CISM). Such online EAP services have been used by many HSE staff in self-isolation due to Covid-19. In addition, the EAP HSELanD programme, Supporting Your Staff's Mental Health: A Programme for HSE Managers is also available to all HSE staff.

The National Telehealth Steering Group is also supporting work streams on 'Video Consultations' and 'Remote Monitoring Tools in Healthcare'. All of this work in telehealth is being developed in full recognition of the capacity within the health system to efficiently roll out new initiatives in a consistent way across the country. At present there is unequal access to reliable broadband and the necessary hardware and software to support the delivery of some resources and use of some platforms. It is acknowledged that education and training will be required for health service staff in this increasingly important area.

4.4 System learning from Covid-19: adapting to meet future needs

To inform the development of this framework it was important to capture and understand the wider system's learning from the experience of Covid-19 and its impact on the health sector. A consultation was undertaken with the members of the Expert Advisory Group which supported the Psychosocial Response Steering Group.

That group was made up of experienced colleagues from a broad range of academic and professional disciplines who were asked to advise on the evolving framework,

based on their expertise, rather than as a representative of a group, sector or discipline. In short, the consultation asked about the positive and negative experiences during Covid-19 and the learning derived for future emergency situations and ongoing planning. A brief thematic analysis of responses by the Expert Advisory Group is presented below.

4.4.1 What worked well in our response to the Covid-19 pandemic?

The adaptability and effort of staff was recognised as a positive aspect of the experience. One EAG member referred to 'an incredible shoulder-to-the-wheel approach' and this was reflected in the appreciation of healthcare workers by the general public. To maintain morale among healthcare workers it will be very important that staff know they are valued by the organisations they work for (including the HSE and private service providers). Notwithstanding the importance of maintaining morale amongst healthcare workers, staff must also be allowed to recognise their vulnerabilities and it is important that the notion of healthcare workers as 'superheroes' is not perpetuated, as that would deny staff the permission to ask for help when they need it.

Other themes emerging included collaboration (for example in the housing and homelessness sector) adaptability of entire sectors (for example in disability and general practice) and innovation in service organisation and delivery, as evidenced by the establishment of community assessment hubs.

A comment from the experience of general practice highlighted a very positive development involving direct GP access to the community mental health team, through a dedicated member of that team, for urgent cases. It was suggested that this should be maintained and be made consistent on a national basis.

The effective use of technology for a range of purposes was highlighted as a success of the response to the Covid-19 crisis. Online platforms were used to provide remote consultations and engage with patients and service users, to communicate effectively with the general population and staff, and, for everyday communication between colleagues in the health sector. Linked to this, it was reported that our messaging and communications were strong and that this provided reassurance and gave confidence which represent important foundations for our psychosocial wellbeing. As one EAG member noted:

> *'The regular daily updates from consistent faces through the media provided reassurance for the general population. The key was consistency and reliability. During times of crisis people will seek out and hold on to anything that provides regularity.'*

4.4.2 What did not work well with our response during Covid-19?

The crisis highlighted some challenges associated with the local and national dynamic within the health sector. It was noted that:

> *'There appeared to be a tension between the national and local psychosocial responses; there seemed to be a top-down national response and a bottom-up local (CHO) response which led to challenges to an integrated response.'*

From a health service delivery perspective, the disruption to routine services was problematic. There will be a knock-on impact on waiting lists that will be felt for some time to come, leading to significant uncertainty for patients. There has been a related curtailment of many important services in clinical settings such as social work and chaplaincy services. Some quite specific areas of difficulty were identified, notably the situation of higher rates of

infection that developed in nursing homes, where a lack of preparedness was associated with very significant levels of morbidity, mortality and trauma.

The anxieties around the availability of personal protective equipment (PPE) became public knowledge early on in the crisis and one input on the subject of PPE brings to light those anxieties and the importance of communication in such circumstances:

> *'The Health Protection Surveillance Centre (HPSC) announcement re mandatory wearing of face masks in all service settings on 22 April landed with no notice and when the PPE supply chain was at its most stretched. This led to significant levels of fear and anxiety among staff and service users.'*

This highlighted that specifying operational requirements that cannot be met can cause stress and worry for service users, service providers and the general public. Added to this, delays in including Section 38 and 39 funded agencies in the PPE supply chain also caused significant stress and concern.

One observation from an EAG member related to health service staffing levels before Covid-19 arrived. It was argued that because staffing levels were problematically low before the crisis, significant efforts and energies were spent prioritising our efforts to mitigate potential disasters.

This may have led to the neglect or de-prioritising of other areas of planning and response. Regarding the management of deaths within health service settings, one EAG member reflected on the impact of those bereaved, not just from Covid-19 but from other causes of death:

> *'It's likely that with better understanding and a better resourced system, this could have been handled much better.'*

Technology and online platforms also featured in the feedback on what did not work well in the health services' response to the pandemic. The term 'digital poverty' was used to highlight the unequal access to hardware and the internet, while confusion over HSE endorsement and permission to use certain software was also noted. While a number of EAG members highlighted the success of the HSE and Department of Health in the area of communications, some also highlighted 'communication overload'. There was a sense that, in the early days of Covid-19 especially, there were too many staff emails and too many detailed memos and reports which amounted to an overload of information and led to confusion for some staff.

Issues around communication were not confined to the health sector. It was felt that the Department of Education did not provide sufficient guidance or support to schools and in turn there was significant variation in the responses of schools in supporting parents and children. Indeed children were highlighted as a population group that were disproportionately impacted, not just because of the variable responses of schools, but also due to socioeconomic issues and the compounding impact of inequality and disability.

4.4.3 The learning from the Covid-19 experience

Learning reported from the experience of the Covid-19 pandemic captured by members of the EAG, and relevant to the development of the framework, is expressed in the following key points:

Resource practitioners to be able to recognise, signpost and where necessary refer service users for psychosocial supports or interventions.

Recognise that a broad range of voluntary and community organisations can play an important role in the psychosocial response to major incidents and public health emergencies. For example, many local community and voluntary agencies were available via phone, which enabled services to continue to be available, but these responses should be coordinated and complementary.

Invest in home supports for older people to help keep them safe and out of hospitals and provide supports for other congregated settings such as nursing homes where the risk of infection is higher.

In the acute hospital system, ensure that as electronic patient records are developed, psychosocial profiles and needs can be incorporated.

Develop the ability in the hospital sector to factor psychosocial needs into the clinical prioritisation process where waiting lists for services are in place.

Adaptations are needed to care for nursing home residents, with higher standards required of staff resources, such as more nursing staff rather than poorly paid care assistants.

Learn from and build on the effective collaboration that resulted from the necessity of responding to Covid-19 – for example between the HSE and disability service providers.

Invest in and mainstream technology for service delivery, in everyday work tasks and communication, so that staff can work from different locations, including home.

Streamline the provision of information by, for example, improving HSE staff knowledge of the library service and the availability of research evidence summaries.

Improve data quality in the health sector by developing better systems for death registration and in relation to health service outcomes.

Section 5

Section 5: The Psychosocial Response Framework for Covid-19

5.1 Guiding principles

Psychosocial interventions across the country vary in scope and character, but to ensure a compassionate and effective response, there are considerations and principles of approach that we recommend all service providers' psychosocial interventions should reflect:

- **Service user and HCW centred** – where principles of service user and staff engagement, participation, choice, coproduction, consent and feedback are central.
- **Targeted and co-ordinated** – International best practice (WHO) suggests that targeted and co-ordinated approaches have the best success in emergency situations.
- **The psychosocial needs of all staff need to be acknowledged** – that includes receptionists, administrators, cleaners, porters, managers, nurses and doctors.
- **Flexibility** – the key to any successful psychosocial response is the capacity to scale up the response as needed, and to take a flexible approach and adapt the response as the crisis evolves.
- **Promoting wellbeing** – providing psychosocial supports at this time should also include being proactive in supporting healthy behaviour, resilience and positive coping mechanisms, focusing the messaging on what individuals can do to help themselves versus the idea that only the professionals can help them recover, and the need to foster a culture of safety and hope amidst uncertainty.
- **Recognition of the importance of social supports** – there is no 'right' pathway for managing and coping with psychological distress, but one of the single most important factors is social support. Support of friends, family, colleagues and others both in the workplace and outside of it is very important, and a co-ordinated response should support these naturally occurring supportive relationships.
- **Enhance existing support structures** – ones that will then cascade through the system from managers, through frontline staff to service users and their families.
- **Foster a supportive culture** – it is vital that support is provided at an individual level, while fostering a supportive culture at a team and or community level during this crisis. The importance of a team-based and or community approach and a culture of support cannot be overstated in responding to a crisis that will potentially impact at every level of the health service and society.
- **Co-leadership** – within the region, between the CHO chief officers and CEOs of the hospital groups, to support the integration of psychosocial responses, and to enable and support psychosocial staff to implement an effective and timely response on the ground.
- **Collaboration and integration** – EAP, psychological services, social work and where relevant non-HSE psychosocial responders (within the community and acute settings), should collaborate on this work, examining what is required to support the mental health and psychological wellbeing of all health sector workers and the public, and ensuring that plans are in full alignment with local services.
- **Decision-making and risk assessments** – in the event of an urgent need, such as a spike in cases, the psychosocial lead, with the support of regional leadership, will need to undertake

rapid decision-making to ensure a timely and agile response. Under non-urgent circumstances decision-making will be collaborative and should be aligned to HR governance processes and a risk assessment on actions proposed should be undertaken. Management teams should have oversight of the risk and mitigate to the greatest possible extent and update risk registers accordingly.

- **National Public Health Emergency Team (NPHET) guidelines adherence** – public health advice has consistently been that it is not advisable or safe to bring groups of individuals together unnecessarily. This can put both the individuals and the service providers at unnecessary risk. Group or individual supports should where possible be provided online or via telephone and here social distancing is paramount. It is critical that providers of psychosocial responses keep up to date with public heath guidance as it evolves over the lifetime of the pandemic.

- **Encouragement of digital (online) health systems** – within the Covid-19 context, the requirement for physical distancing calls for the offering of more distant and virtual forms of intervention, along with the use of existing support structures. Digital health systems enable innovative ways to reach and engage people.

- **Governance and clinical structures** – only HSE and existing HSE-funded partner agencies will be used to provide services within this framework. Any psychosocial services provided will require clear governance structures and should be provided by accredited HCWs with training in Psychological First Aid (PFA) models and or professional accreditation and competency. Funded providers may have existing EAP and or psychosocial programmes and are encouraged to consider the application of the initial guidance set out in this document.

- **Consultation** – research from China indicates that staff, and where relevant members of the public, should be consulted about supports they would find most useful. Psychosocial responses should be offered in a tailored way to meet the needs of each facility and or service and to dovetail with the supports and good practices already available.

- **Local management request** – if supports are being offered and made available to a community service, responses need to be mobilised, based on a direct request only from that service's local management.

- **Proactive and reactive** – supports can be offered both proactively and reactively.

5.2 Covid-19 Psychosocial Response Layered Care Framework

As per WHO IASC (2020) and British Psychological Society (BPS) (2020) recommendations, psychosocial responses need to be provided in a stepped manner. The response is characterised through attempting to address the psychosocial needs of the public and staff in real time, using different forms of psychosocial support, including psychological first aid, with the aim of lessening both current and future distress and mental health needs.

The National Psychosocial Response Team have modified the previous stepped care model outlined in the Psychosocial and Mental Health Needs following a Major Emergency (HSE 2014), and the population-based planning approach in Sharing the Vision, a Mental Health Policy for Everyone (Department of Health 2020), to be applicable to the Covid-19 pandemic environment. The overall aim of this framework, (See **Figure 1**) is to enable an individual to access the range of support and services needed to support wellbeing during the Covid-19 crisis.

In this framework the inverse pyramid represents the total population. A significant proportion of people will have their needs met at level 1. It is expected that only a

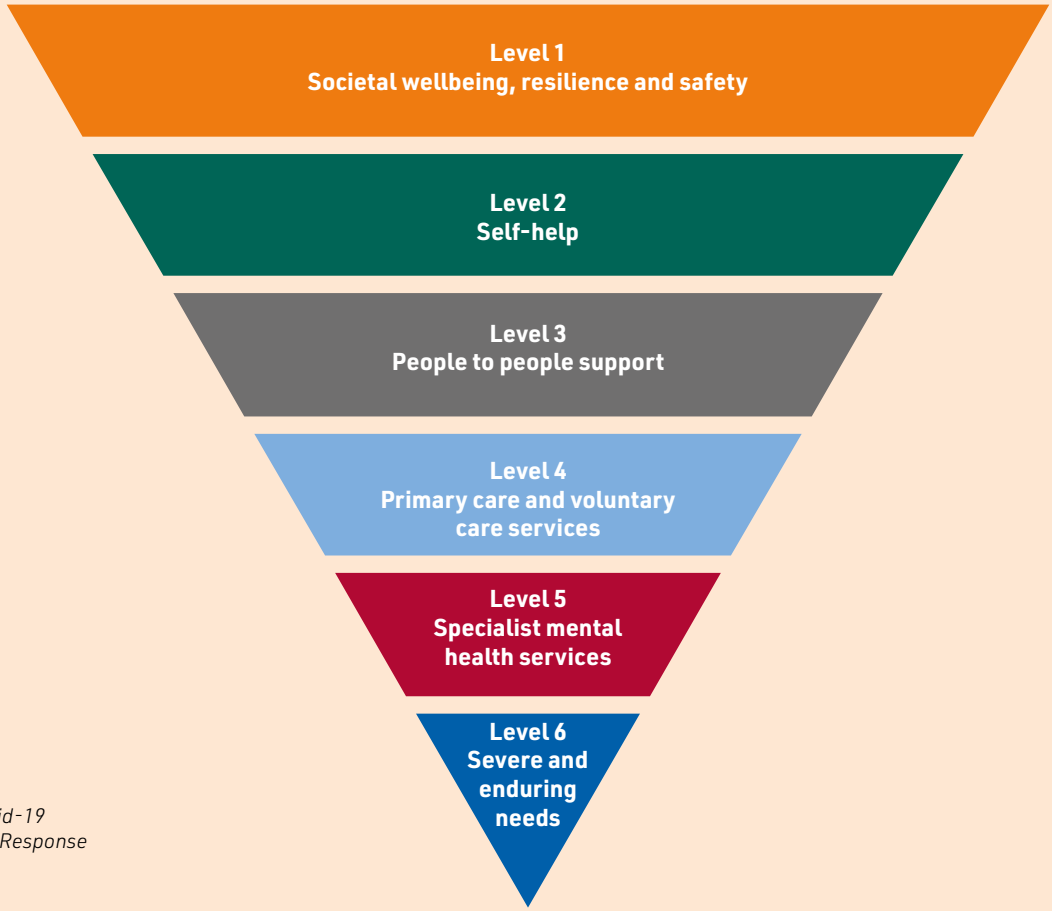

Figure 1. *Covid-19 Psychosocial Response Layered Care Framework*

small proportion of the population will have needs which require Level 5 or Level 6 interventions. Moreover, robust interventions at each level should ensure that peoples' needs do not escalate into the next level, due to lack of appropriate supports.

At one end of the pyramid, the needs relate to promoting societal wellbeing, resilience and safety, while highlighting community connectedness, basic services and supports. Interventions in this area are relevant to society at large in Ireland and include whole government initiatives as well as access to reliable information and signposting to a range of appropriate resources and tools, for example through HSE Live or **www.hse.ie**. These resources then build into self-help supports such as e-mental health tools which can be accessed at this level and which enable individuals to help themselves.

Beyond this in the pyramid, individuals may be supported as required, through different levels of services, from informal care and support in their own community to primary care and specialist mental health services – all based on their psychosocial needs. This can also include accessing support for crisis and or emergency response needs that are more episodic in nature.

Some staff and members of the public will have needs that exceed what can be addressed through psychological first aid, and may require, or prefer, any of the other supports available through the HSE. Principally these include Employee Assistance Support, Occupational Health, Critical Incident Stress Management or targeted psychosocial supports. Primary Care professionals such as National Counselling Services, Counselling in Primary Care (CIPC), Primary Care Psychology services (Child and Adult) and Assistant Psychology stepped care services are also well positioned to support people at the primary care level.

People may also prefer supports from voluntary and other agencies. More formal mental health supports may also be required and these can be facilitated through existing clinical pathways, where secondary level care referrals are made through primary care and inpatient referrals come through secondary care.

All of these services are being promoted and recommended as appropriate, underpinned by the principle of choice, to ensure that the right type of support is available to people when and where they need it.

At the other end of the pyramid, there is a small proportion of the population who have complex mental health difficulties. These individuals typically require intensive multi-disciplinary support over extended periods.

As mentioned in the introduction, in responding to the anticipated needs of the Covid-19 outbreak, the majority of people exposed to a trauma will experience some level of distress. In line with research, most people who experience such distress recover spontaneously, in the short-to-medium-term. A smaller cohort is likely to experience longer-term traumatic impact which may require a more formal intervention.

An important feature of the framework is that the various layers in are not mutually exclusive, but are closely integrated and rely on each other, and may at times be used in parallel. For example, an individual who is accessing specialist mental health services may still require the support of his or her family, community and GP. **Table 1** (right) summarises the different provisions of each level.

See **Appendix 3** for a detailed overview of each level and its alignment of services. The following, provides a brief overview.

Level 1

Societal wellbeing, resilience and safety – providing accurate and helpful information from both broad governmental sources and through a range of media communications promoting wellbeing, resilience and safety and signposting further supports and services, including basic supports to help in everyday living through, for example, **www.hse.ie** and HSE Live helpline.

Level 2

Self-help – providing the tools and information that will encourage and facilitate self-help for people who are willing and able to avail of it, like psycho-education and mobile apps.

Level 3

People to people support – providing both formal and informal one-to-one or group support. This can take many forms, such as confidential one-to-one or peer support groups, psychological first aid and targeted psychosocial supports such as 'buddy' systems.

Level 4

Primary care and voluntary care services – qualified and structured one-to-one or group support via community-based professionals such as GPs, psychologists and social workers, as well as HSE supports for staff such as Employee Assistance Programme, Occupational Health, and HR. The aim would be to provide reassurance and promote wellbeing and help people maintain personal resilience.

Level 5

Specialist mental health services – providing mental health services through Community Mental Health teams (CAMHS and Adult Mental Health Services).

Level 6

Severe and enduring needs – Providing mental health services, including residential services.

Section 6

6.1 Impact of Covid-19 on the public

6.2 Impact of Covid-19 on specific populations and priority groups

6.3 Overview of current psychosocial supports for the general public

Section 6: Response to the general public's needs

This section focuses on the impact of Covid-19 on the general public across the human lifespan, and with specific focus on priority groups that have been impacted significantly by the crisis.

6.1 Impact of Covid-19 on the public

The Covid-19 pandemic has significantly impacted on the general public in profound ways, including our physical and mental health, economic status, relationships and behaviours. It has also disrupted key transition points and societal rituals for large numbers of people, including those experiencing pregnancy and childbirth, death and bereavement. Children and young people undergoing educational transitions, such as beginning primary school, secondary school and third level institutions and those completing state exams have been severely disrupted. So also have couples getting married, people who have lost jobs or occupational opportunities, along with negative impacts on sporting, cultural and recreational activities and foreign travel.

In addition to the above problems, Covid-19 has also provided an opportunity for people to strengthen their resilience. Individuals, families, and communities across Ireland have worked together to support each other in positive ways in response to Covid-19. Section 2.1.2 outlines that the majority of the population will likely maintain healthy functioning or resilience.

As mentioned in Section 2, psychosocial support focuses on ensuring that the mental and social wellbeing needs of individuals and communities are supported, that resilience is nurtured, and that appropriate supports and interventions are in place as required.

Psychosocial supports for the community range from reassuring individuals and communities through clear information, supporting individuals and communities to support themselves and in delivering more specialist interventions, including counselling and mental health and addiction services for people needing such services. As Section 3.2 outlines, there is limited data on the psychosocial impact of Covid-19 on patients recovering from the disease, but emerging evidence indicates a profound impact of long-term symptoms for some people. This, along with the wider consequences the pandemic has had on Irish society, means that psychosocial responses must be understood as a long-term strategy.

6.2 Impact of Covid-19 on specific populations and priority groups

Some groups, as outlined below, are at increased risk of negative psychosocial outcomes during and following the Covid-19 pandemic.

- all people are experiencing a stressful time as there are potential negative outcomes, with fear, anxiety and uncertainty about the future.
- some people are particularly vulnerable to contracting Covid-19.
- some people are vulnerable due to other circumstances and this vulnerability is increased during this time.

Particular groups may be significantly affected by the virus and the requirements for social isolation, beyond that of the general population. There are various groups who require particular consideration. This includes, but is not limited to:

- children and adolescents
- older people
- people at increased risk due to physical health conditions
- people who are currently at risk in terms of social inclusion
- service users who currently access mental health and disability services
- carers who may have had increased demands

because of service disruptions
- people living in congregated settings
- ethnic minorities
- asylum seekers
- Traveller
- Roma
- direct provision
- homeless population
- drugs and alcohol service users
- those who have been bereaved by Covid-19
- healthcare workers.

The following sections outline some considerations about particular population cohorts and priority groups. Identified groups (such as but not limited to those identified here) should participate in auditing responses to the pandemic and in preparing for ongoing and potential future disruptions. This is necessary to ensure that future responses are sensitive to the needs of particular groups and communities.

6.2.1 Children and adolescents

While there have been positive benefits for some children and parents in the quality time families were afforded, worry and anxiety about Covid-19, along with school closures and social distancing has impacted children, young people and their parents. For children and young people living in overcrowded accommodation, households with significant financial pressures, and those in abusive home environments, increased time spent at home has involved increased exposure to risks.

For young children particularly, the reduced opportunity to play with peers (especially for children with no siblings living at home) combined with the added pressure of learning at home and other work pressures on parents has resulted in stressors in the home environment, with many parents feeling unable to meet the needs of both work and their pre-school child (Co-SPYCE Study). Like adults, children are likely to experience similar worries, anxieties and fear, including fear of themselves or a loved one contracting the virus, fear of dying, fear of their relatives dying, or a fear of what medical treatment would involve. Without the structure of school providing a normalising, stimulating and social environment, children have had less opportunity for social support from friends and teachers that is essential for mental wellbeing.

Many children and young people have experienced profound losses, including limitations of social contact, educational losses, losses of rites of passage, uncertainties over exams and sadly for some fear, grief, and bereavement. Children and young people with pre-existing adverse life experiences, mental health disorders or medical illnesses may feel this more acutely, (Condon, 2020).

Access to digital technology has played a huge part in responding to school closure and social distancing, although there is concern about the overuse of digital media and the inequality of access across the country. Pupils who feel less connected to school and who have less support at home are likely to have suffered significant educational losses.

The negative effects of social distancing may be particularly profound for adolescents and young people, although social media may mitigate some of the negative effects. Deprivation of social contact can have long-lasting effects and physical distancing might have a disproportionate effect on an age group for whom social interaction is a vital aspect of development (Orben, Tomova and Blakemore, 2020). The restrictions imposed by Covid-19 have interrupted normal developmental processes whereby adolescents orientate more towards their peer group and away from their family of origin.

For some children and young people with disabilities, changes in routine can exacerbate distress and mental health issues. The extra burden placed on carers is profound as challenging behaviour without the support of school (and other services such as respite services) impacts the whole family system. (Condon, D.)

For children with a high level of pre-existing needs in psychosocial domains prior to Covid-19, their supports through, for example, school, Tusla and youth services will have been reduced by the curtailment of these services during the lockdown, and this may have occurred at a time when their psychosocial needs were actually increasing for the reasons outlined above.

6.2.2 Working age population

The outbreak of the pandemic, and the essential public health measures to contain the spread of the virus have resulted in an economic downturn impacting significantly on people's lives though unemployment, decreased employment, reductions in income and increased uncertainty about future jobs and income. The unprecedented increase in unemployment and short-time working arrangements and closure of non-essential businesses and workplaces has affected workers and business owners everywhere.

However, evidence is already emerging that the economic repercussions of the crisis are falling disproportionately on young workers, low-income families and women (Joyce and Xu, 2020). Studies have found that unemployed people have lower levels of wellbeing than those in work and that job loss is comparable with other traumatic life events such as the death of a spouse. Unemployment has also been associated with several psychological variables such as low mood, anxiety, poor cognitive performance, loss of confidence and psychosomatic problems. (Murphy, Whelan, Mc Gann & Finn).

The pandemic has also resulted in many workers working from home, and although there are positive benefits, likely negative consequences include, for example, inability to 'switch off', isolation from colleagues and lack of support. People who continue to go out to work may experience concerns about health and safety. Although the state financial support interventions have helped, employment and financial concerns are likely to persist for many people into the future.

6.2.3 Older adults

Older adults are active and valued members of our communities. Approximately 330,400 older people over the age of 70 participate in social and leisure activities every week, 206,800 have volunteered their time within the last year, 132,200 provide help and care to spouses, families, friends and neighbours, while an additional 131,700 take care of their grandchildren (Tilda, 2020). Concerns have been expressed throughout Covid-19 about structural ageism, including the framing of older adults as vulnerable, passive or helpless recipients of care (Brennan et al, 2020, Brook and Jackson 2020, O'Neill 2020).

It is accepted that older people who contract Covid-19 are more at risk of developing significant complications and have a higher death rate. Public health measures introduced to protect the physical wellbeing of older people have resulted in the 'cocooning' of this diverse group.

An older person's quality of life is influenced by the strength of their relationships and sense of social connections, their sense of social engagement and ability to exert autonomy and control in their lives (Tilda 2020). These key domains of wellbeing may all be significantly impacted by cocooning, physical distancing and other public health measures. The adverse impact of isolation and loneliness on the health of older people is established (Holt Lunstad, 2015) and this may be exacerbated by restrictions.

For older adults who require supports, the closure of community services such as day services may impact upon wellbeing and the quality of care received at home, given the increased care burden for family carers. Older adults with dementia have specific psychosocial needs and require guidelines and direct resources to support them (Manthorpe and Moniz Cook 2020; O'Neill 2020). Cocooning and social distancing measures are particularly challenging for those with a cognitive impairment (O'Neill, 2020).

6.2.4 People with disabilities

People with disabilities are disproportionately impacted by Covid-19 due to attitudinal, environmental and institutional barriers, in addition to increased clinical risk relating to pre-existing health conditions **(OHCHR, 2020)**. An evidence review by the HSE's **National Health Library and Knowledge Service** has outlined some of the major considerations for people with a disability as identified by the WHO, UN and EU disability forum. Depending on the disability, these may include potential difficulty with hygiene measures (such as hand washing), challenges in implementing physical distancing due to the need for personal care, disruption to supports and services due to health protection measures, communication difficulties relating to the use of PPE, accessible information, financial difficulties and social stigma and isolation.

The sudden shift in service delivery during the pandemic has been very challenging for those who attend community services or reside in specialist disability settings. Community services such as day services facilitate human social interaction and while outreach services delivered during lockdown were much valued and appreciated, there is growing evidence that the extended period of remote service has increased feelings of isolation and loneliness and has led to an increased risk of experiences such as domestic violence among people with disabilities (**WHO, 2020**). It is likely that individuals returning to day services may discover some of their service community have passed away during lockdown, due to the elevated rate of Covid-19 mortality amongst people with disabilities **(OHCHR, 2020)**. This suggests the need for increased provision of bereavement supports. Considerations relating to residential centres are detailed in **Section 6.2.9**. Where people with intellectual disabilities are resident in centres, further consideration must be given to communicating new arrangements in a way that is clear and understood (NDA, 2020).

The majority of people with disabilities live independently, either in their own homes or with family. Many of these individuals will have experienced their independence being compromised due to social distancing measures, and the changes to availability of formal or informal supports for daily living. Strict confinement at home may be particularly challenging for some people, notably those with psychosocial disabilities and people with autistic spectrum disorder, (the Minister for Health clarified that such individuals were exempted from travel radius limits during the lockdown). Children and young people with disabilities have been particularly impacted because of school closures and the move to remote learning (ESRI, 2020) for both social and educational reasons.

6.2.5 Family carers

It is estimated that over 391,000 people in Ireland provide care to a dependent relative (Care Alliance Ireland, 2019), 60,000 of which are estimated to provide care to people with dementia (O'Shea et al, 2017). These family carers include older adults, adult carers who are also employed within the labour force and or have additional child rearing responsibilities, as well as young carers under 18. Care is provided due to age-related care needs, disability, addiction, mental health difficulties and chronic illness. In many cases people receiving care are members of high-risk groups who are at risk of developing serious illness if they contract Covid-19 (Phillips et al, 2020).

A national survey examined family carers' experience of caring during the Covid-19 pandemic in Ireland. Of 1,307 responses, 36 per cent of respondents experienced the closure of day care services, 36 per cent experienced a reduction or cancellation of homecare services and 28 per cent experienced the closure of respite services. Some 60 per cent were concerned about their own mental health and wellbeing in light of the impact of Covid-19 on their care workload. (Family Carers Ireland, 2020). An intensified care workload, concerns around infection and transmission of Covid-19, and additional care responsibilities given school closures may all increase the strain on family carers (Phillips et al, 2020),

while managing the needs of individuals who may experience a deterioration in terms of wellbeing, mental health or behaviour without access to usual services and supports remains challenging (College of Psychiatrists of Ireland,2020).

Young carers may be a particularly vulnerable group, given school closures and subsequent lack of educational and peer support (Phillips et al, 2020). Family carers of people with moderate to severe dementia are likely to be providing round the clock care and managing challenging behaviours which can increase distress (Livingston et al; 2017).

6.2.6 Those bereaved during the pandemic and bereavement care

Covid-19 presents significant challenges in terms of managing the delivery of healthcare and dealing with death and bereavement within this new context (Cann et al, 2020), as the pandemic prevents families and communities from engaging in the usual social and cultural rituals associated with dying and death (Bear et al, 2020; Northern Ireland Social Care Council, 2020).

While the majority of bereaved people do not require professional help, a significant minority (approximately 40 per cent) may require extra bereavement support (Aoun et al, 2015). The prevalence of prolonged grief disorder in a population is estimated to be between 10–20 per cent of bereaved people (Mayland et al, 2020). Deaths during Covid-19 pandemic are associated with risk factors which can lead to prolonged grief disorder in bereaved people and efforts must be made at the earliest opportunity to mitigate this grief and offer support (Selman et al, 2020; Wallace et al, 2020, Mayland et al, 2020).

Bereavement care should begin in palliative care, as the quality of the dying experience predicts bereavement outcomes (Wallace et al, 2020) and the availability of psychosocial support, as required, before, during and after the death is a key measure in significantly reducing prolonged grief, post-traumatic stress disorder and bereavement outcomes among bereaved people (Lichtental et al, 2020, HSE & RCPI 2019, Selman et al 2020, Wallace et al 2020).

The Adult Palliative Care Services, National Model for Ireland (HSE and RCPI, 2019) and the Bereavement Care Pyramid of the Irish Childhood Bereavement Care Network provide models for bereavement support. Based on best practice, these approaches are consistent with the emerging guidance from research on bereavement outcomes in Covid-19. Research indicates a number of psychosocial factors which mitigate poor bereavement outcomes, including the provision of sensitive and timely communication care, pro-actively promoting creative ways to support connection between families and dying individuals, providing death preparedness support, including emotional, social, psychological, spiritual and practical help to dying people and to their families, recognising the need to adapt rituals and grief practices to provide comfort and a co-ordinated bereavement response (Mayland et al, 2020, Selman et al 2020, Wallace et al 2020).

The psychosocial needs of bereaved children and vulnerable adults in family settings require specific attention (Finucane and Murphy, 2020; HSE and RCPI, 2019). A minority of people require bereavement counselling and or specialist support, including those at risk of prolonged grief disorder as outlined in the national Loss, Grief and Bereavement Pathway (HSE and RCPI, 2019).

6.2.7 Existing mental health service users

The impact of Covid-19 on mental health and the inevitable disruption to mental health services are considerable. Existing services must adapt to deal with potential increases in demand. There is also a requirement for structural changes in service provision. The potential for increased demand in a context of decreased capacity to provide services due to service adaptations is concerning.

The pandemic presents challenges for both service users and staff. In community specialist mental health services this includes cancellation or reduction in certain services, including routine appointments, due to concerns about patient and staff exposure. In residential and inpatient settings there is a need to reduce bed numbers and or reconfigure services in certain settings to ensure the safety of patients, service users, family members and staff.

Service disruption has impacted the likelihood of mental health service users attending GP, community and emergency services for supports, and has affected users' ability to engage in programmes and services provided in congregated settings, including day and outpatient services. While alternative treatment options made available through online methods have helped, the change and disruption to routines and face to face contact is considerable. And the impact of Covid-19 has the potential to exacerbate existing mental health issues, including depression, anxiety and fear, as well as the restrictions put in place and their subsequent impact.

6.2.8 Drug and alcohol issues and Covid-19

Those with drug and or alcohol issues are particularly challenged by the pandemic, due to the requirement for social isolation (O'Driscoll, 2020), and reduced access to services.

Priority was given to maintaining the supply of medication to people with addictions during the initial stages of the Covid-19 crisis. For example, there are over 10,000 people in receipt of methadone treatment, a medication which has to be consumed daily and necessitates very frequent attendance at clinics and pharmacies for many people.

Psychosocial addiction treatments, including one-to-one counselling, group therapy and key working and care planning were initially compromised as mental health services were limited (as outlined above).

The closure of, or reduced access to, some buildings and the guidance on social distancing and use of PPE complicated all aspects of usual services. These were adapted using telephone-based interactions and some limited use of telehealth approaches.

Key goals in addiction recovery treatment include the building of social capital and social connection. Covid-19 and the restrictions it imposed upon social interaction and the structure of day-to-day life have compromised the ability of services and clients in the building of recovery capital.

6.2.9 Residential and acute care settings

In all residential and acute care settings, irrespective of age or care needed, the impact of visitor restrictions for all residents, patients and loved ones has affected their psychosocial wellbeing. There is a diverse population residing in nursing homes, which includes older people and younger adults with physical and intellectual disabilities and cognitive impairment. National discussion has focused primarily on residential care services to older people, but Mental Health and Disability Services also provide residential care for service users.

The impact of visiting restrictions and bereavement affect these groups and those inpatients in all acute hospital settings (maternity, paediatric and adult). Psychosocial Interventions and recommendations need to reflect the diversity of those in receiving care in residential settings.

Covid-19 has had a disproportionate impact on nursing homes; with over 60 per cent of Covid-related deaths occurring in those communities. This is likely to have had a significant impact on residents. They have experienced long separation without visits from family and friends who are often their primary advocates within the care setting. They have been disconnected from their local community and for reasons of infection control, may have had limited freedom of movement within their community (Plagg

et al, 2020). They may have been grieving the deaths of fellow residents and have been fearful for their own health (Trabucchi and de Leo, 2020). At the same time, particularly in units with high rates of mortality, familiar care staff may have been unavailable to provide emotional and social support due to staff quarantining and or sickness rates or due to more intensive workloads.

6.2.10 Ethnic minorities, homeless people and asylum seekers

Due to their unique challenges, asylum seekers, refugees, Travellers, Roma and homeless people are at greater risk than the general population. They are more likely to contract Covid-19 and more likely to be adversely impacted, both physically and psychologically.

In Ireland these groups fare poorly on every indicator used to measure social disadvantage, all impacting on physical and mental health. This includes unemployment, poverty, social exclusion, physical and mental health status, infant mortality, life expectancy, accommodation and living conditions (O'Connell et al., 1997; Linehan, Duffy, O'Neill et al., 2002; Van Hout, 2013).

Emerging Covid-specific research also indicates that many social determinants of health, including poverty, physical environment, homelessness, overcrowding, race and ethnicity can have a considerable effect on Covid-19 outcomes (Abrams and Szefler, 2020). Significant social disadvantage places these marginalised groups at greater risk of contracting Covid and poorer prognosis in terms of associated physical and mental health outcomes.

Negative social determinants of health can also impact both an individual's knowledge about healthcare and resources, and limit access to them (Bernazzani, 2016) resulting in inequity of access to healthcare and supports for society's most vulnerable people.

People who live or work in congregated settings and have underlying conditions appear to be those most at risk – such as those living in homeless hostels, direct provision, halting sites and or other settings where self-separation is not possible.

With special consideration and targeted, modified and additional supports, asylum seekers, refugees, homeless, Travellers and Roma can be enabled to access and benefit from mainstream health supports and Covid-19 specific supports, including psychosocial supports.

6.3 Overview of current psychosocial supports for the general public

The following section provides an overview of the psychosocial supports that have been available either at the beginning or during the course of the Covid-19 crisis. Evolving evidence-based practice is being used to assess needs and levels of demand for psychosocial supports on a lifespan approach, as we move towards the recovery phase.

6.3.1 CHO first phase supports

As highlighted in Section 4, key responses co-ordinated in each CHO during the early phase of Covid-19 for members of the public included:

- Establishment of dedicated email and or phone lines to support vulnerable people.
- Development of print and online resource materials to support effective coping responses and psychological adjustment to challenges posed by Covid-19.
- Targeted psychological first aid supports delivered by trained health sector staff to affected members of the public, such as those bereaved, or those having to isolate.
- Co-ordinating psychosocial supports for members of the public operating private nursing homes.
- Working with and supporting community partners in city and county councils with local community level responses.

6.3.2 Psychosocial framework and mapping of current services and supports for the public

For a detailed overview of the range of current provision to the general public across levels 1–5 of the psychosocial framework, please see **Appendix 4**, which details the results of the mapping exercise carried out by the National Psychosocial Response project. For a specific summary of general public psychosocial services and supports, please see **Appendix 5**. The points below summarise the high level findings.

Level 1

Societal wellbeing – current whole population psychosocial interventions aimed at building resilience, promoting wellbeing, with a sense of safety included: provision of reliable information and signposting to evidence-based resources and tools, for example through the HSE website, HSELive, your mentalhealth.ie, local communications to media regarding psychosocial messaging and topics.

A variety of non- statutory service providers offer general mental health and wellbeing supports, and supports for specific target groups such as Travellers, LGBTI adults and young people, and those with specific disorders such as ADHD. Specific online and print resources are also offered, focused on minding mental health and wellbeing during the Covid-19 outbreak and information relating to the pandemic.

Level 2

Self-help – self-help supports include tools and information that encourage and facilitate self-help for people who are willing and able to avail of it.

The national mapping exercise suggested that most mental health services which responded offered a suite of online self-help materials such as podcasts, written resources and online webinars and lectures. There is a wide range of online and face-to-face bespoke training programmes and workshops offered by non-statutory providers, targeting priority and or vulnerable groups and those that provide care and volunteer. Community development activities, specifically with and pertaining to the mental health needs of the Traveller Community are included here.

Level 3

People-to-people – these supports include provision of informal and formal one to-one and or group supports such as provision of psychological first aid to the general public, developed by HSE area psychosocial teams. The HSE also has partnered with many non-statutory agencies to ensure a range of psychosocial supports, including targeted psychological supports such as those developed for older adults (such as Alone helpline), the bereaved (Irish Hospice Foundation Bereavement Support Helpline), supports to young people (such as Spunout and Jigsaw) and supports targeted at responding to crises and suicide prevention such as Crisis textline text50808.

The national mapping exercise suggested that supports at this level included a variety of direct therapies, counselling and crisis supports, the majority of which are face to face, but some therapies have migrated online during the Covid-19 outbreak. Some organisations have had to suspend such face to face therapies for the duration of the outbreak. The types of therapies include traditional one-to-one counselling, prescribed therapeutic approaches such as cognitive behavioural therapy and new integrative therapies such as eco-therapy. Suicide bereavement counselling is also included at this level. Some services have extended counselling provision and or reconfigured staff hours to allow for extended coverage to meet the needs of the general public and priority groups during the Covid-19 outbreak.

Level 4

Primary care and community and voluntary – structured one-to-one or group supports provided by community-based professionals such as GPs, and allied health professionals (such as psychologists, therapists, counsellors and social workers) aimed to

promote wellbeing and help people maintain personal resilience.

Psychosocial interventions at Level 4 included Primary Care psychology services to children, young people and adults continued via telephone and more recently via video calls. HSE counselling in primary care service provided structured telephone counselling and video counselling, as well as services provided by voluntary organisations, including Aware, MyMind online support, Jigsaw, Pieta, Shine and Grow.

The national mapping of services suggests that community and voluntary sector services are primarily brief or time-bound and community-based therapeutic supports. At the CHO level, there was a vast array of services reported – face to face supports that were provided across the lifecycle, covering a wide range of psychosocial issues. For example, Community Children's Disability teams continued to provide remote services to children with disabilities and their parents and or carers.

Primary Care staff have also provided ongoing support to people in the community with life limiting conditions and to residential services, providing assistance on a myriad of issues, including safeguarding, challenging behaviours, and the impact of Covid-19 on residents, relatives and staff.

One of the challenges particularly relevant at this level is early detection of 'at risk' individuals and providing them with speedy intervention. This may require further training at primary care level, for example with GPs, and awareness-raising for risk factors within the general population.

Level 5

Specialist mental health services – service users accessing this level will require increased support and easy access to specialist mental health services, which are provided through Community Mental Health Teams, Child and Adolescent Mental Health Services, Adult Mental Intellectual Disability Services and Psychiatry of Later Life. Service users attending specialist mental health services can also access the National Counselling Service (NCS) where appropriate.

Community mental health teams are multidisciplinary in nature. Psychosocial supports are provided by all team members and this is described in the HSE Model of Care (MoC) for talk therapies. This MoC is the product of significant stakeholder engagement and is due to be published in the coming months. It provides a blueprint for the delivery of psychosocial supports in specialist mental health services. The implementation of this MoC is an essential element in providing psychosocial responses to adults needing specialist therapeutic support.

Formal mental health supports are provided through existing clinical services, where secondary level care referrals are made through primary care and inpatient referrals through secondary care. Measures which prevent future mental health difficulties include targeted supports to those at high risk of psychological disorders, including enhanced awareness and diagnosis of mental health difficulties at primary care level and within Accident and Emergency (A&E), along with improved access to psychological interventions using digital technologies.

Both community and voluntary organisations at national and CHO levels reported far fewer available services and supports. At CHO level, most of the services listed were HSE supports, and the majority were face to face, requiring referral to access. Only one community and voluntary sector respondent listed a service at that level, reflecting the fact that the majority of services from non-statutory sources are community based and generally non-specific, apart from services which target particular age groups, minority groups or identified mental health needs.

Level 6

Severe and enduring needs – there is a small proportion of the population with severe and enduring mental health needs. Such people require intensive multi-disciplinary support over extended periods. The mapping carried out as part of the Psychosocial Project did not request information on services at that level.

These people may be more susceptible to increased emotional stress in response to the pandemic. They may also be more susceptible to the physical effects of the pandemic as they are more likely than the general population to develop respiratory infections (Yao et al 2020). The development of a Covid-19-related illness may also increase the risk of relapse or deterioration in their mental health (Rodgers et al 2018; Holmes et al 2020). Existing services have continued to provide face to face services to those with severe and enduring mental health needs and have added tele-psychiatry and digital working to ensure provision of psychological support. In time, specialist bereavement supports may also be required.

6.3.3 Additional service considerations

Across all current services there is an increased focus on providing digital self-help and digital mental health services (including telephone and text). These can be effective and scalable, though further research is required to understand their limitations in terms of access and impact. There are some concerns about their accessibility for some older people, those with literacy difficulties and those on lower incomes who may have less access to the internet, (UN 2020). There may also be people for whom this mode of access to therapeutic supports presents challenges in terms of engagement and therapeutic relationship. This situation would benefit from research and consideration of alternative approaches to meet the needs of such people.

Bereavement supports exist at Levels 3 and 4, with some specialist interventions at Level 5 and 6. As the pandemic moves out of the acute phase it is important to ensure access to services at Levels 3–6 and to respond to those with pre-existing or newly-developed mental health concerns.

Section 7

7.1 Current situation: healthcare workers and Covid-19

7.2 Impact of Covid-19 on the psychosocial needs of healthcare workers

7.3 Overview of current HCWs psychosocial supports across the nine CHO Areas and acute hospital groups

7.4 Anticipated demand for HSE staff supports

Section 7: Response to healthcare workers needs

7.1 Current situation: healthcare workers and Covid-19

There is widespread acceptance that the unprecedented nature of Covid-19 may impact on the mental health and psychosocial wellbeing of healthcare workers (CDC, 2020; Covid Trauma Response Working Group, 2020; WHO, 2020). For the purposes of this report, the definition of 'healthcare worker (HCW)' includes all health sector workers, irrespective of discipline or grade, including those who deliver care and or services directly to users or indirectly through management, administration and other allied services. In Ireland, HCWs include individuals:

- employed directly by the HSE
- employed by Section 38 or 39 agencies[8]
- volunteering with a health service, psychosocial provider or community service.
- providing support services on a health sector site, such as catering or cleaning
- private healthcare practitioners such as GPs, pharmacists, dentists or HSCPs.

Covid-19 challenges the psychosocial wellbeing of HCWs more than members of the general public (detailed in **Section 6**). They are more likely to face stress over potential exposure to Covid-19 by working with individuals who have or might have contracted Covid-19 and due to being 'essential workers' travelling to work, while others were encouraged to stay at home. HCWs potentially face ambiguity and role conflict due to sudden changes to work tasks, shifting demands and responsibilities, redeployment, challenges in returning to 'regular work' and uncertainty about the future. The initial and continued logistical demands on the health sector during the pandemic has impacted HCWs throughout the system, from national and senior management through to frontline, administrative and support staff.

A clear communications strategy is proposed by all current guidance experts to urgently address these psychosocial needs, (BPS, 2020, Covid Trauma Response Working Group, 2020; Greenberg, Docherty, Gnanapragasam and Wessely, 2020; IASC, 2020). The need for an adequate response is underpinned by legislation, policies and guidance (see **Section 4**).

7.1.1 Support structures for healthcare workers employed directly by the HSE

The Guidance for Psychosocial and Mental Health Needs Following Major Emergencies (HSE 2014) states that the HSE has processes and policies in place for a psychosocial response to all HSE staff. (Refer to **Section 4.1**). The primary HSE support structures include:

- **Workplace Health and Wellbeing Unit (WHWU)** – This unit has core responsibility for the implementation of employee safety, health and wellbeing governance, policies, standards and interventions, and takes a lead role of behalf of the organisation in supporting the safety, health and wellbeing of HSE HCWs. There is a formal reporting structure through which feedback is provided to the organisation on emerging trends and themes impacting the health and wellbeing of staff.

- **The HSE Employee Assistance Programme (EAP)** – This programme has been providing a range of expertise, advice and supports to HSE HCWs and managers during the Covid-19 period. These have included information, brief psychosocial support, consultation and support for managers on staff wellbeing issues, critical incident response and support to staff who were isolating. EAP also

8 Section 38 arrangements involve organisations that are funded to provide a defined level of service on behalf of the HSE. Under Section 39 the HSE grant-aids a wide range of organisations, to a greater or lesser extent. Employees of agencies funded under Section 38 of the Health Act 2004 are classified as public servants; employees of agencies receiving grant aid under Section 39 are not classified as public servants.

works with managers and staff to increase coping capacity and build resilience through pre-incident training, psycho-educational workshops and advises on planning and preparedness.

- **Local Occupational Health (OH) Services** – OH provides expertise to management and HCWs on Covid-19 infection. They manage testing and contact tracing for HCWs and provide information and support, including on those who have been identified as casual or close 'contacts', or who have been confirmed as having Covid-19 infection. Occupational Health have been the initial point of psychosocial support for many HCWs.

- **Organisational Health Division** – a part of WHWU that provides expert advice, guidance and support on work and organisational psychology and psychosocial risks in the workplace. The division also works collaboratively with EAP and Health and Safety to support the organisation's psychosocial response. The service is broken down into four functional roles – strategic, advisory, research and operational. The operational work undertaken by the service includes responding to referrals for support on complex psychosocial risks in the workplace through work and organisational psychology Interventions – for example, stress management and the identification and clarification of work-related stressors (WRS) and identifying solutions to reduce risk and resolving interpersonal conflict (including historical conflict) within teams which is symptomatic in healthcare services experiencing much change, uncertainty and role ambiguity.

- **The National Health and Safety Function (NHSF)** – a part of the WHWU, developing HSE policy from health and safety legislation and best practice, including the HSE's Policy for the Management of Work-Related Stress, 2018. All national policies are developed by undergoing a rigorous consultation process through the National Joint Council (NJC). Implementation of any policy is supported by a number of guidance templates and workshops to facilitate and clarify solutions. The HSE's approach focuses on primary interventions through risk assessment and hazard reductions. This is reflected in the HSE's Risk Assessment Tool that identifies potential risks, putting in place control measures and engaging with the workforce in a reasonable way to address hazards. The hazard must be identified, the risk assessed and control measures identified, implemented and evaluated.

- **Strategic Planning and Transformation, Health and Wellbeing** – under the Staff Health and Wellbeing work stream, this section promotes the health and wellbeing of health service staff and works to create healthy working environments as a key priority of the Healthy Ireland in the Health Service Implementation Plan. This has focussed in recent years on resourcing health organisations to respond to their staff health and wellbeing needs and the promotion of physical activity, responsible alcohol intake, general wellbeing, healthy eating and tobacco control. (This work is distinct from the work of the Workplace Health and Wellbeing Unit, under National HR).

- **HSE Psychosocial Response to Major Emergencies** – At CHO level the HSE Psychosocial and Mental Health Response Plan (2014) designated that a psychology manager in each CHO would lead on the psychosocial response in the event of a major emergency. For Covid-19 this response involved not only providing psychosocial support to the public but also responding to requests for staff support from chief officers/clinical managers and identifying needs. Each psychosocial lead chairs a Health Service Psychosocial Management Team (HSPMT) which has multi-disciplinary membership across HSE community and acute services.

- **Online national supports:** See **Section 4.3**

7.1.2 Support structures for healthcare workers not employed directly by the HSE

Support structures for HCWs not employed directly by the HSE varies according to the employing organisation. All employers have certain responsibilities towards their staff and any policy or guidance developed by the HSE must be implemented by Section 38s in line with the memorandum of understanding (as outlined in **Section 4** and **Appendix 2**). There is an employer responsibility to manage work-related stress and the safety of their staff.

Several of the acute hospitals have devised a long-term survey of hospital staff stress levels in coping with Covid-19 which will inform how to further support staff through this process. It would be helpful for acute Health and Social Care Professions (HSCP) representation to engage with this process further, to detail this work and its future findings. Some non-statutory service providers have also promoted resources targeted at HCWs.

Section 38/39 Guidance for Psychosocial and Mental Health Needs Following Major Emergencies (HSE 2014) proposes that the psychology manager would establish and chair a Partner Agencies Psychosocial Group (PAPG) which would agree the relevant elements of the Psychosocial Response Plan. In areas where the PAPG has been formed formally or informally, this network provides a useful forum for inter-agency networking for psychosocial responses (See **Section 4.2.2**).

7.2 Impact of Covid-19 on the psychosocial needs of healthcare workers

7.2.1 Risk and protective factors of the psychosocial wellbeing of healthcare workers

HCWs are subject to the same risk and protective factors common to all members of the general population (See **Section 2.1**). The literature also points to certain risk and protective factors particularly relevant to HCWs (see **Section 2.4**).

In addition to risk factors predisposing staff to psychological distress (detailed in **Section 2.4**) several protective factors have been identified. Perceived control, for example, is a protective factor. Accordingly, staff who are accustomed to high pressure clinical situations may be better protected from stress than those on the periphery or those redeployed into unfamiliar, demanding roles that are sometimes poorly defined. Other protective factors include, among other factors:

- clear communications
- access to adequate personal protection equipment (PPE)
- adequate rest breaks and shorter shifts
- practical support
- enforcement of infection control procedures
- psychological support
- redeployment should be voluntary if possible
- access to food, hydration and other daily living supplies
- video contact with families
- alternative accommodation if required
- stigma or discrimination should be tackled
- support from line and senior managers and colleagues
- encouragement from patient improvement.
- Kisely et al (2020); BPS (2020).

Further systemic protective factors include: Organisation and management to prioritise Covid-19 specific supports, including adequate training, accurate information, adequate equipment, clear and accessible managerial support, inclusion of staff in Covid-19-related discussions and decisions, all embedded in a culture of safety and support.

Psychosocial support is a protective factor. This support is best provided and most effective at the point of distress. Providing psychosocial support at point of distress is challenging due to the infectious nature of the Covid-19 virus. This can be mitigated by having trained peer support workers in each location to provide immediate appropriate support and signpost

staff to further levels of support. Consideration could be given to psychosocial training of unit staff in a model of psychological first aid so they can be embedded in their own units and available immediately to support staff wellbeing and or staff in distress.

7.2.2 Psychosocial needs of healthcare workers over time

Table 1 below summaries how the psychological response of HCWs will likely vary over the course of the outbreak.

Table 1

Psychosocial needs/processes	Psychosocial/practical supports	Organisational/management requirements
Phase: Throughout the course of the pandemic		
Basic safety needs Daily living requirements Rest/breaks Social connection Reliable information Emotional/psychological support	Good infection control and access to PPE to protect and reduce anxiety Access to healthy nutrition/ hydration/accommodation Adequate rest breaks/work schedules Access to peer and management support/ family and social connections Reliable, streamlined communications Psychological resources/self-help supports/psychosocial supports from psychological first aid through to formal counselling and mental health supports if required	Clear protocols, training and adherence on infection control Provision of access to daily living requirements 24/7 Mobilisation of staff to provide adequate staffing resources Provision of peer support systems/ attuned management re psychosocial needs and supervision/flexibility to ensure opportunities for social connection Communication, co-ordination and leadership via streamlined structures to be provided continually Provision of access to a suite of psychosocial supports via the layered care model
Phase: Preparation phase		
Anticipatory anxiety; Feeling unprepared	Timely, reliable information and communications Access to remote working options Leadership from management Gaining confidence from appropriate training	Co-ordination of public health and psychosocial communications Support for remote working and provision of IT equipment and platforms Psychosocial briefings for managers/staff Provision of pre-pandemic training (particularly relevant for re-deployed staff)

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Psychosocial needs/processes	Psychosocial/practical supports	Organisational/management requirements
Phase: Active phase		
Staff may experience a '**surge to solution'**/bonding with colleagues/ rise to the challenge Working quickly and instinctively may increase mistakes/frustration/ role confusion/breaking social norms/ poor communication and siloed working HCWs may also experience **disillusionment and exhaustion** at this most intense phase. Staff may neglect self-care and/or experience **moral injury** if their capacity to respond is limited and they are unable to act or respond within their own moral or ethical codes or to their usual standards Emotional disconnection from the work becomes a risk and HCWs may engage in avoidant or unhelpful coping patterns Work-life balance becomes harder to maintain Stress can accumulate and existing vulnerabilities are exacerbated	Psychosocial/psychological first aid briefings for managers and staff Psychological call-back service for HCW staff Encouragement of self-care from peers and managers Preparation for potentially morally injurious events (PMIEs) [Greenberg, 2020] to include diffusion of responsibility-shared responsibility Peer support/ 'buddy' systems Listening forums	Predict risk of PMIEs and provide training opportunities for HCWs most likely to experience same Ensure managers are briefed to attune to and meet psychosocial needs of HCWs Provide layered supports to managers to meet their own psychosocial needs, for example bespoke psychosocial supports Align HR and specific pandemic psychosocial response supports being offered Ensure available access to formal psychological or mental health supports Ensure active collaboration with staff through surveys of psychosocial needs Ensure effort of HCWs is acknowledged and appreciated Visible leadership presence or support
Phase: Recovery phase		
In this phase HCWs may have time for reflection Some staff may have flourished or experienced post- traumatic growth Others may be experiencing distress, shame from moral injury or resentment to others or their organisation which they may feel has failed them Individual difficulties may have wider family and/or social impacts which in turn could exacerbate longer-term impacts A proportion of HCWs may be at risk of more long-term psychological/ mental health difficulties. (Allan et al, 2020, Greenberg, 2020)	Opportunities for reflection and processing through staff or team forums such as Schwartz Rounds or other forms of peer support; facilitated reflection Managers to continue to check in and support staff. Clinical supervision is also an essential support.	Organisation to foster a culture of self-care and reflection Creating recovery phase psychosocial supports within a layered model Provision of clinical evidence-based formal psychological interventions with therapist awareness of potential presence of PMIEs and moral injury underlying trauma presentations Supporting clinical research towards assessing effective interventions Ensuring HCWs receive acknowledgement

Adapted from British Psychological Society (2020), Williamson et al (2020) & Greenberg (2020)

7.2.3 Initial challenges to healthcare workers' psychosocial wellbeing posed by Covid-19

In February 2020 at the start of the Covid-19 outbreak in Ireland, there was considerable shortfall across the healthcare system in terms of preparedness for the scale of this unprecedented pandemic. Globally, personal protective equipment (PPE) was in short supply (Gavin et al, 2020). The immediate priorities for the Department of Health and HSE were to swiftly increase the capacity for hospitalisation and or intensive care facilities and PPE, while at the same time providing public health guidelines.

The restrictions imposed by the pandemic were associated with a range of direct and indirect impacts on the healthcare system, and consequently for healthcare staff. For example, there was a decrease in presentations at accident and emergency departments.

7.3 Overview of current Healthcare workers' psychosocial supports across the nine CHO Areas and acute hospital groups

7.3.1 Psychosocial framework and mapping of current services and supports for HCWs

Findings from the mapping exercise, described in Section 1, on the services and supports available to HCWs at CHO level suggest that supports are variable across CHOs, and are primarily concentrated on Levels 1–4 of the model, with limited HCW-specific supports at Level 5. The mapping exercise did not seek information on supports delivered at Level 6 (See **Appendix 4** for full details). Below is a summary of the mapping results for HCWs according to the levels of the psychosocial framework.

Level 1

Societal wellbeing – some CHO areas did not list any supports for HCWs under that level. The supports listed as Level 1 supports by CHO areas varied from written leaflets, websites, helplines and more direct sources of psychosocial support such as the HSE Employee Assistance Programme in all but one CHO area and direct support from local human resources (HR) and psychology teams. A small number of CHO areas listed local mental health associations as a support for HCWs in addition to their support for the general public. The target groups for services and supports at Level 1 ranged from all HSE staff, to frontline HCWs and nursing home staff specifically.

In some acute hospitals psychoeducation leaflets and online resources such as hospital webpage supports were made available to staff.

At a national level, the HSE and professional bodies provided a range of supports, ranging from online resources and supports for frontline staff relating to dealing with Covid-19, to peer supports, on-to-one staff supports and more general society level interventions such as health promotion activities. Most face to face supports identified were business as usual supports and not Covid-19 specific. Covid-19 information resources were primarily digital or phone-based.

Some of the non-statutory service providers offered training programmes and workshops to HCWs working with children and young people, working with LGBTI+ young people and working with marginalised groups such as Travellers.

Level 2

Self-help – the supports listed in Level 2 in the mapping returns primarily focused on psychoeducation, providing information on positive mental health and signposting to other available services and supports. Most supports or services listed were HCW/HSE staff-specific, but there were some general HSE community services included. General community suicide prevention training programmes and bereavement programmes were listed, and what appeared to be some bespoke staff support initiatives. All of the supports listed here were HSE services.

At a national level, the HSE and professional bodies offered, or made available, Covid-19 resources, including information leaflets for staff, newsletters

and web pages or dedicated online resources on organisational websites. Some also carried out online consultations with staff to investigate the impact on Covid-19 on frontline workers. Other Covid-19-specific resources were geared towards protecting staff and client safety, such as standard operating protocols and guidance materials. There were also peer supports forums to help social workers.

Within the HSE, initiatives are underway to support staff health and wellbeing. Focused on raising awareness and building skills to promote healthier lifestyle choices and create enabling work environments, these include smoking cessation, eating healthily, reducing harmful alcohol consumption, being active and looking after our mental health and wellbeing.

Level 3

People-to-people – Psychological first aid (PFA) supports were a large part of the service and support offer listed in Level 3, with variations on PFA being offered in some areas, specifically for nursing home staff, call centre and helpline staff, healthcare managers and other psychosocial responders. Direct support provided to residential care facilities and nursing homes was also included. There were also some supports which were also listed in Levels 2 and 3, such as helplines and stress management workshops. The HSE's EAP service also provided support to HSE staff at that level. In two CHO areas there were bespoke initiatives, one of which focused specifically on the psychosocial needs of staff working from home.

Several acute hospitals established staff support helplines, staff and team training sessions in PFA distress management and 'buddy' systems. Managers were trained and supported in PFA to enable them to also support others. Environmental supports such as 'rest and digest' spaces for staff to cope while on a busy ward were encouraged. Other examples included drop-in clinics and ward-based outreach support.

At a national level, the HSE and various professional bodies offered helplines for staff, such as a helpline for nurses and a bereavement support helpline. Coaching and mentoring were also identified at that level, with those initiatives seen as professional development as opposed to therapeutic interventions. Supports also targeted at the general public were identified at that level, namely the online self-help stress control programme and suicide prevention training.

Although not operational during Covid-19, Schwarz Rounds were identified as a potentially relevant social intervention. These are conversations with staff about the emotional impact of their work. During Covid-19, 'Team time Sessions' were piloted, these being reflective practice sessions, open to services who currently implement Schwartz Rounds. It is important to note that these are not psychological interventions.

Mental Health Ireland offered mental healthcare workers an information seminar on 'Sharing the Vision' for staff and support for Peer Educators and Recovery Education Facilitators in the delivery of Online Recovery Education.

Level 4

Primary care and community and voluntary – the majority of services and supports listed in this section included business as usual initiatives such as the HSE Employee Assistance Programme, staff engagement programmes, Occupational Health, Counselling in Primary Care (CIPC) and competency training programmes and initiatives in areas such as leadership and coaching. As mentioned previously, psychology departments functioned as part of the psychosocial response teams across the CHOs, offering remote counselling and listening supports to the general public, which included non-HSE HCWs. The HSE's EAP service provided remote counselling and listening supports to directly support HSE staff.

It should be noted that that CIPC is only available to those with medical cards and due to resourcing issues,

primary care psychology is not available to all adults, including HCWS in Ireland. However, a recent EAP recruitment campaign, to address these gaps, will enable the EAP service to have the capacity to provide extended therapy for HCWs who fall within these two categories.

Apart from referencing community and voluntary services that contribute to the CHO level psychosocial groups like the Brothers of Charity, the HSE received marginal feedback on HCW supports listed from the community and voluntary sector.

At a national level, the HSE and various professional bodies provided, or made available direct supports for HCWs in the form of training programmes, one-to-one organisational supports such as employee assistance programmes, therapies for staff experiencing mental health difficulties and other supports to manage stress, such as mindfulness. Coaching and mentoring professional development supports were also included.

NGOs provided supports to targeted HCWs in the form of talks to staff in CAMHS support, training seminars for GPs and information resources for practitioners on eating disorders.

Levels 5 and 6

Specialist mental health services – there were no direct services or supports listed which were specifically for HCWs at those levels across the nine CHO areas, but one specialist service did provide information leaflets for staff working in their specialist mental health and intellectual disability service.

At a national level, the Covid-19 specific support identified was direct Covid-19 testing and information for staff, which is also a support for the general public. More specialist psychosocial supports were also included, such as psychiatry and addiction supports through GPs.

7.3.2 Workplace health and wellbeing unit supports and services

The following outlines the Covid-19 specific guidance, information, posters, infographics, and leaflets for HSE staff and line managers provided by EAP and workplace health and wellbeing unit (WHWU) to date. All of these resources are available on the HSE website.

- **Staff self-care** – guidance and messaging were developed, maximising local and national coverage such as a number of guidance and information resources which were developed and circulated by WHWU. These can be accessed on the HSE website.
- **Direct engagement** – through local networks for service managers, including HR managers and occupational health service managers.
- **Individual referral to occupational health services** – for fitness for work advice and where possible where work-related stress identified. Follow-up with HCWs who had had close contact with a confirmed Covid-19 case, or those who required testing.
- **Collaboration with other services**
  - Supporting local contact tracing and public health teams in partnership with local psychosocial response initiatives
  - Working with occupational health to support HSE staff in self-isolation
  - Partnering regional services about psychosocial responses.
- **A dedicated national helpline for HCWs for Covid-19** – integrating the expertise within WHWU to provide consistent, up-to-date advice and support for HCWs. The helpline signposted to relevant psychosocial supports.
- **The national health and safety function** – providing numerous other Covid-19 supports, including the topic of the safe return to work for HCWs, which can be viewed **here.**
- **New channels of service delivery** – included EAP virtual counselling and consultation.

7.3.3 Major emergency psychosocial responses led by psychology psychosocial leads

There were variations across the CHOs in terms of the response, led by psychosocial leads (detailed in **Section 4.2.1**), but interventions and services included:

- Psychosocial call-back psychological first aid for staff
- Nursing homes – private and public manager and staff bespoke supports
- Psychology supports for mothers experiencing post-natal depression and or difficulties referred by public health nurses (PHNs)
- Call centre support in situ or remotely for call centre staff
- Support for public health service
- PFA briefings for managers and staff
- PFA training for psychosocial responders
- PAPG partner agency psychosocial groups and network supports
- Communications – media news articles and radio presentations
- HSEland modules for managers and staff about supporting staff wellbeing during Covid-19
- Videos on staff wellbeing during Covid-19
- Acute hospital survey

7.4 Anticipated demand for HSE staff supports

It is anticipated that demand for support from HSE staff seeking direct support will increase for both personal and work issues.

Ongoing psychosocial support and information on formal and informal supports will continue to be available through EAP and ACMTs. EAP will continue to provide psychosocial support, one-to-one workplace counselling and group support for staff, while developing and reporting on the main themes and issues drawing on all EAP services. All support services will use appropriate pathways to secondary mental health services.

EAP will provide briefing and training for managers on active monitoring of staff mental health and referral pathways. Online and face to face group sessions will be provided on Covid specific issues as outlined **here** and addressing Covid specific post-traumatic stress (PTS), burnout, complicated grief, stress reaction and anxiety for staff as appropriate.

Organisational health interventions have recommenced for services with complex psychosocial risks. Psychosocial guidance documents are subject to ongoing review to ensure up-to-date information and advice is available to HCWs.

During Covid-19, numerous psychosocial guidance documents including Return to Work – Supporting HCWs during this transition were developed and referrals from HSE services for support have recommenced.

7.4.1 Longer-term supports for HSE staff

The Workplace Health and Wellbeing Unit will continue to take a lead role in employee safety, health and wellbeing on behalf of the HSE during recovery and post the Covid-19 pandemic. The Unit in its structure and mandate, under the direction of its national clinical lead will continue to implement its model of care, as follows.

- Prevention of ill-health caused or exacerbated by work
- Timely Intervention, easy and early treatment for the main cause of sickness absence
- Rehabilitation, to help workers stay at work or return to work after illness
- Health assessments for work, to help manage attendance, retirement, and related matters
- Promotion of health and wellbeing, using work to improve health and wellbeing and using the workplace to promote health
- Teaching and training; encouraging workers to support staff health and wellbeing.

This work will contribute to:

- Reducing HCW exposure to complex psychological risks and work-related stress in the workplace in the aftermath of the Covid-19 pandemic.
- Creating work environments where managers and workers are psychologically safe and where health and wellbeing is supported.
- Supporting teams to enable the development of work environments that build on resilience and resilient service delivery, which in turn has the potential to impact positively on quality and building of patient care.
- Build pre-incident preparedness by increasing knowledge of stress management and positive coping skills as well as awareness of potential normal reactions to stressful events

WHWU is in prime position to provide the vital support to HSE staff, managers and the organisation, post Covid-19. Interventions and supports planned will be provided by highly experienced, qualified HSE practitioners, who through their staff support experience and organisational knowledge are uniquely equipped to support all HSE staff.

EAP will continue to provide individual counselling and group support during and following challenging workplace incidents, situations and traumas. There may be post-trauma stress reactions emerging. There may also be increased, or decreased, staff engagement and commitment, based on their perception on how they were treated by their employer during a difficult time when they were vulnerable. These issues tend to emerge when the 'crisis' is over.

These supports will work with certain issues, including the following:

- Anger towards management, staff unrest, possibly fractured or damaged working relationships after Covid
- Bereavement and complicated grief in the healthcare setting
- Burnout in HCWs
- Depression – high rates reported in HCWs involved in coronavirus response (Kang et al., 2020)
- Family demands and caring responsibilities being superseded by additional Covid-related work demands
- Fatigue and sleep hygiene
- General atmosphere in work at the moment
- Group support platforms being requested through EAP
- Critical incident response
- Issues around staff who have underlying health issues
- Managers and the impact of Covid-19 on them
- Moral injury
- PTS/PTSD
- Work-life balance sessions
- Stigma and Covid-19 negative perceptions in their community, family or friends around HCWs possibly being contagious
- Trauma support, including vicarious trauma in a healthcare setting
- Resignation and early retirement of staff who prior to the pandemic did not plan on leaving the service
- Post-Covid-19 supports for HCWs who contracted Covid-19 and may be suffering from prolonged medical symptoms and psychological distress

Organisational Health will continue to provide support to services and teams to proactively reduce HCW exposure to work-related stressors which is critical to employee safety, health and wellbeing; and building work environments where HCWs feel psychologically safe too. Work and organisational psychology interventions will continue in response to, supporting and or needing to address complex psychosocial workplace risks, including:

- Work-related stress risk assessment; work demands, change, role, control, support, relationships (Management Standards and HSE WRS Policy Framework)

- 'Working in challenging work environment' – established workshop for teams
- Interpersonal conflict
- Low morale
- Support on 'return to work' for teams
- Team burnout and self-care

7.4.2 Supports mandated by the HSE for HSE staff

In addition to the mandated responsibilities outlined in **Section 4**, the activity of the Workplace Health and Wellbeing Unit is being systematically planned in order to manage the increased demand on its services. HCWs will continue to be at the front line of Covid-19 and are at risk of infection and hazards, including pathogen exposure, shift work, psychological distress, fatigue and burn out.

The role of the WHWU is to provide the strategic direction and guidance on staff health and wellbeing in both a Covid-19 and non-Covid environment through a range of expertise, advice and supports to healthcare staff and managers, specifically on Occupational Health, Employee Assistance Programme, Work Rehabilitation, and Health and Safety. Along with current service demands, the medium-to-longer term will require that WHWU are able to respond to and support staff with regard to:

- Current evidence-based practice
- On-going testing, monitoring and contact tracing of HCWs
- Managing cases, including pregnant HCWs and immune-suppressed HCWs
- Fear and anxiety
- Anger, workplace conflict, work grievances
- Trauma, bereavement, loss, grief, death in service
- Stigma, guilt
- Family and domestic conflict, family challenges related to restricted movement
- Redeployment stress, swift changes in team dynamics and workload
- Stress related to working from home
- Health and safety risk assessment and requirements regarding physical distancing in the workplace
- Staff travelling for work
- Returning to work
- Health and safety auditing and training
- Optimising case management
- Evidence-based psychosocial responses

7.4.3 Current themes and trends relating to the impact of Covid-19 on healthcare workers

The following themes which were observed from data collected for the period March to June 2020 following HSE EAP interactions with staff, calls to the HCW Helpline and referrals for support to Organisation Health, reveal the following are the key concerns for HSE managers and staff (note: this is not an exhaustive list).

- Personal
  - Anxiety regarding Covid-19 and panic attacks
  - Bereavement
  - Depression
  - Addiction and substance misuse
  - Financial stress
  - Relationship issues
  - Pregnancy concerns

- Workplace and work environment
  - Support on 'return to work' phase for workers coming back to the health system
  - Work-related stress
  - Communication
  - Fear of exposure to Covid-19 at work
  - Response to workplace incident and assault in the workplace
  - Work-life balance affected due to Covid-19 crisis
  - Working from home issues (feelings of guilt and being isolated)
  - Role change due to Covid-19, re-deployment issues
  - Anger towards management

Section 8

Section 8: Recommendations

This section details the report's main recommendations to allow the health sector to adequately respond to the scale and impact of this pandemic and its enduring effect on the lives of people and communities. To aid implementation, the recommendations have been summarised into the following eight key action areas.

1. **Oversight and governance structures**
2. **Re-alignment of existing services towards the implementation of the psychosocial framework**
3. **Priority groups**
4. **Healthcare Workers (HCWs)**
5. **Technology and innovation**
6. **Research, evaluation and monitoring**
7. **Communications and engagement**
8. **Future preparedness for national public health emergencies**

Within these key action areas, the main recommendations are highlighted, with additional information and supporting actions. A baseline implementation plan, reflecting the recommendations, will also be provided to the national board (See **recommendation 2**).

8.1 Action area 1: Oversight and governance structures

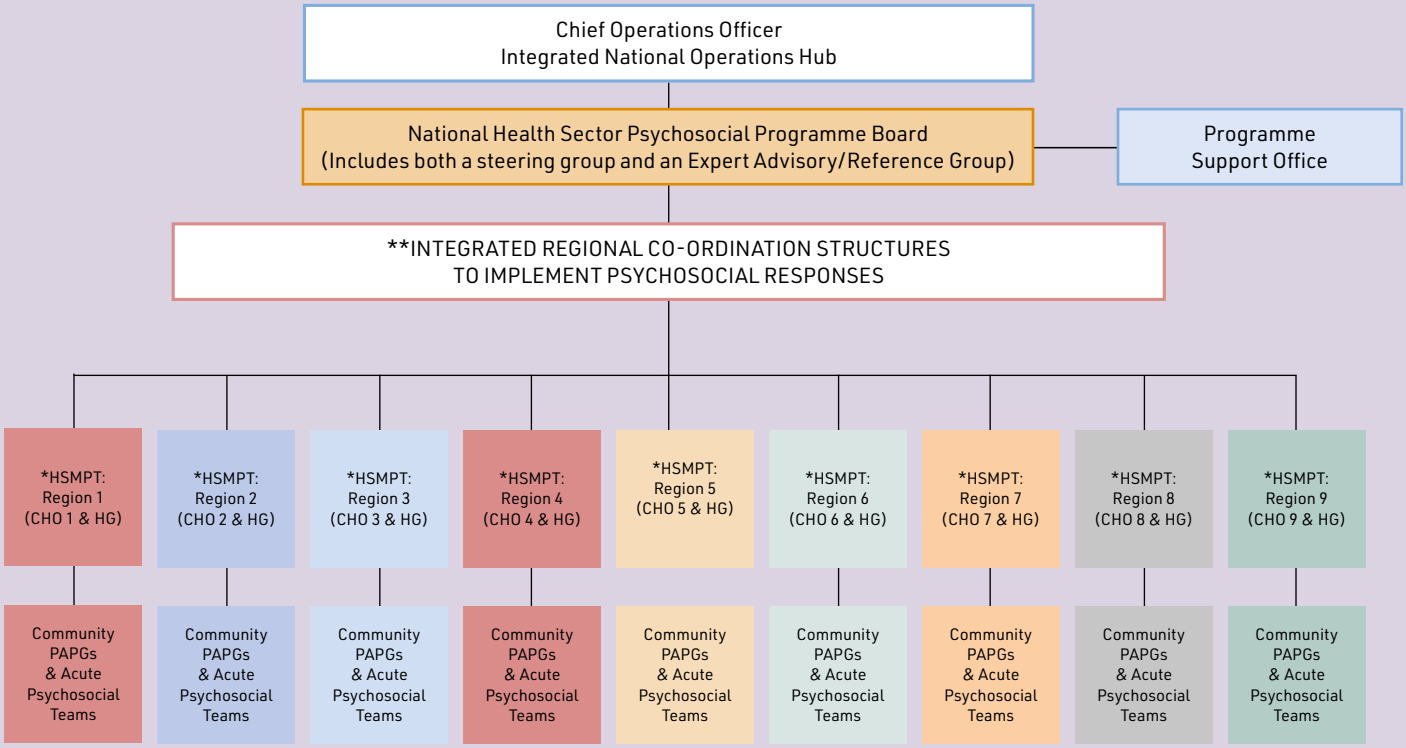
These recommendations are focused on the structures responsible for overseeing and co-ordinating the implementation of this framework across national and regional health structures as they evolve under the healthcare reforms of Sláintecare.

Note: *Due to the unprecedented and rapidly changing nature of the Covid-19 pandemic, recommendations may need to evolve and/or be adapted as new evidence emerges, and if the pandemic changes and unfolds in currently unforeseen circumstances.*

Key features of the recommended structures:

- Aim to strengthen, evolve and utilise experienced and existing structures and teams.
- Focus on integrating community operations and acute hospital psychosocial services.
- Provide an umbrella structure to bring together the diverse groups needed to provide an effective psychosocial response and ensure co-ordination and networking across inter-disciplinary, inter departmental, inter-agency and non-statutory service providers.
- Strengthen the co-ordination of psychosocial services and access for priority groups across the array of providers to avoid unnecessary duplication.
- Membership of these groups will be based on areas of expertise and competency and should not be primarily based on representation from specific organisations.
- Provide a future structure, ready to address the potential of another national public health emergency.

The following organogram illustrates the recommended governance structure of the health sector psychosocial response.



**Health Service Psychosocial Management Teams.*
**
- *Dedicated Psychosocial lead with admin support*
- *HSMPT will lead/co-ordinate integrated hospital / community approach*
- *Governed via joint Chief Officer & HG CEO planning and implementation forum*

***Note:** this structure will evolve from nine Community Healthcare Organisations (CHOs) to six Regional Health Authorities (RHAs), as Sláintecare implementation progresses. The remainder of section 8.1 provides more detail for each of the proposed structures.*

Recommendation 1: Maintain the current national psychosocial response project structures, such as the Steering, Working and Expert Advisory groups until the new National Health Sector Psychosocial Programme Board is established, in order to maintain momentum and cohesion (See **section 8.3**).

Key objectives for transition:

- Maintain leadership focus on the psychosocial timeline and the importance of continued actions, to prevent problems caused by Covid-19, six months to two years down the line.
- Oversee the formation and establishment of the recommended new oversight body, the National Health Sector Psychosocial Programme Board, and the enhancement of CHO psychosocial structures (See **section 8.3**). This would include the development of terms of reference and clear expectations of roles and responsibilities.
- Establish a psychosocial monitoring and evaluation dashboard (See **recommendation 19**).
- Prioritise research and getting feedback from the lived experiences of people, particularly those in the groups identified as exceptionally impacted by the pandemic, for example feedback from residents in nursing home settings, about their experiences throughout the pandemic and what their needs are now and what they needed at the height of the outbreak (See **recommendation 20**).
- Continue with the communications plan to raise awareness of key psychosocial messages, ongoing work being done and psychosocial supports available (See **recommendation 21**).

Recommendation 2: Establish a National Health Sector Psychosocial Programme Board. Its overall responsibility will be to oversee the effective implementation of the health sector psychosocial plan, represent psychosocial response at a national level, drive and support actions, ongoing communication and monitoring.

Key features of the board:

- **Board structure** – based on the effectiveness of the existing project's structures and the need to be agile, it is recommended that the board be constituted into two components: 1) a steering group for organisational and co-ordination purposes, and 2) working and sub groups based on need and specific knowledge and expertise.
- **Reporting lines** – it is proposed that the board reports to a national oversight structure to be determined by the Chief Operations Officer in consultation with the HSEs Executive Management Team.
- **Membership** – as outlined in **Section 3**, early psychosocial responses lacked joined up connections and alignment of shared offerings. It is proposed that this new board will bring together all areas under one roof, focused specifically on the national Covid-19 psychosocial response.

Specific features of the board's membership include:

- Its composition should cross care sectors and priority groups, and not be only mental health specific, due to the broad remit of an effective psychosocial response.

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- The board will need to be connected to existing structures and its members need to be key decision-makers at a senior level to function and to ensure timely decision-making and maximum effectiveness.
- The board membership size should enable prompt and effective decision-making and national issue and risk resolution, with the board not carrying out consultation-related tasks that should take place at the work stream and advisory group levels.
- Acknowledgement of the added value and importance of partnering with non-statutory service providers to provide full psychosocial community supports. This partnership at all levels builds on recent collaborative experiences, improves communication, integrates planning, maximises capacity and avoids duplication.

Suggested membership of the board and supporting substructures such as work and advisory groups may include:

- Each care group – primary care, mental health, disability, older persons, health and wellbeing (HSE)
- Acute hospitals (HSE)
- Nine CHO psychosocial leads (See section 8.3.2) (HSE)
- National HR (HSE)
- WHWU – to include Occupational Health, EAP (HSE)
- National health and social care profession, including social work, psychology etc.
- Medical and nursing professions
- Representative(s) of the public
- National Section 38 and 39 organisations across community and family organisations
- Public health (HSE)
- Adult Safeguarding and Domestic Violence service
- National Educational Psychological services (NEPS)
- Telehealth
- Government agencies such as Tusla and National Safeguarding Office for Vulnerable Adults.
- Internal, external and media communications

- **Areas of responsibility** – the first essential task of the board will be to develop a work programme which sets up work processes, plans for the implementation of recommendations, prioritises actions, aligns funds, sets up specific initiatives to achieve alignment with the framework and plans communications.

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The following are some suggested additional areas of responsibility:

- Provide national governance, oversight and advice to the programme
- Update the terms of reference for regional structures (See recommendation 5), including clear direction on reporting lines, engagement with the future evolution of Area Crisis Management Teams (ACMTs).
- Under the existing HSE Accountability Framework protocols, support national commissioning teams to manage non-statutory service providers by aligning their existing services and supports to the framework, effectively meeting emerging critical needs and building up the psychosocial response's national capacity. For example, each service provider can be commissioned to provide a service for the psychosocial framework. The national mapping exercise showed that many funded services provide important aspects of the national psychosocial response across individual, families, communities and vulnerable groups.
- Promote consistency and standardisation to reduce regional variation, maximise resources and reduce duplication of effort
- Monitor and evaluate the effectiveness of psychosocial responses
- Support regional and local areas, as and when required
- Capture, share and replicate examples of good practice
- Support national training and educational initiatives
- Promote research into the understanding and development of psychosocial response improvement and innovations
- Determine national responsiveness and readiness
- International representation with relevant organisations including the WHO and the UN

- **Programme support office** – to support the board in carrying out its core functions, a full-time programme support office is recommended. This function will be responsible for the day-to-day roll-out of plans and the system-wide communications and linkages with all involved members and groups. This office will be supported by the Chief Operations Officer to promote effective engagement across community operations and acute. Note: current internal HSE structures may change with internal reviews.
- **Timeframe** – based on international experience and research, it is envisioned that the board will be in place for two years. Meeting frequency will be based on either acute or the needs of the different psychosocial stages. After the two-year period, it is envisioned that the board will continue to meet once to twice yearly to maintain readiness and to retain the essential working relationships required for a rapid response, should a similar national public health emergency re-occur.

Recommendation 3: Establish the role of the regional psychosocial lead as a full-time post responsible for overseeing the roll-out of psychosocial responses, chairing the HSMPT, driving integration with the acute services, targeting priority areas most impacted by Covid-19 and supporting the implementation the framework's recommendations.

Key supporting actions include:

- **Allocation of a full-time post** – due to the substantive future nature of this role, it is recommended that the psychosocial lead post is made into a full-time position for the duration of the Covid-19 psychosocial impacts, estimated to last two years (See **section 8.4.1**).
- **Build on experience** – to maintain momentum on the ground, addressing the Covid-19 situation, building on the experience of the current postholder would be advised. Where this situation is not possible, if for example, the current postholder will not be continuing in post, it is recommended that the holder of this post be appointed based on relevant skill sets, competency and experience. The post may be filled from psychology, social work, and psychiatry, health and wellbeing, EAP or other disciplines. A job description based on core competencies would aid this process.
- **Local flexibility** – the method of resourcing and operationalising this post needs to be determined and agreed in consultation by the chief officer at regional level.
- **Reporting line** – based on a co-leadership approach, the regional psychosocial lead, as chair of the HSPMT, will have a reporting line into CO, with regular updates and meetings with the hospital group CEO.
- **Dedicated administration and project support** – to support the work of the psychosocial lead and community psychosocial teams. This support will need to be available for the full duration of the psychosocial response, but can be adjusted based on the stage of need (See **section 8.4.1**). The assignment of administrative supports for the psychosocial lead is to be determined by the chief officer regarding the role as outlined in this framework.

Recommendation 4: Identify a group psychosocial co-ordinator for each hospital group. The role of the co-ordinator is to oversee the roll-out of the group's psychosocial responses across each of the group's hospitals, targeting priority areas most impacted by Covid-19, representing the group at a regional level and integrating acute and community psychosocial supports.

Key supporting actions include:

- **Allocation of protected WTE** – to sustain this position moving forward, it is recommended that the group psychosocial co-ordinators have specific and appropriate time prioritised and allocated to this role, within their current Whole Time Equivalents (WTEs), (See **section 8.4.1**). The method of resourcing is to be determined and agreed in consultation with the CEO and hospital group management.
- **Competency based** – it is recommended that the person chosen for this position be identified based on relevant skill sets, competencies and experience in the field. For example he or she could be from psychology, psychiatry, social work, health and wellbeing, EAP or elsewhere.
- **Reporting line** – based on a co-leadership approach, the group psychosocial co-ordinator will have a reporting line into the regional psychosocial lead and the hospital group CEO.
- **Dedicated administration and project support** – to supplement the work of the hospital group's psychosocial co-ordinator and hospital acute psychosocial teams. This support will need to be available for the full duration of the psychosocial response, but can be adjusted based on the stage of need (See **section 8.4.1**). The allocation of the exact amount of WTE within existing roles is to be determined and agreed in consultation with the CEO and hospital group management.

Recommendation 5: Maintain and or establish (where needed) Health Service Psychosocial Management Teams (HSPMTs) and enhance them to address the wider societal needs of the Covid-19 pandemic and its anticipated prolonged effects.

The HSPMT's role, supported by the national board, will be to act as a point of local co-ordination with relevant stakeholders, including the acute services. HR/WHWU, to reduce duplication of effort, streamline communications and deliver on psychosocial initiatives for the public and HCWs who have been impacted by the Covid-19 emergency.

Recommended enhancement features:

- **Joint reporting to the chief officer (CO) and hospital group CEO** – this dual reporting line or co-leadership is crucial to fully involve the acute services within the enhanced structures and will be through a joint planning and implementation forum. HSMPTs reporting directly into the chief officer, is necessary, since the psychosocial response crosses all care groups and is crucial in terms of timeliness of decisions, redeployment of staff, ring-fencing resources, avoiding care group silos, partnering with non-statutory service providers and achieving maximum effectiveness.
- **Representation** – on the National Health Sector Psychosocial Programme Board. The psychosocial leads, as chairs of each of the HSPMTs, will represent the CHO regions on the national board. It is recognised that regional crisis structures may be stood down and or scaled up, depending on the nature of the pandemic. Each HSPMT needs to ensure that they co-ordinate their work with any existing crisis structures and have appropriate representation on those structures, such as local Area Crisis Management Teams (ACMTs).
- **Membership** – the proposed membership will be developed in consultation with the CO and CHO management. Membership should aim to bring together local services and disciplines, providing direct psychosocial response areas with the CHO. Suggestions include, but are not limited to experts from:
  - CHO and hospital group senior management
  - Local care groups, including primary care, mental health, disabilities, older persons, health and wellbeing
  - Child and adolescents services
  - Social inclusion
  - Palliative and chronic condition services
  - Internal HSE psychosocial services such as EAP, Occupational Health, HR
  - Principal psychologists and social workers within the CHO
  - Local Section 38 and 39 organisations
  - National Counselling Service
  - Resource Officers for Suicide Prevention (ROSPs)
  - Adult Safeguarding and Domestic Violence Service
- **Areas of responsibility** – these would mirror the national board's responsibilities, but within a CHO regional context. The immediate task of the HSPMTs will be to develop a regional psychosocial implementation plan, based on direct guidance from the national board. Additional suggested responsibilities could include, but not be limited to the following:

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- As part of local psychosocial planning, to facilitate the establishment of local community Partner Agencies Psychosocial Group (PAPGs), as detailed in the 2014 guidance document.
  This will ensure that the psychosocial needs of both the general public and priority groups are met, at a local level, while promoting their social support networks. On the ground experience during Covid highlighted the importance of local community groups in providing localised and bespoke services for specific community needs.

  The function of PAPGs is to develop inter-agency plans for preparing, exercising and delivering local and community response plans. Representatives should be from the local configuration of mental healthcare and psychosocial services. Many HSPMTs and local HSE professionals such as social workers have developed strong links with community, voluntary and other partner agencies, which can be formalised into local PAPGs. It is recognised that not all areas would require these teams and or have the resource capacity. CHO psychosocial planning should consider where they are needed and provide supports as required.

- Similarly, within certain acute hospitals, teams of psychosocial responders were established to address the psychosocial needs of both the patients and the staff within their hospital. The HSPMT in liaison with the hospital group psychosocial co-ordinator should review how best to provide these teams with supports.

- Detailed mapping of local psychosocial services would be a continuation of the baseline mapping already completed, but with specific focus to ensure inclusivity of all relevant services while identifying service gaps. This work can ensure psychosocial responses are in line with the psychosocial framework and facilitate agreement on roles and responsibilities. It is recommended that a working group is convened through the CO's office that would include local service providers, and could go through the baseline mapping list to identify those agencies that are best placed to provide psychosocial support which addresses particular vulnerable groups.

- Support local commissioning teams under the HSE's Accountability Framework to manage non-statutory service providers by aligning their existing services and supports to the framework to effectively meet emerging critical needs and build up the psychosocial response's local capacity, so that each service provider can be commissioned to provide a service as part of the psychosocial framework. The CHO mapping exercise showed that many funded services provide important aspects of the local psychosocial response across individual, families, communities and vulnerable groups. HSMPT members' awareness and understanding of existing SLA protocols will need to be improved, if required.

- Recognition of the services and interventions provided by all disciplines in meeting psychosocial needs at local level.

- Commission, monitor and evaluate the level of psychosocial service.

- Communicating local care referral pathways and options to members of the public and HCWs, to support presenting needs and those people with specific mental health issues as a result of the pandemic, for example, where people should go as first port of call and with clear links to EAP, health and wellbeing, counselling, family and community supports.

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- Develop local service delivery models to integrate responses across care services, community operations, acute services, health and social care disciplines and local agencies.
- Staff and service user feedback to ensure that information from users on the ground gets feedback up the system to management.
- Engage with health and social care professionals to build on existing expertise in the delivery of psychosocial services and deliver educational and information workshops to address local training gaps such as staff abilities to identify and know where to refer psychosocial concerns.

8.2 Action area 2: Re-alignment of existing services towards the implementation of the psychosocial framework

This set of recommendations focuses on re-aligning existing services and functions to the psychosocial framework and utilising them to advance the implementation of the report's recommendations.

Recommendation 6: The Covid-19 Psychosocial Response Framework will form the basis for strategic and operational planning, resourcing and funding for the health sector's psychosocial response.

This approach should be consistent with existing policy frameworks and most importantly with the principles of healthcare reform as set out in Sláintecare.

As noted in Section 5, this framework has a broader focus and looks beyond psychosocial response in terms of individual psychological distress caused by the Covid crisis, but frames it in a wider context, looking equally at the social impacts, the effects on family and community, and the need to build resilience in the face of both the pandemic and a potential economic recession.

At a strategic and operational level, the framework provides a structured approach to:

- Plan services that promote service levels in support of the whole of the population.
- Allocate targeted costing for each level based on the premise that the lower down a level is in the pyramid (such as specialist mental health services), the higher the cost of the service or support per person accessing the service.
- Create ongoing analysis and understanding of where current service and supports are for each area and organisation while strategically planning to focus on one or two levels or address gaps at each level where they may exist.

At the psychosocial responder level, the framework provides a structured approach to:

- Focus on the various layers of need and supports that should be considered.
- Understand the interventions that can be adapted to suit different stages of the psychosocial process and different effects of Covid-19.
- Outline the practical steps required to provide the necessary psychosocial supports to both the public and HCWs.

Recommendation 7: Re-configure and ring-fence funding for psychosocial response based on the psychosocial framework and fund elevated robust psychosocial responses to Covid-19 for **1)** Direct community and acute workforce provision, **2)** Extending of provision, **3)** Oversight and co-ordination of services, **4)** Direct psychosocial interventions, and **5)** Research and additional provisions.

Direct community and acute workforce provision

Sustaining and building an effective psychosocial response, cannot be achieved alongside obligations to provide normal services without adequate resources. The funding recommendations below are based on the staffing resources required to set up, build and sustain an effective psychosocial response, within both community and acute services. These recommendations are not part of standard service planning and commissioning processes, but are based on the need for:

- Existing staff resources to be re-orientated to align with the psychosocial framework.
- Ring-fencing and targeting of existing staff resources, based on identified service gaps in the current psychosocial provision and how best to strengthen that response.
- Resources to be ring-fenced based on estimates for both national and regional level needs.
- Psychosocial response to be sustained when care services return to normal service delivery.
- Equal and full national coverage of psychosocial supports.

Key supporting actions include:

- **Provide HCWs direct psychosocial supports** – for a HCW psychosocial response, additional funding resources need to be allocated to enhance the permanent staff support structures for public sector HCWs – for example for WHWU staffing establishments.
- **Develop regional psychosocial workforce plans** – both CHO and acute hospital management need to work with their psychosocial leads, hospital group co-ordinators and WHWU staff to conduct a rapid workforce plan. The aim will be to quickly identify gaps in local or HSE provision, review evolving psychosocial service needs, take into account exiting gaps in core services, and identify a plan on how to fill the gaps and ensure adequate staff for effective provision.
- **Resource nine regional psychosocial leads** – to sustain an effective local psychosocial response, personnel working in this role need to be assigned full-time (See recommendation 3). Resources need to be made available to cover subsequent backfill requirements. The exact duties re-allocation should be agreed at the CHO level, with guidance from the board for national consistency.
- **Maintain and build dedicated psychosocial teams** – to ensure continuity and prepare for emerging psychosocial needs and local psychosocial workforce planning needs to address:
  - The retention of existing skilled staff – where existing staff are required to provide a dedicated psychosocial response beyond the scope of their usual work, this time needs to be quantified and backfilled accordingly, to ensure continuity in existing services.

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  - Engagement of staff previously trained in core skill areas – core psychosocial skills have already been part of professional training to date, like psychological first aid (PFA) for mental health nurses, crisis interventions for social workers, and many staff have completed online PFA training. Community and acute planning needs to incorporate this cohort.
  - Re-deployment of additional dedicated staff – with assigned WTE. To achieve the necessary cohort of a psychosocial team, the use of other disciplines and services, beyond psychology is necessary, such as counsellors, social workers, nurses and occupational therapists, but with the appropriate skill mix to address emerging needs of children, adolescents, adults and older persons.

- **Resource psychosocial teams in acute hospitals** – to support existing staff, ensure the sustainability of a psychosocial response and address patients' needs, hospital management need to address the capacity needs of their psychosocial response. Similarly the workforce plan needs to address the need to have protected time for local psychosocial co-ordinators and staff, retention of existing staff and additional staffing requirements. It is important that hospitals may also have patients and their families who are at risk of extreme distress due to Covid-19, such as palliative, cystic fibrosis and diabetic patients, and need to be resourced for that need.

Additionally, smaller hospitals that may lack key staff, such as psychologists and social workers, should integrate their workforce plans with their local community psychosocial response teams, to pool resources and agree dedicated time allocation or specific psychosocial supports.

Extending of provision

Within the overall system, we need to build up our psychosocial capacity to address the medium-to- long-term need. Recent CHO experience has highlighted the importance of spreading the delivery of supports across all grades and disciplines through training. Psychosocial supports at Levels 1–3, do not require professionally trained personnel. However, qualified personnel can extend the reach of psychosocial services by training others, such as in psychological first aid. That training will enable multiple staff to be available to deliver a psychosocial response. Dedicated funding is needed to support:

- The expansion of existing online and on the ground PFA training.
- Where gaps exist or new needs have emerged, the development of updated training such as online videos.
- Continuous professional development (CPD) and supervision needs of staff involved in providing psychosocial response at all levels.
- Training partner non-statutory agency staff, in psychosocial responding principles.

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Oversight and co-ordination of services

In order to support and sustain the planning and delivery of ongoing psychosocial responses and the framework's recommendations, there is a resource requirement for:

- **A national programme office and project support** – to support national delivery and the co-ordination of the implementation of recommendations. These resources need to be dedicated for psychosocial demand and not directed away elsewhere.
- **Local CHO project and nine administration resources** – to support CHO delivery and implementation of recommendations, there needs to be one WTE administrator to co-ordinate and support the administrative functions of the psychosocial response across the region and to ensure protected time for project management support.

Direct psychosocial interventions

National and regional resource recommendations for detailed levels of psychosocial interventions will be made at the national board and HSPMT level. However, to aid that process and the overall strategic distribution of resources, the psychosocial framework provides the basis to target and review resource re-alignment within existing strategies and operational plans. Based on an analysis of each level (See section 5), the recommendations are:

- **Level 1: Societal well-being** – to ensure the quality of this level which includes universal supports such as Your Mental Health and focused campaigns, it will be necessary to engage in regular quality assurance of content. One dedicated or full-time resource is required to coordinate online content, resources and services relevant to the public and healthcare worker psychosocial needs, in keeping with the plans of the HSE's National Mental Health Steering Committee (See **recommendation 21**).
- **Level 2: Self-help** – this level is important for mitigating the need for people to progress to the next levels. Recommended focus here is to fund further resilience building supports for HCWs and to develop a systematic way to review, quality assure and signpost mobile self-help apps.
- **Levels 3 and 4: People to people/primary care and community and voluntary** – current Sláintecare and HSE corporate plans to expand and resource the delivery of primary care services, including primary care psychology, are in line with the needs of the psychosocial framework. It is essential to address public and staff needs while they are still at the primary care level, before their needs elevate and they need to progress onto secondary level mental health services.

Currently there are services provided at this level by both the HSE and partner agencies. It will be important to look at the service offerings at a local level to ensure that duplication of service and gaps in services are identified and addressed. This may entail some changes in current practices.

  - For the public – one area for resource allocation will be to increase GPs' awareness of and responsiveness to psychosocial needs, and their ability to direct people to supports at this level.

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- For HCWs – identify models of support similar to those in the HSE, such as EAP, for non- statutory providers, which may include resourcing a shared service response.
- For both the public and HCWs – a strengthening and tightening of partnerships with the community and voluntary sector will improve strategic investment, monitoring mechanisms, evaluation and ultimately the quality and reach of community and voluntary supports.

- **Levels 5 and 6: Specialist Mental Health Services** – there is a need to strengthen core mental health services so that they are in a position to address an anticipated increase in mental health referrals at those levels. The activities and needs at those levels of the framework can be resourced and addressed within current mental health funding structures. However, from a psychosocial perspective additional funding should be allocated to:
  - Advance the implementation of the Model of Care for Talking Therapies, by extending the planned pilot sites from three to nine, in order for the project to have national coverage.
  - Telehealth – ongoing work in telehealth is to be resourced in keeping with the proposals reviewed and approved by the INOH Telehealth Steering Group.
  - Addressing capacity issues for increased levels of more complex needs – such as complex presentations which may now also include post traumatic stress disorder (PTSD), and prolonged and complex grief responses due to Covid. Increased demands for service in a context of decreased capacity due to Covid prevention responses will mean that there is a need for increased staffing in order to respond.

Research and additional provisions

To support ongoing delivery and development of the service, additional funding will be required for:

- **Evaluation** – for the design and development of an evaluation framework and its establishment, including the setting up a key performance indictor dashboard and ongoing automated monitoring system (See section 8.5).
- **Mapping** – at Levels 3 and 4 of the psychosocial response framework, the key problem is a lack of clarity on the services and needs available. Within the limited timeframe, this project's CHO mapping exercise could not adequately address this. The recommendation is to allocate resources to accurately map services at Levels 3 and 4, in order to allow for funding decisions.
- **Research** – to develop our understanding of the current Covid-19 pandemic in terms of its psychosocial impact on the population and to prepare for future national public health emergencies, further research will be needed. The recommendation is for allocated funds to be given to specially commission pieces of research within the Irish context (See **section 8.5**).
- **Public Foras** – to cover the incurring cost of participation in public consultation sessions.

Note: *Each associated business unit in the HSE as part of their estimates planning process will need to take the psychosocial framework into account.*

8.3 Action area 3: Priority groups

This set of recommendations details population groups and the associated planning that needs to be prioritised in the next phase of psychosocial response supports and services.

Recommendation 8: Planning processes to remain informed and cognisant of the specific needs arising within particular settings and population groups, in line with evidence arising internationally and nationally, with respect to the impact of Covid-19 for priority groups: **1)** Older adults, **2)** Family carers, **3)** Bereavement care, **4)** People with disabilities, **5)** People using Mental Health Services, **6)** Children and young people, **7)** Marginalised groups.

Older Adults

Continued resourcing of disciplines with specific training and expertise in psychosocial responses on community multi-disciplinary teams (MDTs) – for example, Primary Care teams, Safeguarding and Protection teams, Integrated Care Teams and Community Mental Health Teams, aligned to current national recommended levels.

Family carers

The alleviation of family carer stress requires a combination of practical, emotional, social and psychological psychosocial support. The nature of the care burden means family carers may need support around the co-ordination of care arrangements, in order to maintain resilience or engage with psychological or listening support.

- The national board in collaboration with identified stakeholders to develop protocols to support family carers during the course of the pandemic.

Bereavement care

- During the pandemic period, the bereavement supports, as outlined in the National Loss, Grief and Bereavement pathway of the Adult Palliative Care Services Model for Ireland, 2019, should be available to all individuals.
- A co-ordinated communication, care and bereavement service should be provided in all care settings with high rates of mortality during the pandemic.
- Access to the full range of community and mental health psychosocial supports should be standardised for all residents of care settings.
- Residents of care settings must be supported to use technology to access virtual support, if required.

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People with disabilities

- Return services to as near to pre-Covid levels as soon as possible to minimise the impact on service users and their families.
- Provide increased provision for bereavement supports. Individuals returning to day services may discover that some of their service community have passed away during lockdown.
- Monitor mental health and provide appropriate interventions where necessary for those living in residential settings who are likely to have experienced increased isolation, loneliness and the loss of opportunity to engage in community-based activities.

Mental health service users

- Continued development and provision of specialist mental health services to support existing and future service users in accessing appropriate level support and care at the earliest opportunity .
- Prioritise the implementation of the HSE model of care for talk therapies in specialist mental health services.
- Implementation of alternative services to acute inpatient care and congregated care settings within mental health services to include home-based care treatment teams and crisis resolution teams in line with Sharing the Vision: A Mental Health Policy for Everyone.
- In order to meet a potential increase in acuity of presentations within the mental health system, and the known importance of early intervention in the management of mental ill-health, continue to prioritise the provision and development of evidence-based psychological interventions, including those recommended by mental health clinical programmes.

Children and young people

Consideration to the impact of the significant interruption to the lives of children and young people to be reflected in mental health and wellbeing programmes and guidelines and in shaping new policies and frameworks, as referenced in Connecting for Life: Ireland's National Strategy for the Reduction of Suicide and Self Harm and Sharing the Vision: A Mental Health Policy for Everyone.

- Continue the development and delivery of early psychological interventions to support young people at both primary and secondary care level in order to address existing challenges and prevent further increases in waiting list numbers, as noted in Connecting for Life: Ireland's National Strategy for the Reduction of Suicide and Self-Harm and Sharing the Vision: A Mental Health Policy for Everyone.
- Implement CAMHS telehealth hubs to increase capacity for assessments and reduce waiting lists, in line with Sharing the Vision: A National Mental Health Policy for Everyone and the HSE Corporate Plan 2020–2025

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Marginalised groups (See **section 6. 2.10** for further details)

- Supports must take into consideration:
  - the impact of the disadvantaged social determinants of health experienced by marginalised groups
  - the needs of marginalised groups
  - the impact of pre-existing post traumatic stress disorder and or trauma and required supports
  - the barriers that prevent equity of access to all supports and services
- The HSE to gather available ethnic minority data related to the spread of Covid-19, the impact of Covid-19 in terms of access to and benefit from psychosocial supports.
- Identify barriers faced by minority groups in accessing psychosocial supports and develop strategies to actively negate existing barriers.

Recommendation 9: Planned responses for the public, under the Psychosocial Framework will reflect best practice, quality and align to existing strategy and policy as appropriate.

Supporting actions include:

- All service providers to have clear pathways and referral options in place, in order to effectively support the presenting needs of the general public and those with specific mental health issues as a result of the pandemic. (See recommendation 5)
- Public psychosocial responses need to be integrated to allow for early intervention in both community, hospital and residential care settings to mitigate the impact of Covid-19 on psychological wellbeing as far as possible.
- Improving access to evidence-based psychosocial supports at an early stage to prevent and minimise the impact of mental health difficulties. For example talk therapies and peer supports should form a key element of the health sector psychosocial response, in line with the recommendations of Sláintecare and Sharing the Vision.

8.4 Action area 4: Healthcare workers

The following recommendations address actions to provide an effective psychosocial response for all healthcare workers across the full healthcare sector. Working in partnership with the national board, responsibility for implementation will be under the remit of national HR, WHWU and EAP.

Recommendation 10: Develop and agree national and regional partnerships between the Regional Psychosocial leads and EAP/WHWU for the duration of the current and future public health emergencies.

Key supporting actions include:

- Develop and agree a national protocol for standing up, scaling-up and stepping down of the regional psychosocial response for HCWs during national major public health emergencies.
- National partnership agreement to include arrangements for complementing EAP services where required. Pathways and linkage with psychology services and the National Counselling Service (NCS) are essential.
- Based on the national partnership agreement, regional services develop localised partnership agreements.
- Allocate resources to ensure psychosocial responders and or peer-support workers are embedded across all the care divisions and have capacity to respond during the height of an emergency as normal services are stepped back.

Recommendation 11: Develop an employee recognition programme framework in recognition of HCWs' efforts during a national public health emergency.

Key supporting actions include:

- Oversee a staff recognition initiative, to acknowledge and show appreciation for the work staff have done to date in delivering psychosocial supports across all care groups.
- Developing a framework to acknowledge and recognise the efforts staff have made over the Covid-19 crisis, including staff who have stepped up and have been flexible and willing to work under new and demanding circumstances, such as re-deployed staff to testing centres, assessment centres and contract tracing units.

Recommendation 12: Establish consultation fora to inform and guide best practice regarding staff psychosocial resources and processes for all health sector organisations (including Section 38/39 agencies and the private sector).

Key supporting actions include:

- Organise consultation fora across HSE, acute and non-HSE service providers.
- Ensure there is representation of staff from all levels and disciplines whose working life has been directly and indirectly affected by the Covid-19 crisis, including re-deployed staff, support staff, cleaners and porters.
- Identify gaps and areas for improvement in addressing staff's current and potential needs, based on experiences to date and lessons learned.
- Update HCW psychosocial plans and responses based on feedback from the fora.

Recommendation 13: Investment recommended by the national board should focus on longer term staff health and psychosocial support, including preventive measures for public health sector staff.

Greater investment is required to build preparedness in the WHWU staff support structures. The HR director will decide on funding allocations to resource the permanent staff support services for public sector HCWs.

The following investment areas are primarily intended for public health sector staff:

- A psychosocial peer support programme in a model of psychological first aid to be designed and delivered in a blended training format.
- WorkPositiveCI as a workplace stress risk assessment tool to be implemented by the HSE. For more details see Appendix 6.
- HSE to implement WHO Healthy Workplace Framework (HWF) and model, of which pillar two of the model focuses on the psychosocial work environment.
- Implement WHWU blended training model for managers on managing stress and building resilience in the workplace.
- Develop and roll out WHWU managers' pack, including available resources and supports in preparation for second surge or future public health emergencies.
- Develop and implement HSE Workplace Wellness App (information portal with interactive sections, including signposting to HSE psychosocial staff services).
- Develop and implement a training programme to enhance HSE staff preparedness for redeployment in advance of future public health emergencies.
- Case management training for occupational health services across the entire service, including acute hospitals, to focus on specialist case management for staff severely affected by the psychosocial impact of Covid-19.

Recommendation 14: To sustain and develop psychosocial awareness and expertise, build on existing psychosocial materials and initiatives, to address the emerging training and educational needs of healthcare staff.

Key supporting actions include:

- **Creating more blended psychosocial training** – by developing the capacity to have both on the ground training which is supplemented by moving sections of psychosocial training to online platforms. This would build on psychosocial modules recently developed for HSElanD.
- **Educating staff** – map and build on existing expertise, to work with acute and primary care resource clinicians and the broad range of health and social care professionals, so that they are able to recognise and address psychosocial needs in patients, like being tuned into the possibility of psychosocial difficulties and know where to refer or signpost.
- **Further development of psychosocial support material and toolkits** – clear support materials for clinicians to integrate psychosocial needs assessments and response actions into their practice.
- **Further development of support materials for HCWs** – many support materials have been developed to date, but as the characteristics of the Covid-19 crisis is changing, new psychosocial material will need to be developed to further inform the public and HCWs.
- **Liaise with colleges** – in the development of material and the alignment of training of professional groups.

Recommendation 15: Health sector organisations should provide interventions and support in line with the changing psychosocial needs of HCWs across the different phases of the pandemic, informed by relevant research evidence.

Please see **Appendix 7** for the full details of the activities and services that health sector organisations need to provide for their HCWs for each of the following phasesv of a pandemic:

- Throughout the pandemic
- During the preparation phase
- During the active phase
- During the recovery phase

8.5 Action area 5: Technology and innovation

Innovation and agility in adaption of new working practices was a positive outcome of the health sector's Covid-19 response to date. This set of recommendations addresses areas of technology and innovation that are particularly important in terms of providing psychosocial supports and services. These recommendations align with the work of the National Telehealth Steering Group.

Recommendation 16: Psychosocial service delivery models should incorporate online and phone-based supports and services in keeping with the work of the National Telehealth Steering Group.

Telehealth resources and services have been meeting significant psychosocial need for both the public and HCWs during the Covid-19 emergency. These resources and services also provided a lifeline for existing mental health service users for whom access to regular services was limited. The National Telehealth Steering Group approved a plan for additional online supports which align with the framework of this report (resonating across Levels 1 to 4 in particular).

Key supporting actions include:

- **Prioritising sustainable implementation of online resources and services**, but not limited to:
  - Quality online content, providing public health information and signposting supports
  - Self-help tools such as the CBT-based modules made available to staff during Covid-19, quality assured mental health mobile apps listed on yourmentalhealth.ie and mental health e-books for healthcare workers made available through the HSE Library Service
  - Online support groups and other 'person to person' supports such as text message and telephone-based supports
  - A range of online therapies, in line with national mental health policy and the commitment of the HSE to the creation of a national digital therapy service of support the wellbeing of citizens and reduce the demand for further upstream on clinical services.
- **Advocating for a strategy to facilitate greater access to digital resources** – digital poverty, literacy and contextual barriers (for example, difficult living circumstances) were identified as barriers to online support for some groups in society. A digital grant similar to free electricity grants currently available would help to address some aspects of this issue, for example to facilitate access to broadband and relevant hardware like mobile tablets. Issues related to access should also be routinely addressed in all future digital health service initiatives.

Overall, we fully support the recommendations of the Telehealth work stream of the INOH, for developing digital and phone-based services into the medium and long-term.

Recommendation 17: Support, interact with and promote the HSE National Health Library and Knowledge Service and its work on preparing and collating a wide range of evidence summaries to guide the health sector response to Covid-19.

During the initial stages of the Covid-19 crisis a significant level of duplication of work occurred and time was wasted by staff conducting their own research and literature searches. Information overload also occurred through the sharing of the same articles from multiple sources. To address this situation, the National Health Library and Knowledge Service, referenced in Section 3, initiated a project to develop a series of evidence summaries on a range of clinical and psychosocial aspects of the public health emergency.

Key supporting actions include:

- Further resourcing and embedding this initiative into sustainable working practices.
- Developing a communications strategy to increase awareness of this resource among healthcare professionals.
- Other relevant and potentially overlapping information resources (such as through the Health Protection and Surveillance Centre) should be identified and a mechanism should be developed to collate relevant outputs for the benefit of clear communication to clinicians, health and social care professionals and health service managers.

8.6 Action area 6: Research, evaluation and monitoring

The health sector's response to Covid-19 highlighted the importance of good data and the value of evidence-based research, within the Irish context. This set of recommendations details how we can apply this experience to the next phase of psychosocial responding and proactively respond to emerging service demands.

Recommendation 18: The national board should establish and maintain an evaluation and monitoring system, which contributes to and informs both the national board and regional HSPMTs to ensure the psychosocial response is evidence-informed and needs-based.

Key supporting actions include:

- The design, development and establishment of the evaluation framework, including details on how it will be monitored and reviewed as part of ongoing procedures.
- The development of a psychosocial key performance Indicator (KPI) dashboard. Features of the dashboard would include:
  - The national board and HSPMTs utilising the dashboard to direct interventions and supports, in line with the changing psychosocial needs of both the public and HCWs.
  - The dashboard would include two or three KPIs at the:
    - → Micro or individual level – it will be important to understand service users' (including families and social groups), changing levels of need and their access routes through the framework. Outcome data should also be captured where it is practical to do so.
    - → Meso or organisation level – which will look at the coherence of responses at the HSE and NGO levels and where possible the level of support outcomes.
    - → Macro or societal level – the changing levels of societal needs and the effects of psychosocial initiatives. This will help to inform future health and social policy as well as guiding ongoing health service planning.

Recommendation 19: Commission and prioritise psychosocial research into our learning from the Covid-19 experience and continue to review and disseminate clinical and non-clinical based national and international evidence.

Key features of advancing further research include:

- Prioritising focus on those who have suffered worst outcomes of disease to date, such as nursing homes, pallatiative patients, frontline staff and identifying improvements to ongoing public responses and staff wellbeing.
- Providing an evidence base to improve psychosocial plans and enable better preparedness for a resurgence of Covid-19 and for potential future public health emergencies.
- Continuing to inform the planning processes based on national and international evidence, such as obtaining feedback from local acute hospital research which is examining long-term stress levels suffered by hospital staff in coping with Covid.
- Ensuring psychosocial clinical interventions and responses have a sound clinical evidence-base.
- Working in partnership with the Health Research Board, the HSE Research and Development Function and the Department of Health.
- Liaising with the national colleges to identify potential research gaps for psychosocial response.
- Promote the dissemination of evidence and learning through public information, the publication of papers and reports, and the presentation of findings at meetings and conferences.

8.7 Action area 7: Communications and engagement

Communications and active engagement with the wider psychosocial stakeholders, both at a national and local level, will be crucial. These recommendations address this vital area.

Recommendation 20: National communications to update and resource the national psychosocial communications plan, to support the implementation of both national and local communications with specific focus on 1) Online communications, 2) Clear and joined up signposting, 3) HCWs, 4) the general public.

Communication plan to include:

- **Continued linkage with and dedicated resources from national communications and the press office** – psychosocial communications initiatives need leadership and coordination at a national level with support regionally as required. This relationship needs to continue to support clear signposting, develop the psychosocial messaging and co-ordinate with future media campaigns. One dedicated resource is also required to coordinate online content, resources and services relevant to the public and healthcare worker psychosocial needs.

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- **Continued engagement with Mental Health Communications Steering Group** – to align the strategic priorities and to incorporate psychosocial messaging into ongoing public mental health communications through all relevant channels.
- **Enhancing and adapting an online social media presence** – psychosocial response requires continued emphasis on enhancing and adapting its online presence. For example, in the event of increased need due to public health conditions, visibility of psychosocial supports should be increased, using targeted online advertising and social media promotion of relevant content. All online communications should be in keeping with the HSE's Digital Roadmap and take account of different audiences, such as the general public and HSE staff, both of which are reached through different channels. This approach should be managed through a formal relationship with HSE digital and in consultation with the Mental Health Communications Steering Group.
- **Joined up and co-ordinated online presence** – the health sector's psychosocial structures and available services for both the public and HCWs – at both a national and local level – should be clearly communicated on the HSE website. This will require a review of all the current public and HCW platforms and a review of the psychosocial webpage, to include clear links with existing sites and vice versa. This webpage should provide clear signposting to relevant supports, within the HSE and across other government services and community and voluntary supports as available.
- **A psychosocial communications strategy for HSE staff** – developed by the national board in collaboration with WHWU and HSE Internal Communications.
- **A psychosocial communications and engagement plan for members of the public** – which focuses on communication to and obtaining feedback from, members of the public and their lived experience of Covid-19. This approach should be coordinated in line with planned mental health communications for the wider population.
- **Local communication audits** – communication at a local level on the impact of Covid-19 on psychosocial and mental health services does not appear to have been as effective compared to the national level. For example, 25 per cent of mental health services users recently surveyed stated they had received no communication at all from their local service provider. An audit of communication processes during Covid-19 would be useful, to ensure effective messaging.
- **Ensure that communication and engagement is provided in a range of accessible formats** – and with appropriate supports to allow people with different languages and types of impairments or disabilities to access this information.

8.8 Action area 8: Future preparedness for national public health emergencies

This action area focuses on recommendations to effectively prepare for another resurgence of Covid-19 or for another potential national public health emergency.

Recommendation 21: The Covid-19 psychosocial response framework and associated recommendations should form the basis of preparedness and the response to future national public health emergencies.

This report's recommendations form the basis of preparedness for potential future national public health emergencies or pandemics by:

- **Setting in place robust and sustainable national and regional psychosocial structures** – which incorporate the wide range of key stakeholders essential for an effective psychosocial response. The healthcare sector has learned from this initial experience just how important it is to integrate support responses to the public and HCWs. It is imperative to ensure that during future such emergencies a comprehensive and well-resourced psychosocial programme is in place alongside effective public awareness campaigns.
- **Establishing a national co-ordination structure** – a national overseeing body is essential to strengthen national and regional support and co-ordination of psychosocial responses and that it operates under the remit of the national emergency team.
- **Ring-fencing and prioritising specific psychosocial roles** – These roles outline where existing resources and staff need to be redeployed and the specific roles required to drive a response at national and regional levels and how this can be sustained in parallel to other crisis and or normal services.
- **Enabling rapid response** – in the crucial initial stages of a pandemic and or during an emerging crisis, to be able to innovate and be agile is critical. The recommended structures and dedicated roles – with their associated networks and communication pathways – give sufficient flexibility to adapt and commission new and innovate responses to intervene and meet urgent and emerging needs, as a when they occur.
- **Providing the Psychosocial Response Framework** – which details a structure, based on which psychosocial responders can organise and deliver a strong response across all levels of need in terms of both the public and HCWs.
- **Laying the basis for service improvements** – which will significantly contribute towards increasing our capacity and skill base in the future.

In addition to the psychosocial framework and this report's recommendations, to further strengthen our preparedness and capitalise on our experience to date, recommended supporting actions, include the following:

- **Establish what circumstances might trigger activation of the re-mobilisation of the psychosocial response** – and by whom.
- **Prepare an initial psychosocial response checklist** – which clearly outlines the key psychosocial actions that need to occur in the initial few days or weeks of a future pandemic and with a particular focus on integrated responses between community and acute healthcare settings, for example what key communication messages need to be given, how and to whom, and how to effectively deal with and utilise volunteers.

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- **Improve psychosocial data quality** – in the health sector in relation to need, service provision and outcomes.
- **Learn from the Covid-19 experience** – as detailed in **Section 8.5**, this research should clearly outline the learning and key characteristics of what we did well, where we did not do well, what we need to maintain and where we can improve. To inform this report learning reviews were conducted, but wider research will be needed to maximise our preparedness for a future crisis.
- **Maintain psychosocial structure and working relationships (post-Covid)** – through scheduled meetings. The meeting schedule would be significantly scaled down to perhaps bi-yearly, but they would enable national and local psychosocial staff to maintain their working relationships and to continue preparation planning. Experience to date has shown that developed working relationships would be critical for; a rapid response, supporting partnership, forming a collaborative approach and increased transparency. Each of these factors would be crucial in the initial days and weeks of another crisis.
- **Implement the HCWs preparedness actions for psychosocial response** – as detailed in **Appendix 7**.

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