EHPS

volume 22 issue 1
February| 2021

www.ehps.net/ehp

The European Health Psychologist

Bulletin of the European Health Psychology Society

Editorial

Editorial EHPS COVID-19 Special issue

Angela Rodrigues
Northumbria University, UK
Pamela Rackow
University of Stirling, UK

We are all writing our individual coronavirus story and while our stories are deeply personal, they also have a lot in common: online meetings, challenges, being able to constantly adapt to new situations, being exhausted and looking for the positive side of things. We are therefore dedicated to reflecting that in our first special issue on COVID-19. The special issue on COVID-19 showcases extraordinary work by EHPS members and health psychologists, explores how different countries have dealt with the worldwide pandemic and contains a reflection piece about studying psychology during a pandemic.

Roseanna Brady et al. and **Sian Amstrong, Danielle Watson et al.** present papers about a joint project and collective of 145 psychology professionals where a set of guidelines to support the well-being of health-care worker was produced and tested. These two papers demonstrate the incredible work of health psychology professionals in medical settings. The Health Psychology exchange (HPX) was formed to volunteer their services to health, social care, and public health organisations throughout the UK and Ireland.

Sian Amstrong, Danielle Watson et al. describe how 13 organisations including hospital trusts, care homes, local authorities and colleges were supported by health psychology consultants from HPX during the pandemic. Support ranged from providing reflective practice, public health messaging, psychological support initiatives, and staff engagement. The paper by **Roseanna Brady at al.** describes the process of developing and evaluating the Psychosocial Needs Assessment Tool (PNAT) using the Theoretical Framework of Acceptability.

Celestin Mutuyimana and Andreas Maercker write about African best practices in measures used to fight against COVID-19. This article informs about methods used in Africa to prevent and slow down the spread of Covid-19 and highlights the lessons learnt from other severe health challenges such as HIV/Aids and Ebola.

The final paper of our special issue is about the impact of COVID-19 on university students. In her reflection piece "Positivity through adversity in the race to the BSc finish line – Reflections on the impact of the COVID-19 Pandemic on final year studies" **Kelly Murray-Hodcroft** reflects about her own and her families' experience with COVID-19, being a final year BSc student in psychology and how the last year has been a struggle and an achievement at the same time.

We are sure that a lot of our readers would agree and we are looking forward to receiving more refection pieces for future issues.

Pamela Rackow & Angela Rodrigues

Angela Rodrigues
Department of Psychology,
Northumbria University, UK
angela.rodrigues@northumbria.ac.uk

Pamela Rackow
Faculty of Natural Sciences,
Psychology, University of Stirling
pamela.rackow@stir.ac.uk

Original Article

Supporting organisations to improve the psychological wellbeing of their staff during COVID-19 pandemic: Case Studies

Sian Armstrong
Glasgow Caledonian University, UK on behalf of the Health Psychology Exchange
Daniella Watson
University of Southampton, UK on behalf of the Health Psychology Exchange
Jemma Byrne
Glasgow Caledonian University, UK on behalf of the Health Psychology Exchange
Laura Howells
University of Nottingham, UK on behalf of the Health Psychology Exchange
Lucie Byrne-Davis
University of Manchester, UK on behalf of the Health Psychology Exchange
Ainslea Cross
University of Derby, UK on behalf of the Health Psychology Exchange
Eleanor Bull
Manchester Metropolitan University, UK on behalf of the Health Psychology Exchange
Roseanna Brady
Psychology for Health Associates, UK on behalf of the Health Psychology Exchange

Abstract

Introduction:

During the COVID-19 pandemic, frontline healthcare workers and the public were deemed to be at risk of psychological harm. Organisations were encouraged to proactively protect staff and public wellbeing, through regular monitoring and support using an evidence-based approach where possible.

Case studies:

A group of 140+ health psychologists and trainee health psychologists formed a collective of researchers and practitioners - the Health Psychology Exchange (HPX) – in order to volunteer their services to health, social care, and public health organisations throughout the UK and Ireland during the pandemic. The Psychological Interventions subgroup of HPX members supported workforces with senior managers in the health, care and local authority organisations during the COVID-19 pandemic. A total of 13 organisations including hospital trusts, care homes, local authorities and colleges were supported by health psychology consultants from HPX during the pandemic. Support ranged from providing reflective practice, public health messaging, psychological support initiatives, and staff engagement.

Discussion:

Client organisations felt well supported by health psychology consultants from HPX during the pandemic. Health psychology consultants were instrumental in translating high-level guidance on optimising the psychological health of staff into practice for organisations. The basis of this consultancy work will strengthen the role of health psychology consultancy to client organisations in the future.

Introduction

Frontline healthcare workers were deemed to be at significant risk of psychological harm during the early weeks of the COVID-19 pandemic in the United Kingdom (UK) (Greenberg, Docherty, Gnanapragasam, & Wessely, 2020; Lai et al., 2020). During the pandemic, frontline healthcare workers internationally experienced fears of contamination, moral injury, disruption of supportive networks, and work stress (Holmes et al., 2020; Lai et al., 2020). As UK coronavirus prevalence peaked, two third of healthcare professionals in the National Health Service (NHS) reported feeling unsupported

by their hospital trust, reporting a lack of access to Personal Protective Equipment (PPE) as a cause of stress (Iqbal & Chaudhuri, 2020). Additionally, a systematic review and meta-analysis found that whilst frontline health professionals valued psychological support services, staff with the most severe mental health problems were least likely to request or receive support (Bell & Wade, 2020).

Paradoxically, Chinese healthcare staff refused psychological support as they felt they weren't experiencing emotional symptoms, yet wanted to be trained themselves in skills to support psychological needs of patients (Chen et al., 2020). However, continual guidance proposed that the provision of facilitated reflective practice, online support and supportive communications could optimize the psychological needs of healthcare workers (Chen et al., 2020; Cheng et al., 2020; Rimmer & Chatfield, 2020). As such, a priority for health psychology is to identify how organisations could rapidly respond to staff needs in a time of uncertainty and with ever-changing priorities.

The British Psychological Society (BPS) published evidence-based guidance that outlined a set of principles and practical recommendations for healthcare leaders and managers on how to respond to the psychological needs of healthcare staff during the pandemic (BPS, 2020). The document proposed a stepped-care approach and described three phases of anticipated psychological responses: Preparatory Phase, Active Phase, Recovery Phase. The challenge for the health psychologists was to translate this evidence-based guidance into practice. To respond and action everchanging guidance and best-evidence, organisations turned to the help of consultants, including Health Psychology consultants (Michie & Abraham, 2008).

To address the challenges to staff psychological health during the pandemic, a group of 140+ health psychology professionals in research, practice, education and trainees formed a collective - the Health Psychology Exchange (HPX) – to volunteer their services to health, social care, and public health organisations throughout the UK and Ireland during the pandemic (Health Psychology Exchange, 2020). HPX received many practice-based consultancy requests from organisations who had staff working on the frontline. These requests prompted the formation of the HPX Psychological Intervention subgroup who developed a consultancy tool to hold supportive conversations, guide strategy and help implement wellbeing plans (Brady,. 2020). As such, this paper outlines the consultancy case studies of organisations supported by this group using the developed consultancy tool.

Case studies

A total of 13 organisations were supported between March-September 2020 of which five will be described in detail in this paper. The supported organisations were identified though initial contact with HPX. A flyer was created with a brief description of HPX's 'offer' during the COVID-19 pandemic, plus relevant case studies of what health psychologists do. The flyer was then circulated to professional networks, including the north west psychological professions network and the north west hub for behavioural and social sciences. HPX members who also sit on the BPS behavioural science and disease prevention taskforce circulated the flyer to the behavioural science group - SPI-B UK's Independent Scientific Pandemic Influenza Group on Behaviours. From there, as psychological consultancy work began, other organisations heard through word of mouth. These included healthcare, social care, local authorities and college organisations from across the UK. Table 1 outlines the diverse outcomes from client organisations supported by HPX.

These case studies are the result of health psychology consultant reflections after supporting client organisations. By estimating how many staff

Table 1. Summary of client organisation outcomes supported by health psychology consultants.

Type of organisation	Outcome
District and community hospitals	Encouraged old and created new spaces for staff to decompress during shifts
	Commitment to introduce reflective practice groups
	Encouraging uptake of Psychological First Aid training by staff
Local Authority	Public health messages on healthy living in food hampers
	Campaign for young people to stop attending raves
	Public messaging on road traffic signs
Charity	Pilot of Online Group Reflective Practice now being rolled out to health professionals
College	Support for students who were working on the frontline
Trust	Webinar providing psychological support for staff
Social care	Advice for autism and Learning Disability staff wearing PPE
	Development of online social support network for isolated practitioners
	Support for development of reflective practice and engagement in adaptive coping strategies
	Webinar to 100+ care home managers on providing psychological support for staff
Regional Public Health England	Support development of Public Health England framework for identifying risk of psychological harm in care homes
Ambulance service	Staff engagement on health and wellbeing
	Evidence-based self-care checklist

and community members were impacted as a result of the HPX consultancy, the consultants were able to explore the overall impact of the consultancy work.

In addition, to understand the impact of receiving HPX support from the client perspective, each client was asked the following:

(1) What was the enquiry/issue/question that the client needed support with?

(2) What did the health psychology consultants do?

(3) What was the outcome?

Case Study One: District and community hospitals

A senior workforce manager at an NHS hospital trust (one district and two community hospitals) approached HPX in May 2020 for advice on providing psychological support for staff. Two HPX consultants, (an experienced health psychology consultant (RB) and a trainee health psychologist (LH)) met with the client via videoconference to discuss their needs. Prior to the meeting, the experienced consultant had developed a guide (Brady et al., 2020) to enable the health psychology trainee to co-lead the meeting using the developed consultancy tool. The clients discussed issues where they needed additional

support: negative emotions expressed by staff returning to work after shielding, and psychological responses from frontline staff, consistent with those expected during the Recovery Phase of the pandemic (BPS, 2020). The two strategies of PFA and facilitated reflective groups were discussed. Ideas on how best to implement them were explored and the consultants answered questions using evidence-based guidance and experiences from working with clients dealing with similar challenges. The managers recognised that the trust lacked the expertise in facilitation skills for the reflective groups and requested further support from the consultants. This client is currently seeking funding for this which may involve an ongoing relationship with the consultants on an individual basis.

Case Study Two: Local authority

Senior managers of a local council approached HPX for support with public health messages. Two experienced health psychologist consultants and a trainee health psychologist (DW) held initial conversations with local authority leaders to assess the needs and opportunities to support staff and the community in the COVID-19 response and recovery phase. "Leadership and Communication" was discussed to be the priority for the authorities. The group supported the local authority to develop positive behaviour change messages such as: 'Keep Wirral Well' (Bonell et al., 2020; West, Michie, Rubin, & Amlôt, 2020) and build trust and synergy between the community, staff, third sector/faith sector, and the council. Community members directly and indirectly were impacted by behaviour change public health messages delivered by community anchors, road traffic signs, social media and leaflets on physical distancing for young people, healthy eating, and government advice, as advised by the HPX volunteers.

Case Study Three: NHS organizations

Health psychology consultants (AC, EB) worked with NHS organisations to assess their current provision to support staff psychological health and consider areas in which they could expand and strengthen the provision. An NHS Partnership Trust organisation contacted HPX requesting support with prioritising and assessing the psychological needs of staff within the organisation, particularly those who were shielding or adjusting to role and responsibility changes. The health psychology consultant (AC) initially provided guidance on how managers and leaders could structure well-being conversations and check-ins with staff, as well as providing resources on psychological first aid, developing psychological flexibility (Harris, 2020) and post traumatic growth.

Case Study Four: Social Care

The client, a senior public health leader requested advice from HPX with regard to supporting regional care home staff. At that stage of the pandemic, early May 2020, UK care home managers were expressing distress at initial delays in ensuring adequate supplied of PPE and at the consequences of discharging patients from hospitals to care homes without testing them for COVID-19. Public health managers were supporting care homes with implementing infection control procedures but were unsure how to advise care home managers on providing psychological support for their staff. As a result, it was agreed that three HPX consultants (including RB, EB) would develop a webinar to introduce topics of psychological wellbeing using the developed consultancy tool, explain their relevance and importance and demonstrate how to engage in conversations about the topics with care home managers. The webinar

was aimed at public health, local authority, and commissioning staff working closely with care home managers and was widely publicised in the region.

One author (RB) worked with a public health manager who was in daily contact with care home managers, to develop a role play to illustrate how public health managers could approach conversations with care home managers to help them identify how they might enhance psychological support for their employees. The public health manager played the role of a care home manager based on her knowledge and experience. The HPX consultant (RB) played the role of public health manager. The role play was not scripted and the HPX consultant responded to the issues and questions raised by the public health manager in roleplay to illustrate effective communication and information gathering skills . The webinar was well attended (135 attendees), well received, and the most positive feedback related to the role play. Following the webinar, the slides were made available to attendees together with written guidance on how to approach conversations with care home managers. Further guidance on psychological needs topics was provided by HPX and published on the public health website. This resource has been accessed 398 times between August and September 2020.

Case Study Five: Social Care (2)

A social care partnership approached HPX with a request for psychological support for isolated care home managers in mental health and learning disability sectors. Using the consultancy tool, two trainees (JB, SA) with experience in social care established a need for psychological space to discuss, reflect and decompress to avoid inevitable burnout in managers of social care teams. Furthermore, due to the lack of specific social care guidance, the managers desired knowledge sharing to reduce duplication of work. This led to the development of a consultancy offer and the facilitation of a peer-based support group based on a matched care model. This enabled a psychologically safe space for practitioners to share practical, emotional and physical difficulties such as stress, communication and mask wearing. The purpose of this was to encourage reflective practice and adaptive coping strategies. The trainee health psychologists continue to work with this organisation to deliver weekly coaching groups with the intention of developing and upskilling internal staff to self-sufficiently deliver this intervention in future. Furthermore, they are collaborating with the organisation to produce a report that highlights the value of this piloted intervention to advise relevant stakeholders.

Discussion

The breadth of the psychological support from health psychology consultants during the pandemic was perceived as supportive and impactful by clients and fellow health psychology consultants. Health psychology consultants found value in using the developed consultancy tool to initiate conversations and assessment with client organisations, and the clients expressed gratitude for the support provided. The impact and reach stretched from a webinar viewed by over 100 care home workers to city level public health messages, to clients seeking more funding for extended support from health psychology consultants. This showcases the extensive skillsets that health psychology has to offer.

Health psychology has been supporting the health sector since the 1970s through research and practice and has evolved in the last decade towards supporting health behaviour change (Quinn, Chater, & Morrison, 2020). Arguably, the evolution of health psychology might be further accelerated due to the instrumental application of health

practice and knowledge in response to COVID-19. This ranged from health psychologists advising on the UK's Independent Scientific Pandemic Influenza Group on Behaviours (SPI-B), Scientific Advisory Group for Emergencies committees (Scientific Advisory Group for Emergencies, 2020), to the collective action of HPX volunteers supporting health, social, third sector and educational organisations (Health Psychology Exchange, 2020).

Whilst the HPX Interventions group have been successful in establishing consultancy collaborations with new organisations and thus raising the profile of health psychology, there are challenges in providing support and sustaining the collaborations for future health psychology work. During the pandemic, all the organisations were supported on a voluntary basis, which was manageable as many health psychology consultants working patterns shifted due to national lockdown. However, as lockdown eased and usual clinical and academic responsibilities resumed, health psychology consultants found that they had limited capacity to support organisations voluntarily. All organisations had no previous engagement with health psychology consultants, yet many spoke about employing psychologists on a permanent and temporary basis, and therefore it is the right time to establish how health psychology consultants can support new services and projects. The HPX have been considering the legacy of this voluntary collective, including how to build capacity in behaviour change for organisations through permanent health psychology positions or health psychology consultants, both qualified and in-training. To support the latter, members from the Psychological Intervention sub-group delivered a webinar series to over 100 health psychologists in the UK, which provided a framework of consultancy to include practical principles and illustrated by case study examples. Our HPX work demonstrates the unique health psychology contribution to the assessment of client organisation needs, relationship building and successful implementation of many psychologically informed interventions for psychological coping and health behaviour change. Such skills that have been historically underestimated in health psychology practice (Hilton & Johnston, 2017). This therefore exemplifies the critical contribution of health psychology practice in the management of health and social care workers wellbeing in COVID-19.

Conclusion

Client organisations valued the timely expertise provided by health psychology consultants from HPX during the pandemic. The support reached regional workforces and members of the public during a time when public health messages and psychological needs were rapidly changing according to the pandemic and lockdown trajectory. This has raised the profile of health psychology consultancy. Although there are challenges in funding and resources for providing future support, health psychology as a discipline has again proven its value to public health, health, and social care sectors by translating high-level guidance into practice for organisations and supporting the delivery of micro-level interventions and will endeavour to strengthen the role of health psychology consultancy in the upcoming months.

Acknowledgements

The authors wish to thank the senior leaders from the organisations that the Health Psychology Exchange supported for sharing feedback about their experiences which contributed to the case studies reported in this manuscript.

The authors wish to thank the co-founders of the Health Psychology Exchange (Jo Hart and Angel Chater) for forming the HPX and supporting/advising the psychological interventions sub-group.

Ethics

This work is classified as service improvement so ethical approval not required. Researchers followed guidelines for ethical conduct established by the Declaration of Helsinki, the Research Governance Framework for Health and Social Care, and the British Psychological Society's Code of Ethics and Conduct (2018).

Funding

None

Declarations of conflicting interests

Laura Howells is a consultant for the University of Oxford on an educational grant funded by Pfizer, unrelated to the submitted work.

Authors' contributions

LBD, JH & AC formed and lead the Health Psychology Exchange (HPX) and EB formed and lead the HPX Psychological Intervention sub-group. LBD & JH received requests for voluntary health psychology expertise from organisations seeking psychological support and passed requests onto HPX volunteers, including those in the HPX psychological intervention sub-group (RB, JB, LMH, AC, EB SA, DW and others). RB initiated the development the Psychological Needs Assessment Tool that supported HPX volunteers to facilitate meetings with organisations; all authors consulted organisations and provided feedback to form the case studies described in this manuscript. SA and DW produced the first draft manuscript; all authors provided input towards the final manuscript.

References

Bell, V., & Wade, D. (2020). Mental Health of Clinical Staff Working in High-Risk Epidemic and Pandemic Health Emergencies: A Rapid Review of the Evidence and Meta-Analysis. *medRxiv*. https://doi.org/10.1101/2020.04.28.20082669

Bonell, C., Michie, S., Reicher, S., West, R., Bear, L., Yardley, L., . . . Rubin, G. J. (2020). Harnessing behavioural science in public health campaigns to maintain 'social distancing'in response to the COVID-19 pandemic: key principles. *J Epidemiol Community Health*. 74:617-619. http://dx.doi.org/10.1136/jech-2020-214290

Brady, R., Bull. E., Armstrong, S., Watson, D., Lavalle, J., Cross, A., . . . Hart, J. (2021). Translating the guidance on promoting frontline healthcare worker psychological wellbeing during COVID-19 pandemic: Psychological Needs Assessment Tool. *European Health Psychologist*, 22(1), 745-756.

British Psychological Society, Covid19 Staff Wellbeing Group. (2020). *The psychological needs of healthcare staff as a result of the Coronavirus pandemic*. Retrieved from https://www.bps.org.uk/sites/www.bps.org.uk/files/News/News%20-%20Files/Psychological%20needs%20of%20healthcare%20staff.pdf

Chen, Q., Liang, M., Li, Y., Guo, J., Fei, D., Wang, L., . . . Li, X. (2020). Mental health care for medical staff in China during the COVID-19 outbreak. *The Lancet Psychiatry*, 7(4), e15-e16. https://doi.org/10.1016/S2215-0366(20)30078-X

Cheng, P., Xia, G., Pang, P., Wu, B., Jiang, W., Li, Y.-T., . . . Wang, J. (2020). COVID-19 epidemic peer support and crisis intervention via social media. *Community mental health journal*, 56:786–792. https://doi.org/10.1007/s10597-020-00624-5

Greenberg, N., Docherty, M., Gnanapragasam, S., & Wessely, S. (2020). Managing mental health challenges faced by healthcare workers during covid-19 pandemic. *BMJ*, 368 :m1211.

Harris, R. (2020). *FACE COVID. How to respond*

effectively to the Corona crisis. Retrived:https://drive.google.com/file/d/1MZJybtT9KmiE9Dw9EKvPJsd9Ow7gXaMe/view

Health Psychology Exchange. (2020). *What is the Health Psychology Exchange and what can it do?* Retrived:https://www.nwppn.nhs.uk/attachments/article/2706/health%20psychology%20exchange%20intro%20extra%20case%20studiesv2.pdf

Hilton, C. E., & Johnston, L. H. (2017). Health psychology: It's not what you do, it's the way that you do it. *Health psychology open,* 4(2). https://doi.org/10.1177/2055102917714910

Holmes, E. A., O'Connor, R. C., Perry, V. H., Tracey, I., Wessely, S., Arseneault, L., . . . Everall, I. (2020). Multidisciplinary research priorities for the COVID-19 pandemic: a call for action for mental health science. *The Lancet Psychiatry*. 7(6) 547-560. https://doi.org/10.1016/S2215-0366(20)30168-1

Iqbal, M. R., & Chaudhuri, A. (2020). COVID-19: Results of a national survey of United Kingdom healthcare professionals' perceptions of current management strategy–a cross-sectional questionnaire study. *International Journal of Surgery*. 79, 156-161. https://doi.org/10.1016/j.ijsu.2020.05.042

Lai, J., Ma, S., Wang, Y., Cai, Z., Hu, J., Wei, N., . . . Li, R. (2020). Factors associated with mental health outcomes among health care workers exposed to coronavirus disease 2019. *JAMA network open*, 3(3). 10.1001/jamanetworkopen.2020.3976e203976-e203976.

Michie, S., & Abraham, C. (2008). *Health psychology in practice*: John Wiley & Sons. Blackwell publishing. Oxford, UK

Quinn, F., Chater, A., & Morrison, V. (2020). An oral history of health psychology in the UK. *British Journal of Health Psychology*. 25: 502-518. https://doi.org/10.1111/bjhp.12418

Rimmer, A., & Chatfield, C. (2020). What organisations around the world are doing to help improve doctors' wellbeing. *BMJ,* 369. doi: https://doi.org/10.1136/bmj.m1541

Scientific Advisory Group for Emergencies. (2020). *The role of behavioural science in the coronavirus outbreak*. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/873732/07-role-of-behavioural-science-in-the-coronavirus-outbreak.pdf

West, R., Michie, S., Rubin, G. J., & Amlôt, R. (2020). Applying principles of behaviour change to reduce SARS-CoV-2 transmission. *Nature Human Behaviour, 4*, 451–459. https://doi.org/10.1038/s41562-020-0887-9

Sian Armstrong
Department of Psychology, School of Health and Life Science, Glasgow Caledonian University, Glasgow, United Kingdom
sarmst208@caledonian.ac.uk

Daniella Watson
Global Health Research Institute, School of Human Development and Health, Faculty of Medicine, University of Southampton, United Kingdom
D.watson@soton.ac.uk

Jemma Byrne
Department of Psychology, School of Health and Life Science, Glasgow Caledonian University, Glasgow, United Kingdom
JBYRNE205@caledonian.ac.uk

Laura Howells
Centre of Evidence Based Dermatology, School of Medicine, University of Nottingham, Nottingham, United Kingdom
Laura.Howells1@nottingham.ac.uk

Lucie Byrne-Davis
Founder and lead of the Health Psychology Exchange
Division of Medical Education, University of Manchester, UK
lucie.byrne-davis@manchester.ac.uk

Ainslea Cross
School of Psychology, University of Derby, Derby United Kingdom
A.Cross1@derby.ac.uk

Eleanor Bull
Department of Psychology, Research Centre for Health, Psychology and Communities, Manchester Metropolitan University
Eleanor.Bull@mft.nhs.uk

Roseanna Brady
Psychology for Health Associates, United Kingdom
bradykbs@msn.com

Original Article

Translating the guidance on promoting frontline healthcare worker psychological wellbeing during COVID-19 pandemic: Psychological Needs Assessment Tool

Roseanna Brady
Psychology for Health Associates, UK
on behalf of the Health Psychology Exchange
Eleanor Bull
Manchester Metropolitan University,UK
on behalf of the Health Psychology Exchange
Sian Armstrong
Glasgow Caledonian University, Glasgow, UK
on behalf of the Health Psychology Exchange
Daniella Watson
University of Southampton, UK
on behalf of the Health Psychology Exchange
Jacqueline Lavallée
University of Manchester, UK
on behalf of the Health Psychology Exchange
Ainslea Cross
University of Derby, UK
on behalf of the Health Psychology Exchange
Laura Howells
University of Nottingham, UK
on behalf of the Health Psychology Exchange
Lucie Byrne-Davis
University of Manchester, UK
on behalf of the Health Psychology Exchange
Jo Hart
University of Manchester, UK
on behalf of the Health Psychology Exchange
Angel Chater
University of Bedfordshire, UK
on behalf of the Health Psychology Exchange

Abstract

Frontline health and social care workers are at high risk of experiencing mild to severe psychological difficulties from their role supporting patients and the public in response to COVID-19. A number of guidance documents were written to help organisations support the psychological wellbeing of their staff. A collaborative of practice-based health psychology professionals offered to support organisations to develop their staff support plans. Based on British Psychological Society guidance, the group developed a needs assessment tool to assist consultants in identifying gaps in psychological support for staff during the pandemic, enabling leaders to develop action plans to address identified gaps. The Psychological Needs Assessment Tool (PNAT) has subsequently evolved through practice and reflection. The group evaluated the tool using domains of the Theoretical Framework of Acceptability and found it to be acceptable and effective in guiding strategic discussions with client organisations. The tool has been successfully used to guide initial conversations with national charities, NHS trusts, social care partnerships and academic organisations. In future, the group will continue to evaluate the tool in other settings, contexts, and countries, and by consultants with varied career experience.

Key words: COVID-19; Health Psychology Consultant; psychological wellbeing; tool development

Introduction

Across Europe, frontline health and social care workers have been the vanguard of countries' responses to the COVID-19 pandemic. As the virus spread globally, national experts began to identify their frontline healthcare workers as citizens at particular risk of psychological injury, given the

many stressors involved in providing direct care in a crisis situation (Geoffroy et al. 2020; Greenberg et al., 2020; Lai et al., 2020). Lai and colleagues (2020) were amongst the first to report that a considerable proportion of frontline Chinese healthcare workers were experiencing symptoms of depression, anxiety, insomnia and distress. These symptoms were in direct response to the extreme pressures they faced providing care to those with the newly emerging virus (Lai et al., 2020). Others suggested that health and social care professionals often put the needs of patients first, sometimes at the expense of their own psychological and physical health, leading to psychological injury and burnout (Chen et al., 2020). As a result, numerous resources and guidance for providing psychological support to health workers to mitigate this risk were published on websites, via social media and in peer-reviewed journals (WHO, 2020a, 2020b).

The pandemic in the UK began to escalate in March (British Psychological Society, 2020): COVID-19 cases began to rise exponentially and, in response to national and international pressure, the UK government finally announced a national lockdown on 23rd March 2020. Although authorities emphasised the importance of sharing COVID-19 learnings internationally and readying a coronavirus response, two thirds of UK healthcare professionals felt unsupported by their hospital trust and shortages in Personal Protective Equipment (PPE) were widely reported (Bedford et al., 2020; Iqbal & Chaudhuri, 2020). This highlighted the urgent need for healthcare managers to proactively protect physical health and psychological wellbeing of staff, through regular monitoring and support (Greenberg et al., 2020).

Drawing from numerous other sources, the British Psychological Society (BPS) published evidence-based guidance on psychological support for health workers during the coronavirus pandemic (BPS, 2020). This provides healthcare leaders and managers with a set of principles for responding to the psychological needs of healthcare staff. The document suggested we could expect three phases of psychological responses over the course of the pandemic: Preparatory Phase, Active Phase, Recovery Phase. Each stage involved unique psychological challenges and thus different support needs for staff. Recommendations for leaders and others involved in staff support included ensuring access to physical safety including PPE (given the vital importance of a sense of physical safety for psychological wellbeing), having a clear communication strategy, providing visible leadership, normalising psychological responses and using a stepped care approach to psychological support (Figure 1). In 2011, WHO published guidance on how to implement, Psychological First Aid (PFA) in crisis situations (WHO, 2011). The relevance of the guidance for those experiencing distress was highlighted during the psychological response to COVID-19 (Lai et al., 2020).

A steady stream of national resources to support healthcare staff have been published since the early stages of the coronavirus pandemic. Amongst these resources are those from Support the Workers, a group of experts in disaster response, crisis psychology and high-pressure decision-making, who offered crisis-relevant advice on sleep hygiene, communication, interdependence and dehydration amongst others (Smith, 2020). Recommendations from other sources include facilitation of reflective practice, online support, and suggested helpline communications (Chen et al., 2020; Cheng et al., 2020; Geoffroy et al. 2020; Rimmer & Chatfield, 2020). National government and local authorities have also issued generic information and guidance for social care staff on supporting patients and the public (Care Inspectorate, 2020; Local Government Association, 2020; National Institute for Health and Care Excellence, 2020; Scottish Social Services Council, 2020).

There was a large body of guidance and evidence

appearing in relation to supporting the psychological needs of health workers in the NHS with a corresponding paucity of specific advice in the social and community care sectors early on in the pandemic response (Hanratty et al., 2020). The authors, a group of health psychology professionals working with healthcare staff in practice and academic settings, received anecdotal evidence that frontline colleagues were overwhelmed with the volume and frequency of communications. Following the reconfiguring of healthcare services, and redeployment of workers (Rimmer, 2020), one healthcare leader said that keeping track of incoming guidance was "like sipping water from a hosepipe" (personal communication March, 2020). In addition to the vast amount of information, providing psychological support to health workers was hampered by geographical variations in availability of expert psychology input into strategy, planning and implementation of psychological support (Care Quality Commission, 2017). For those in social and community care, published guidance early in the pandemic lacked specificity with regard to mental health and learning disability services, a further source of distress for social care managers (Care Inspectorate, 2020; SSSC, 2020). The lack of data and adequate guidance in this sector highlighted an evident gap in 'pandemic planning' and prioritisation of staff and resident's needs (Hanratty et al., 2020). Clearly then, there was a need to provide expert advice and support to some health and social care leaders to help translate the plethora of reports and guidance and to implement workable plans to provide psychological support for their workforce.

Health Psychology and COVID-19

During the early days of the pandemic in the UK, a collective of 145 health psychology professionals (including researchers, practitioners and trainee health psychologists), the Health Psychology Exchange (HPX), was formed to volunteer their services to health, social care, and public health organisations throughout the UK and Ireland (HPX, 2020). In the UK, since 2001, professional training of health psychologists includes consultancy as a core competence (Michie & Abraham, 2008). The British Psychological Society define consultancy in health psychology as "the use of specialist health psychology skills and knowledge to provide a service to an external business client" (BPS, 2018). In practice, this involves translation of health psychology theory and behavioural science evidence to working with a wide range of organisations (clients) involved in healthcare, e.g. public health, NHS, social care, and private healthcare organisations. Consultancy can include working with clients to explore problems and potential solutions, providing expert advice, and sometimes involves implementing solutions (Earll &Bath, 2008). Several consultancy requests received by HPX related to information and guidance on providing psychological support for staff.

Responding to the need

The HPX group collectively provided expert consultancy, support and guidance to several organisations in response to COVID-19. After understanding the current and emerging evidence-based guidance in relation to providing psychological support for healthcare workers (BPS, 2020, Smith, 2020, WHO, 2011) and discussion with clients, the group learnt that current guidance was either sparse or overwhelming sector-specific. In response to the requests for support for frontline staff, members of HPX with experience in psychological interventions and practice developed a translational tool for health psychology consultants to hold strategic, supportive conversations with senior managers.

This paper reports on our findings and

reflections on rapidly developing a consultancy tool in times of crisis and shares initial indications of acceptability for other health psychology professionals to explore its use.

The Psychological Needs Assessment Tool (PNAT) Aims and Principles

The aim of the tool was threefold: 1) to map existing provision against the guidance 2) to conduct gap analysis to identify risks of psychological injury, and 3) to be adaptable to different health and social care settings. We developed the Psychological Needs Assessment Tool (PNAT) to guide health psychology undertaking consultancy to facilitate a needs assessment for organisation-level psychological support for health and social care staff during the coronavirus pandemic. The PNAT does not attempt to plan how to address psychological intervention gaps. It is, in essence, a needs assessment tool. However, it enables consultants to help leaders and managers to respond quickly to develop a strategic plan grounded in evidence and expert published guidance, without the need to review all sources of evidence themselves. The PNAT includes six main topics: physical safety, physical health requirements, space to decompress, psychological needs, decision making, and leadership. These six topics were adapted from the BPS (2020) guidance on this topic as depicted in the figure below (figure 1).

The PNAT content is based upon the stepped care model which highlights the importance of addressing basic needs and physical resources as a foundation for delivering formal psychological care as well as addressing information and peer support, and psychological first aid as first line supports. The PNAT content is depicted in the below flowchart (Figure 2).

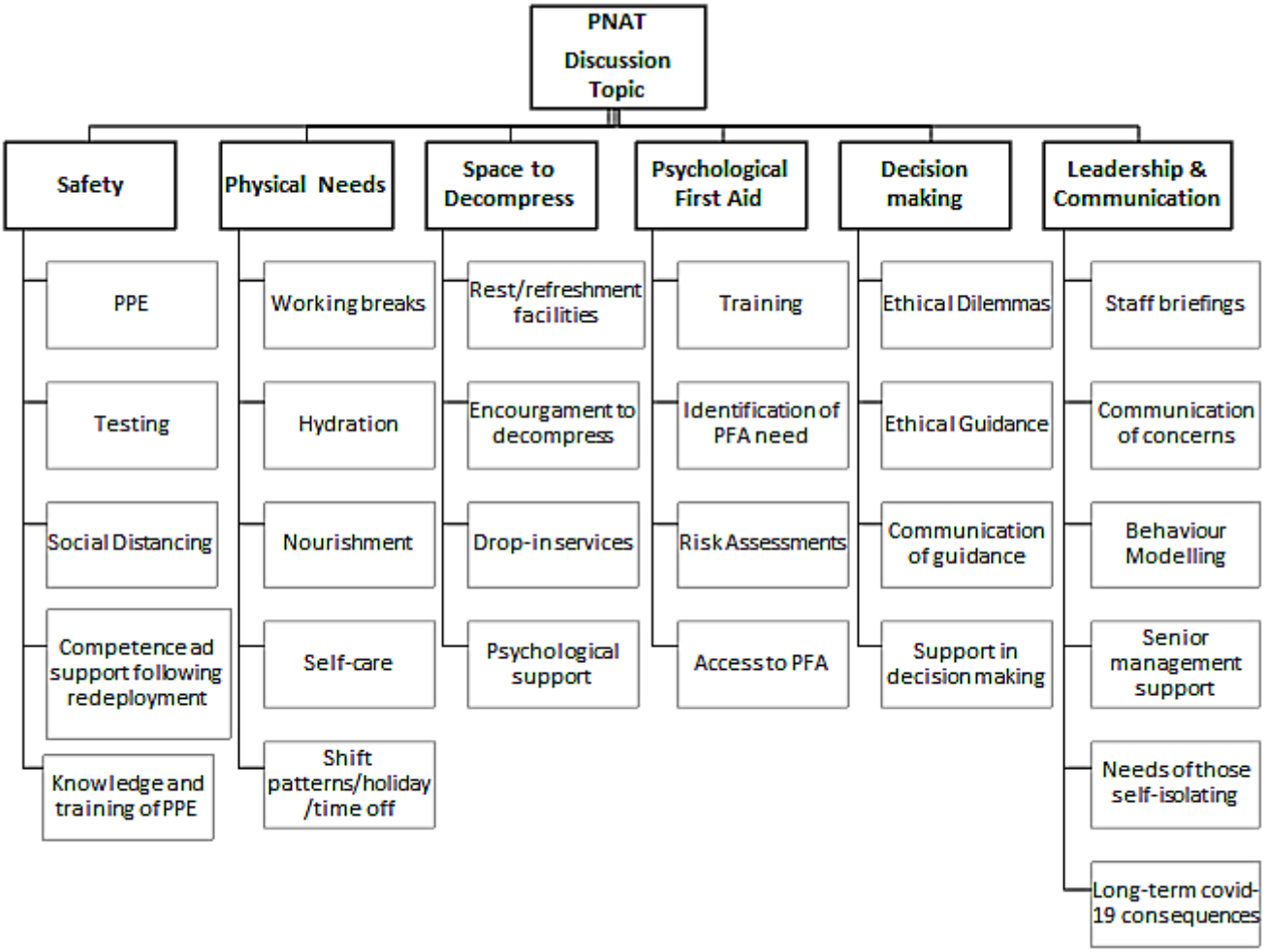
Figure 1. Stepped care model taken from BPS guidance on the psychological needs of healthcare staff as a result of the Coronavirus pandemic (BPS, 2020).

Method

Developing the tool

The tool was developed iteratively and collaboratively. Initially, to prepare for a meeting with an NHS hospital trust, one author (RB), an experienced Health Psychologist consultant, wrote a topic guide with prompts based on the official guidance (BPS, 2020; WHO, 2011). These topic prompts included physical safety, nourishment, time and space for reflection, open communication and ongoing psychological support (personal communication, 2020). This early version of the PNAT had the topic headings as in figure 1, but less detail than in the final version. Following the meeting she reflected with the HPX intervention subgroup colleagues on the topic guide's use: feasibility, comprehensiveness, and effectiveness in

Figure 2. Overview of PNAT tool discussion topics



facilitating open conversation about the psychological needs of the hospital workforce. This topic guide led to the development of a first draft PNAT tool.

These reflections led to improvements in the clarity of terms, options for self-care resources, transparency of staff communication styles and staff involvement in decision making. Two months of discussion within the HPX Psychological Interventions subgroup led to four further iterations which culminated in the addition of discussion prompts surrounding access to PPE, sleep hygiene and long-terms consequences of working on the frontline. The subgroup members then began to use the final PNAT version in conversations with client organisations.

A further four group members used the tool in conversations with local government and third sector organisations. Finally, the tool was reviewed by an independent health psychologist consultant (LBD) who compared PNAT with the previously published COVID-19 wellbeing support guidance (BPS, 2020; Smith, 2020; WHO, 2011) to add elements that did not appear.

Evaluating acceptability, monitoring tool use and initial indicators of impact

To more formally capture our group's ongoing experiences, acceptability and potential impact of using a PNAT tool in health psychology during COVID, we developed an evaluation questionnaire based on the Theoretical Framework of Acceptability (Sekhon, Cartwright, & Francis, 2017) which includes seven component constructs relating to acceptability of healthcare innovations: affective attitude, burden, perceived effectiveness, ethicality, intervention coherence, opportunity costs, and self-efficacy. The questionnaire contained 25 items, 15 requiring Likert scale (8 items, 5- point scale) and 10 free text responses on users' acceptability of the tool, the areas of use, potential improvements and post-use reflections (see appendix 1). Group members also collected their own more detailed field notes about the topics discussed with clients from health and social care organisations. The group also collected qualitative client feedback where provided from organisations, but we did feel it was feasible to ask clients to complete further evaluation activities such as questionnaires when under intense workload pressures during the pandemic's first wave.

Findings

Use of the PNAT with clients

In its first month, eight of our group's health psychology consultants used the tool in nine HPX consultancy meetings, either alone or with a co-facilitator. During meetings with HPX clients including public health, NHS, and health charity leaders, health psychology consultants validated the good work already implemented by leaders in the health and social care sectors to provide psychological support. This was helpful particularly for those leaders without access to psychology expertise. During most of the conversations, the tool also helped the client reflect on gaps in staff support provision (e.g. lack of access to facilities for staff breaks within COVID zones in one hospital), further outlined in Armstrong and colleagues (2020). This naturally led to solution-focussed working: clients took the opportunity to discuss ideas on how these might realistically be addressed with the health psychology consultant. Consultancy strategies included ideas for restructuring environments to allow better access to rest facilities, providing information on how best to introduce PFA in organisations, how to encourage staff to build regular hydration habits into their busy work days, pathways in organisations to raise open and honest communication of concerns, holistic return to work plans, implementation of reflective practice groups in organisations and evidence-led health messaging (Armstrong et al., 2020). In addition, consultancy work using the PNAT allowed the more experienced members of the HPX psychological interventions subgroup to offer opportunities to trainee health psychologists to develop consultancy skills through shadowing and co-leading consultancy meetings with clients (Byrne et al., 2020). Client feedback from interactions with both trainee and experienced consultants was positive. One social care manager commented "I have found them both to be very supportive and given valuable feedback and examples and ideas of their own experience to problem solve". Other feedback from public health and NHS trusts reported that "The HPX have been incredibly responsive and have gone above and beyond expectations to help cascade their expertise for the benefit of key workers" and "Their prime skill is in taking complex concepts and distilling them into ideas that you can understand and

recognise as interventions that would work in your organisation. They have helped shape our thinking and I quote them regularly to colleagues!".

PNAT acceptability as a consultancy tool

The team's evaluation informed PNAT reiterations and the development of the 'how to' guide (appendix 2). The acceptability questionnaire recorded nine occasions where our group of volunteer health psychology consultants used the PNAT and data suggested that the PNAT had high acceptability, as defined by the TFA. Indeed, in five of nine consultations, health psychology consultants reported that the tool was 'completely' acceptable, suitable, and enjoyable to use. In eight of nine consultations, users reported that the tool took some effort to use supporting the group's view that the tool is best used by health psychology consultants in conversations with clients, rather than by clients themselves. Further qualitative feedback from all of the five consultants including early career and trainee health psychologists, revealed high self-efficacy using the tool, especially after the development of a 'how to guide' (appendix 2). The evaluation also captured potential future tool developments. Practitioners suggested adding safeguarding, COVID-19 testing, and employment of psychological staff, which were not specifically captured by the consultancy tool. Our group also found that although all sections of the PNAT were relevant for psychological wellbeing, the time needed to explore all areas of the PNAT required more than one or two meetings with organisation leaders. Further development of the PNAT could include guidance on how to prioritise areas.

As well as being acceptable, our evaluation questionnaire suggested that consultants found PNAT effective in identifying gaps and enabling organisations to address them. More importantly, consultant field notes included examples of clients' comments, for example "The tool allowed me to raise issues that the staff nor I would have thought of or discussed without the tool". All organisations went on to implement at least one recommendation as a result of the PNAT conversations. The implemented recommendations are discussed in full elsewhere (Armstrong et al., 2020). Relationships with clients have been overwhelmingly positive and, as a result, individual health psychologists have been contracted to work with healthcare organisations on implementation projects.

Further developments: a 'How To' use the PNAT guide

As a result of consultant feedback from the evaluation the brief 'how to' guide was written (Appendix 2). The guide contains prompts to use evidence-based communication skills during the meetings. It includes guidance on agenda setting, boundaries, and how to prioritise topic areas. Both trainee and experienced consultant feedback indicated that the how to guide helped to increase consultant confidence and reduced the time taken to cover the topics in the PNAT.

Discussion

The PNAT has allowed consultants to support clients in identifying gaps in provision of psychological support for healthcare staff, and to share their ideas about how to address those gaps with psychologists. In addition, it has enabled consultants to encourage organisations to identify and to reflect positively on their achievements in supporting the psychological needs of their staff (Rodgers, 2002). These include, developing and piloting a model for online group reflective practice (Brady et al., 2020), designing evidence-based

public health messages, and translation and synthesis of government guidance (Armstrong et al., 2020). To date, the PNAT, a consultancy tool based on evidence-based guidance, has been applied to successfully support leaders in cancer support services, NHS hospital trusts, local government, public health, social care and educational institutions.

Health psychology as a discipline has informed the COVID-19 response by advising independent scientific committees (Scientific Advisory Group for Emergencies, 2020), conducting rapid reviews (Ghio et al., 2020) and research studies, by continuing to practice clinically and, through consultancy, a key competency of the discipline. The BPS health psychology guidance provided an opportunity to develop a consultancy tool to improve the confidence and effectiveness of consultants in health psychology. We believe that by developing the PNAT, we can scale up and structure the support provided by health psychologists in translating international, national and local guidance into practice for client organisations.

The main strength of the tool is that it has been developed by health psychology consultants for health psychology consultants, who are familiar with the evidence for providing psychological support for staff during crises, who work within professional boundaries and who are sensitive to ethical implications when supporting clients. The tool was developed rapidly in response to the pandemic and was implemented and evaluated across a range of UK client organisations. As the tool is still in early use, there is as yet little data on transferability to different contexts.

We encourage health psychology consultants to continue to use the tool to guide needs assessment with organisations. We would be glad of a wider range of evaluation responses to our acceptability questionnaire, including from 'consultancy clients'. Further application of the PNAT will enable health psychology consultants to support client organisations to tailor psychological support according to the needs of their staff, and to organisation priorities and resources. We envisage that it may also be possible to pool feedback from different organisations to advise government and policy makers on the challenges faced.

Conclusion

PNAT is a translational instrument used to support health psychology consultants in initial consultancy conversations with client organisations about frontline staff psychological and physical wellbeing. It is a supportive and structured tool facilitating a needs analysis leading to clients developing action plans for their organisation. The tool is in its infancy and needs further use and evaluation, and we encourage health psychology consultants nationally and internationally to trial the tool and share their findings.

Acknowledgements

Acknowledgements: The authors wish to thank the senior leaders from the organisations that the Health Psychology Exchange supported for sharing feedback about their experiences which contributed to the case studies reported in this manuscript.

The authors wish to thank the co-founders of the Health Psychology Exchange (Jo Hart and Angel Chater) for forming the HPX and supporting/advising the psychological interventions sub-group.

Ethics

This work is classified as service improvement so ethical approval not required. Researchers followed guidelines for ethical conduct established by the Declaration of Helsinki, the Research Governance Framework for Health and Social Care, and the

British Psychological Society's Code of Ethics and Conduct (2018).

Funding

None

Declarations of conflicting interests

Laura Howells is a consultant for the University of Oxford on an educational grant funded by Pfizer, unrelated to the submitted work.

Authors' contributions

AC, LBD & JH formed and lead the Health Psychology Exchange (HPX) and EB formed and led the HPX Psychological Intervention sub-group. AC, LBD & JH received requests for voluntary health psychology expertise from organisations seeking psychological support and passed requests onto HPX volunteers, including those in the HPX psychological intervention sub-group (RB, JB, LMH, AC, EB SA, DW and others). RB initiated the development the Psychological Needs Assessment Tool that supported HPX volunteers to facilitate meetings with organisations. SA and DW produced the first draft manuscript; all authors provided input towards the final manuscript.

References

Armstrong S.,Watson, D., Byrne, J., Howells, LM., Hart, J., Byrne-Davis, LMT, Cross, A., Bull, E, Brady, R. (2021). Supporting organisations to improve the psychological wellbeing of their staff during COVID-19 pandemic: Case Studies *European Health Psychologist 22 (1),* 736-744.

Bedford, J., Enria, D., Giesecke, J., Heymann, D. L., Ihekweazu, C., Kobinger, G., . . . Schuchat, A. (2020). COVID-19: towards controlling of a pandemic. *The Lancet*, 395(10229), 1015-1018.

Bell, V., & Wade, D. (2020). Mental Health of Clinical Staff Working in High-Risk Epidemic and Pandemic Health Emergencies: A Rapid Review of the Evidence and Meta-Analysis. *medRxiv*.

BPS. (2018). *The British Psychological Society Promoting excellence in psychology Qualification in Health Psychology (Stage 2) Candidate handbook*. Retrieved from www.bps.org.uk/qualificationswww.bps.org.uk/qualifications

Brady, R., Varkonyi-Sepp, J., & Byrne, J. (2020). Consultancy Case Study: Piloting online group reflective practice for health professionals during the coronavirus pandemic. (in press).

British Psychological Society Covid19 Staff Wellbeing Group. (2020). *The psychological needs of healthcare staff as a result of the Coronavirus pandemic*. Retrieved from https://www.bps.org.uk/sites/www.bps.org.uk/files/News/News%20-%20Files/Psychological%20needs%20of%20healthcare%20staff.pdf

Cai, H., Tu, B., Ma, J., Chen, L., Fu, L., Jiang, Y., & Zhuang, Q. (2020). Psychological Impact and Coping Strategies of Frontline Medical Staff in Hunan Between January and March 2020 During the Outbreak of Coronavirus Disease 2019 (COVID-19) in Hubei, China. Medical Science Monitor: *International Medical Journal of Experimental and Clinical Research*, 26, e924171-924171.

Care Inspectorate (2020). *Coronavirus*. Retrieved from https://www.careinspectorate.com/index.php/coronavirus-professionals

Care Quality Commission. (2017). *The state of care in mental health*. Retrieved from https://www.cqc.org.uk/

Chen, Q., Liang, M., Li, Y., Guo, J., Fei, D., Wang, L., . . . Li, X. (2020). Mental health care for medical staff in China during the COVID-19 outbreak. *The Lancet Psychiatry, 7*(4), e15-e16.

Cheng, P., Xia, G., Pang, P., Wu, B., Jiang, W., Li, Y.-

T., . . . Wang, J. (2020). COVID-19 epidemic peer support and crisis intervention via social media. *Community mental health journal*, 1.

Earll, L., and Bath, J. (2008). Consultancy: What is it, how do you do it and does it make any difference? In S. Michie and C. Abraham (eds.), *Health Psychology in Practice*, BPS Blackwell

Ghio, D., Lawes-Wickwar, S., Tang, M. Y., Epton, T., Howlett, N., Jenkinson, E., Stanescu, S., Westbrook, J., Kassianos, A., Watson, D., Sutherland, L., Stanulewicz, N., Guest, E., Scanlan, D., Carr, N., Chater, A., Hotham, S., Thorneloe, R., Armitage, C., . . . Keyworth, C. (2020). What influences people's reponses to public health messages for managing risks and preventing disease during public health crises? A rapid review of the evidence and recommendations. *PsyArXiv*: https://psyarxiv.com/nz7tr/

Greenberg, N., Docherty, M., Gnanapragasam, S., & Wessely, S. (2020). Managing mental health challenges faced by healthcare workers during covid-19 pandemic. *Bmj*, 368.

Geoffroy, P. A., Le Goanvic, V., Sabbagh, O., Richoux, C., Weinstein, A., Dufayet, G., & Lejoyeux, M. (2020). Psychological Support System for Hospital Workers During the Covid-19 Outbreak: Rapid Design and Implementation of the Covid-Psy Hotline. *Frontiers in Psychiatry, 11*, 1. https://doi.org/10.3389/fpsyt.2020.00511

Hanratty, B., Burton, J. K., Goodman, C., Gordon, A. L., & Spilsbury, K. (2020, June 24). Covid-19 and lack of linked datasets for care homes: The pandemic has shed harsh light on the need for a live minimum dataset. *The BMJ*, Vol. 369. https://doi.org/10.1136/bmj.m2463

Health Psychology Exchange. (2020). *What is the Health Psychology Exchange and what can it do?*

Holmes, E. A., O'Connor, R. C., Perry, V. H., Tracey, I., Wessely, S., Arseneault, L., . . . Everall, I. (2020). Multidisciplinary research priorities for the COVID-19 pandemic: a call for action for mental health science. *The Lancet Psychiatry*.

Iqbal, M. R., & Chaudhuri, A. (2020). COVID-19: Results of a national survey of United Kingdom healthcare professionals' perceptions of current management strategy–a cross-sectional questionnaire study. *International Journal of Surgery*.

Keyworth, Ghio, Lawes-Wickwar, Tang, Thorneloe, Epton, Chater, Hotham, Byrne-Davis, & Hart. *What are the most effective public health messages for managing risks and preventing disease during public health crises?*. PROSPERO 2020 CRD42020188704 Available from: https://www.crd.york.ac.uk/prospero/display_record.php?ID=CRD42020188704

Kisely, S., Warren, N., McMahon, L., Dalais, C., Henry, I., & Siskind, D. (2020). Occurrence, prevention, and management of the psychological effects of emerging virus outbreaks on healthcare workers: rapid review and meta-analysis. *BMJ* (Clinical Research Ed.), 369, m1642. https://doi.org/10.1136/bmj.m1642

Lai, J., Ma, S., Wang, Y., Cai, Z., Hu, J., Wei, N., . . . Li, R. (2020). Factors associated with mental health outcomes among health care workers exposed to coronavirus disease 2019. *JAMA network open*, 3(3), e203976-e203976.

Local Government Association. (2020). *Protecting vulnerable people during the COVID-19 outbreak*. Retrieved from https://www.local.gov.uk/sites/default/files/documents/COVID-19_vulnerable%20people%20briefing%20updated.pdf

Michie, S., & Abraham, C. (Eds.). (2008). *Health psychology in practice*. John Wiley & Sons.

Michie, S., Van Stralen, M. M., & West, R. (2011). The behaviour change wheel: a new method for characterising and designing behaviour change interventions. *Implementation science*, 6(1), 42.

National Institute for Health and Care Excellence. (2020). Mental wellbeing of older people in care homes. Retrieved from https://www.nice.org.uk/about/nice-communities/social-care/tailored-resources/mwop?type=careproviders

Rimmer, A. (2020). How can I cope with

redeployment? *Bmj*, 368.
Rimmer, A., & Chatfield, C. (2020). What organisations around the world are doing to help improve doctors' wellbeing. *Bmj,* 369.
Rodgers, C. (2002). Defining reflection: Another look at John Dewey and reflective thinking. *Teachers College Record*, 104(4), 842-866. doi:https://doi.org/10.1111/1467-9620.00181
Scientific Advisory Group for Emergencies. (2020). *The role of behavioural science in the coronavirus outbreak*. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/873732/07-role-of-behavioural-science-in-the-coronavirus-outbreak.pdf
Sekhon, M., Cartwright, M., & Francis, J. J. (2017). Acceptability of healthcare interventions: an overview of reviews and development of a theoretical framework. *Bmc Health Services Research, 17*(1), 88.
Smith. (2020). *Support the workers.* Retrieved from https://www.supporttheworkers.org/
SSSC. (2020). *Supporting the wellbeing of social service workers.* Retrieved from https://learn.sssc.uk.com/wellbeing/
World Health Organization. War Trauma Foundation and World Vision International (2011). *Psychological first aid: Guide for field workers*. WHO: Geneva.
World Health Organization. (2020a). *Coronavirus disease (COVID-19) outbreak: rights, roles and responsibilities of health workers, including key considerations for occupational safety and health: interim guidance*, 19 March 2020. Retrieved from https://www.who.int/publications/i/item/coronavirus-disease-(covid-19)-outbreak-rights-roles-and-responsibilities-of-health-workers-including-key-considerations-for-occupational-safety-and-health
World Health Organization. (2020b). *Critical preparedness, readiness and response actions for COVID-19: interim guidance, 19 March 2020.* Retrieved from https://www.who.int/publications/i/item/critical-preparedness-readiness-and-response-actions-for-covid-19

Appendix 1. PNAT Acceptability questionnaire

Acceptability of the psychological needs assessment consultancy tool

The psychological needs assessment consultancy tool is an agenda setting tool. It aims to help health psychologists to have consultancy conversations where they would like to identify the psychological needs of staff within an organisation during the COVID-19 pandemic.

This brief questionnaire below is designed to collect your valuable feedback and reflections on how useful and acceptable the tool is in doing this. Acceptability questions are based on the Theoretical Framework of Acceptability (Sekhon et al. 2017).

Questionnaire

1. Health psychology team member name:
2. Date of conversation:
3 .How many professionals did you speak with in this conversation?
4. What type of professional(s) was your conversation with? (Frontline practitioner, Local manager, HR/wellbeing personnel, Senior Leader in the organisation, Other)
5. What is their role in relation to COVID-19 issues?
6. What was the reason for the conversation today?
7. How acceptable did you find using the tool today? (Likert Scale)
8. How much did you like using the tool today? (Likert Scale)
9. How much effort did it take to use the tool today? (Likert Scale)
10. How fair or moral did it feel to use the tool

today? (Likert Scale)

11. Using the tool helped me identify the psychological needs of staff during the COVID-19 pandemic (Likert Scale)

12. It makes sense to me how the tool will result in organisations better supporting their workers' psychological needs during COVID-19 (Likert Scale)

13. How confident would you feel about using the tool again in future? (Likert Scale)

14. How did you find using the tool today? Please expand on the points above in sharing your reflections.

15. Do you think anything important is missing from the tool? (yes/no)

16. Do you think all sections are relevant to include in the tool? (yes/no)

17. Is there anything within the tool that you don't understand? (yes/no)

18. Finally, do you have any other suggestions for improving the usefulness and acceptability of the tool

Roseanna Brady
Psychology for Health Associates, United Kingdom
bradykbs@msn.com

Eleanor Bull
Department of Psychology, Research Centre for Health, Psychology and Communities, Manchester Metropolitan University
Eleanor.Bull@mft.nhs.uk

Sian Armstrong
Department of Psychology, School of Health and Life Science, Glasgow Caledonian University, Glasgow, United Kingdom
Sarmst208@caledonian.ac.uk

Daniella Watson
Global Health Research Institute, School of Human Development and Health, Faculty of Medicine, University of Southampton, United Kingdom
D.Watson@soton.ac.uk

Jacqueline Lavallée
Division of Medical Education, University of Manchester, UK
jacqueline.lavalee@manchester.ac.uk

Ainslea Cross
School of Psychology, University of Derby, Derby, United Kingdom
A.Cross1@derby.ac.uk

Laura Howells
Centre of Evidence Based Dermatology, School of Medicine, University of Nottingham, Nottingham, United Kingdom
Laura.Howells1@nottingham.ac.uk

Lucie Byrne-Davis
Founder and lead of the Health Psychology Exchange
Division of Medical Education, University of Manchester, UK
lucie.byrne-davis@manchester.ac.uk

Jo Hart
Division of Medical Education, University of Manchester, UK
Health Psychology Exchange, United Kingdom
Jo.Hat@manchester.ac.uk

Angel Chater
University of Bedfordshire, UK
Angel.Chater@beds.ac.uk

African best practices in measures used to fight against COVID-19

Celestin Mutuyimana
University of Rwanda, Rwanda
Andreas Maercker
University of Zurich, Switzerland

1.Introduction

In early 2020, on January 12, the World Health Organization (WHO) confirmed that a novel coronavirus was the cause of respiratory illness in a group of people in Wuhan City, Hubei Province, China. The outbreak was reported to WHO on December 31, 2019. WHO announced the COVID-19 outbreak as a pandemic on March 11, 2020 (Reynolds & Weiss 2020).

In Africa, the first case was confirmed on February 14 in Egypt. There were fears that the new virus could quickly overwhelm the largely fragile health systems on the continent and kill many people (Soy, 2020). This assumption was made because there are many risk factors in Africa that favor the spread of the pandemic, such as high levels of poverty, urban density, widespread infectious diseases, limited access to health care, crowded informal settlements, and cultural routines (Smith, 2020). Weak African Health systems with low health infrastructure, low economic income, and insecurity were other risk factors that were expected to accelerate the spread of the pandemic in African countries (Holmes, 2020).

In most African countries, there was concern about the impact of the pandemic on people's lives, especially in West African countries where Ebola had killed many people in recent days (Smith, 2020). Nevertheless, it seems that due to the constant confrontation, with several health challenges, including HIV/AID, tuberculosis epidemics diseases like Ebola and because of the fear of mass death; Africa will be effective in combating the covid-19 and protect their population (Soy, 2020, Williams, 2020). Consequently, drastic measures to slow the spread of the virus have been implemented more aggressively in many African countries than in the United States and Europe (The New York Report, 2020). In some countries, such as Lesotho, drastic measures were taken even before a single case was reported. Lesotho declared a state of emergency on March 18 and closed schools. About 10 days later, a three-week lockdown was imposed, as in many other states in southern Africa (Soy, 2020).

In the first wave of pandemic, worldwide, there have been 50,459,886 confirmed cases of COVID-19 as of November 10, 2020, including 1,257,523 deaths.

With the exception of Antarctica, which has few cases, Africa is the first continent to have fewer confirmed cases and deaths compared to the tests conducted (Soy, 2020, WHO dashboard, 2020). In the second and third waves of the pandemic, the number of deaths and cases increased slightly compared to the first and second waves, but most African countries still have the pandemic under control. Today, Africa is the penultimate continent with fewer confirmed COVID-19 cases and deaths, followed by the Western Pacific (WHO Dashboard, 2021). Daily change data also shows that only Africa and the Western Pacific are two regions with fewer new cases. This has led us to question why Africa was performing better than all other continents, although it was unexpected. This article highlights the best practices used by African

countries to reduce the harmful effects of Covid-19 on their populations.

2.African strategies for responding to the COVID-19

Africa's response to the pandemic has been adapted to its own realities, challenges, resources and strengths. This has led to a number of innovations and adaptations in the response to coronavirus in Africa - initiatives that are still ongoing. Preparedness, political will, education, mass sensitization, improved hygiene, continued efforts to demystify COVID-19 and support for vulnerable families in crisis situations; characterize Africa's adaptive response to the new coronavirus pandemic (Africa Center for Strategic Studies, 2020).

2.1. Political will

African heads of state, commissions and governments held joint meetings anti-COVID-19. The first major meeting was held by Africa Centers for Disease Control and Prevention (CDC) and African Union Commission led by Chairman Moussa Faki Mahamat with all health ministers on 22 February 2020. At this meeting they agreed on the need for a coordinated continental strategy based on cooperation, collaboration, alignment and communication. Another outcome was the establishment of the Africa task force for Coronavirus preparedness and response. The infection prevention and control part of the task force is co-chaired by Nigeria and Africa CDC. The laboratory part is jointly led by Senegal, Africa CDC and the World Health Organization (WHO) (Africa Renewal 2020). Another example is the East African Community (EAC) Heads of State Meeting chaired by Paul Kagame the President of the Republic of Rwanda on 12 May 2020, which noted the status of the COVID-19 outbreak in the region and commended the Ministers of Health, Trade, Transport and EAC Affairs for their initiative to take a regional approach to the COVID-19 pandemic.

In addition, many African countries such as Rwanda, Nigeria and Uganda have created COVID-19 task forces of public health and sector experts as an institutional innovation to guide the response to the pandemic (Africa Center for Strategic Studies, 2020) and hold regular government meetings.

The task force has facilitated information sharing among African countries to share lessons learned and best practices, movement controls between countries and access to food markets, and countering rumors, misinformation, and fake news.

2.2. Preparedness

Since the first appearance of the virus in Wuhan, China, in December 2019, some African governments, such as Rwanda and Lesotho, have established multidisciplinary teams to assess and strengthen pandemic preparedness and response (Binagwaho, 2020, Soy,2020). Fever screening systems for passengers at the airport have been established in most countries in Africa. Passengers are mandatorily screened and provide information on their travel history. Similar screenings take place at all borders (WHO, 2020). Health and security measures have also been strengthened to prevent the spread of the virus. For example, citizens are urged to avoid handshakes and close physical contact such as hugging, to cover their mouths and noses when coughing or sneezing in public, and to refrain from unnecessary travel. Digital thermometers were also purchased and placed in public places. Health facilities were equipped with COVID-19 tests to test suspected cases. In different countries, centers and training of health workers varied in their preparedness to

receive COVID-19 patients. In countries such as Rwanda, Senegal, Nigeria, Kenya, and South Africa, health workers, including hospital laboratory technicians, were trained in infection control, prevention, enhanced screening at airports, and risk communication with the public (Ighobor, 2020, Rwanda Biomedical Center, 2020). All hospitals were required to establish isolation areas where patients with suspected COVID -19 symptoms could be treated separately from other patients, and special centers were prepared and equipped to receive COVID-19 patients. Preventive measures were also taken to protect health workers in the course of their duties. In Nigeria, lessons learnt from the 2014 outbreak West Africa Ebola were used to treat coronavirus patients, avoid rapid infection and not disrupt the usual functionality of the health system. Note that during the 2014 Ebola outbreak crisis Nigerian Government directly mobilized the Nigerian Center for Disease Control (NCDC) and the Nigeria Field Epidemiology and Laboratory Training Program (NFELTP) to investigate, manage and control the epidemic. They established a system for tracking, quarantining and managing contacts.

Control efforts in Nigeria included massive mobilization, sensitization and education of the public on the dangers, signs and symptoms of the epidemic and acceptable practices inside and outside health facilities. Volunteer health workers were deployed in the two cities of Lagos and Port Harcourt to combat the disease. NFELTP residents were deployed to contact, monitor and isolate cases. This led to delay in resumption of school activities and shortened duration of national camping programs (Oleribe, 2015 p. 55).

2.3. Education

Many African countries have taken the lead in educating their citizens about COVID-19 prevention and treatment. Capacity building has begun with the following elements:

1. educating the public about the epidemic of COVID-19, its symptoms, consequences and prevention mechanisms. The message was disseminated through radio, television, posters and community information through local leaders. Prevention focused on social distancing and hygiene, as handshakes and hugs are common in Africa. Extraordinary measures were taken to ensure that hygiene was maintained in all public places such as banks, markets, hospitals and bus parking areas (Iom, 2020, WHO, 2020). Drivers in public or private vehicles have been asked to carry no more than half the passengers of their normal vehicle seats. In some countries, such as Rwanda, public awareness has been raised to another level. In Rwanda, drones and vehicles equipped with megaphones buzz around the country's roads and villages, reminding pedestrians of the social distance and other prevention mechanisms (WHO, 2020).

2. Mandatory wearing of masks and restriction of social gatherings: In African culture, visiting, gathering, socialising and participating in various cultural ceremonies are part of their values. Therefore, governments have taken measures to educate the public about the dangers of gatherings and set a limited number of participants in various events such as weddings and funerals, and ban house parties or visits (The conversation, 2020). In many countries, including Rwanda, South Africa and Nigeria, the wearing of masks is mandatory. Citizens were required to wear non-medical cloth masks when they left their homes. Governments helped industry produce more masks for citizens. Local and international partners supported poor families to get enough masks. In Rwanda, it is compulsory to wear a mask, even in non-public areas (on the street when walking alone, in the office when with other people, etc.).

People who don't wear masks, or don't wear them well, are sent to stadiums for the entire night and fined $5. The press is often invited to send

pictures of the punished to discourage others from ignoring the rules (World, Africa 2020).

3. Curfews: given the high levels of poverty in Africa, lockdowns without social protection plans could lead to severe consequences, including famine and the depletion of coping mechanisms, especially among the most vulnerable populations. Therefore, countries such as Rwanda, South Africa and Uganda have moved to a curfew-based strategy with strict movement controls (Africa Center for Strategic Studies, 2020).

4. Church control and attitude change: from the beginning of the pandemic until now, most churches have been closed. The opening of some churches requires strict control by local authorities, the establishment of hygiene facilities and the decision on the maximum number that can attend a meeting, considering social distancing. In the church, the prevention mechanisms must be implemented by each participant and the leaders of the churches. For example, the Catholic Church, which makes up to 80% of the Rwandan population, has also discarded the "greeting of peace" with handshakes. They have also discarded the practice of receiving bread on the tongue during the celebration of the Eucharist (Word, Africa, 2020). They have also forbidden the use of a common vessel of holy water for purification, in which the faithful dipped their hands at the entrance before entering the church, and the wearing of a mask in church is obligatory. The seats of the churches are separated from each other by 2 meters (World, Africa, 2020).

5. Closure of places of assembly and public places: Authorities have decided to close bars, nightclubs, various games and schools for extended periods of time to curb the rise in COVID -19 infections. In some countries like Kenya and Rwanda, bars and nightclubs are still closed today, schools are gradually reopening but every student has been tested beforehand. Hotels are open, but always with a social distance of 1.5 meters, with temperature tests and with a book register before entering. No one is allowed to get drunk in the hotels and no social ceremonies are allowed (Tasamba,2020).

6. Cashless or digital payment: In some countries, the population was encouraged to use mobile money and online banking whenever possible to limit the transfer of paper money that would spread the pandemic.Although the initial reflex at the start of the crisis was to withdraw cash (World Economic Forum, 2020), bank customers gradually wanted to make more electronic payments than cash. This helped to reduce the spread of the pandemic (Girancourt et al., 2020). The Egyptian government increased the limit on electronic payments to encourage the exclusive use of digital payments (Egyptian State Information Service website, 2020). An online payment platform (South Africa) recorded a 35 to 40 percent increase in transactions and an increasing number of retailers requesting online payment systems to cope with increased customer demand (IT Web, 2020). In Rwanda, the central bank mandated that cashless payments be made available with zero fees for all transfers between bank accounts and mobile wallets, zero fees for all mobile money transfers, and zero fees for point-of-sale payments. This strategy reduced the use of individual mobile wallets in Rwanda (Eco Africa, 2020).

2.4. Demystification

As COVID-19 continues to spread around the world, rumors, myths, misinformation and fake news about the pandemic are circulating. Videos, voicemails, texts, and stories from unproven sources claim that Africans are somehow immune to COVID-19, despite a wealth of evidence to the contrary. Africans are responding to the challenge in different ways: Many presidents and senior health executives are using their daily briefings to dispel rumors and misinformation about COVID-19.

In South Africa, a private company, Praekelt.org, has set up a WhatsApp-based helpline that provides real-time data and automated responses in numerous languages to educate and raise awareness about the truth. Nigerian Presidential COVID-19 Task Force has also established a 24-hour hotline that provides up-to-date information to inform and protect the public from misinformation and rumors. In Rwanda, a permanent hotline and official social media (Twitter, Facebook) were used in combination with daily reports on the status of COVID-19 (Africa Center for Strategic Studies, 2020).

2.5. Targeting vulnerable populations

Because of COVID-19, some families fell into economic crisis. There was a danger of migration to meet the basic needs of the family. Therefore, governments such as those of Rwanda, Ethiopia and Kenya took the initiative to support families in crisis and prevent the spread of COVID-19, either by providing food or direct cash transfers (Africa Center for Strategic Studies, 2020).

2.6. Further mechanisms to avoid spreading

Technology is the first other mechanism used primarily in medicine to reduce the rate of spread. In Rwanda, robots are used for various tasks such as temperature control and monitoring patients. This protects health workers from being exposed to the disease (WHO, 2020). Drones are used to deliver blood and enforce restrictions to slow the spread of Covid-19 (WHO, 2020). Second, in African countries such as Ethiopia and Rwanda, young volunteers have been recruited and trained to strengthen the fight against COVID-19 (Tasamba, 2020, Unicef Ethiopia, 2020). In Rwanda, more than 5,000 volunteers have been deployed in public places and high-risk zones across the country. Their role is to ensure that people wear face masks, wash their hands and distance themselves socially (Tasamba, 2020). They work closely with the police to make further reports when needed.

Other mechanisms include a contact tracing task force, free testing in high risk areas and free treatment for patients with COVID-19, border closures, research on the spread of COVID-19, continuous training of community members, reducing the number of vendors in markets and offices, and disinfecting markets in countries such as Rwanda, Uganda, Botswana (Africa Center for Strategic Studies, 2020).

Conclusion

The methods used to prevent COVID-19 in Africa are obviously productive. We can surmise that lessons learned from previous outbreaks have influenced current strategies. Most African governments ensured rapid and early intervention by establishing a multidisciplinary team against COVID-19. They prepared centres to isolate COVID-19 even before the first case was reported. They set up a contact tracing system and a quarantine system. They used healthy community volunteers and youth volunteers to track and prevent the spread of the pandemic. They used technological methods in treatment and economic activities. They continuously shared information about the development of the pandemic in the neighbouring country and closed the borders. They established a strict quarantine system for new arrivals from outside. All of these measures were either used by the country to control other outbreaks or adopted by another country. Consistent adherence to these COVID-19 prevention measures reduced the intensity of the epidemic in the population compared to expectations. With limited resources,

fragile health systems, existing disease burden, urban density, conflict, and record population shifts, Africa continues to face an uphill battle COVID-19; yet African governments and societies have shown a remarkable level of responsiveness, cooperation, and adaptability to the pandemic. Today, African countries have fewer COVID-19 patients than other continents, and most African countries do not have the repeated blackout periods that many European countries have. However, European and American countries with adequate medical and economic resources are still experiencing increases in COVID-19 patient numbers, neglect of preventive measures, and blackout periods. Some strategies, such as raising public awareness and using community volunteers, appear to be difficult to apply in other continents because of the different cultures and education levels of the population. Other strategies seem to be well established before the pandemic, such as cashless payments and hygienic equipment. Still others seem to be bearing fruit everywhere, such as mandatory use of masks, constant adherence to preventive measures, strong mechanisms for screening new entrants, etc. In this respect, they need to take a lesson from Africa.

References

Africa Center for Strategic Studies (2020, April 15). African Adaptations to the COVID-19Response. https://africacenter.org/spotlight/african-adaptations-to-the-covid-19-response/

Binagwaho, A. (2021, January 7). *Lessons from Rwanda's fight against COVID-19*. The Japan Times.https://www.japantimes.co.jp/opinion/2021/01/07/commentary/worldcommentary/lessons-rwanda-covid-fight/.

ECO Africa. (2020, July 3). *Rwanda to start new cashless era after COVID-19*. https://www.dw.com/en/rwanda-to-start-new-cashless-era-after-covid-19/a-54038132.

Egyptian State Information Service website. (2020, March 22). *Central Bank of Egypt raises electronic payment limits amid COVID-19 outbreak*. https://www.sis.gov.eg/Story/144167?lang=en-us.

Ighobor. (2020). *Together we can win the war against COVID-19. Africa Renewal.* https://www.un.org/africarenewal/magazine/special-edition-covid-19/together-we-can-winwar-against-covid-19.

Iom. (2020, April 28).*Local leaders mobilised to fight against COVID-19 in Ethiopia. Africa Renewa*l (un.org). https://www.un.org/africarenewal/news/coronavirus/local-leadersmobilised-fight-against-covid-19-ethiopia.

IT Web. (2020, Mars 20). *Digital payments soar amid COVID-19 fears*. https://www.itweb.co.za/content/j5alrMQaya2MpYQk.

Jurd de Girancourt, F., Kuyoro M., Ofosu-Amaah, N. A. Seshie, E & Twum, F.(2020). *How the COVID-19 crisis may affect electronic payments in Africa*. Retrieved from how-the-covid 19-crisis-may-affect-electronic payments-in-africa.pdf (mckinsey.com)

Oleribe, O. O., Salako, B. L., Ka, M. M., Akpalu, A., McConnochie, M., Foster, M., & Taylor Robinson, S. D. (2015). Ebola virus disease epidemic in West Africa: lessons learned and issues arising from West African countries. *Clinical medicine (London, England), 15*(1), 5457. https://doi.org/10.7861/clinmedicine.15-1-54.

Reynolds, M., & Weiss, S. (2020, May 27). " *How coronavirus started and what happens next,explained. WIRED*. https://www.wired.co.uk/article/china-coronavirus.

Soy, A. (2020, October 7).*Coronavirus in Africa: Five reasons why Covid-19 has been less deadly than elsewhere - BBC News*. https://www.bbc.com/news/world-africa-54418613.

Tasamba, J. (2020, March 23). *Rwanda steps up efforts to beat coronavirus. WORLD, AFRICA.* https://www.aa.com.tr/en/africa/rwanda-steps-up-efforts-to-beat-coronavirus/1774728.

Tasamba, J. (2020, June 6). *Rwandan youth*

volunteers helping fight against COVID-19. WORLD, AFRICA. https://www.aa.com.tr/en/africa/rwandan-youth-volunteers-helping-fight-againstcovid-19/1867456.

THE CONVERSATION (2020, May 5). *African countries are moving to make masks mandatory:key questions answered*. https://theconversation.com/african-countries-are-moving-tomake-masks-mandatory-key-questions-answered-137516.

UNICEF Ethiopia (2020, September 30). *Youth volunteers take to the streets to mobilize against COVID- 19 in Ethiopia*.https://www.unicef.org/ethiopia/stories/youth-volunteers-take streets-mobilize-against-covid-19-ethiopia-0.

WHO. (2020, July 20).*COVID-19 response in Rwanda: Use of Drones in Community awareness*. https://www.afro.who.int/news/covid-19-response-rwanda-use-drones-communityawareness.

WHO. (2020, July 31). *Robots use in Rwanda to fight against COVID-19*. https://www.afro.who.int/news/robots-use-rwanda-fight-against-covid-19

Williams, W. (2000, March 25).“*COVID-19 and Africa's Displacement Crisis,” Spotlight, Africa Center for Strategic Studies*. https://africacenter.org/spotlight/covid-19-and-africasdisplacement-crisis/.

World Economic Forum. (2020, April 2). *West Africans are switching from cash to mobile money because of COVID-19*. https://www.weforum.org/agenda/2020/04/coronavirus-set-to-spurmobile-money-growth-in-w-africa.

WORLD, AFRICA (2020, August 7). *Rwandans sent to all-night lectures as punishment for breaking COVID rules*. https://www.deccanchronicle.com/world/africa/070820/rwandanssent-to-all-night-lectures-as-punishment-for-breaking-covid-r.html.

Celestin Mutuyimana
Department of Psychology, University of Zurich, Switzerland
University of Rwanda/Center for mental health
celestin.mutuyimana@uzh.ch

Andreas Maercker
Department of Psychology, University of Zurich, Switzerland
maercker@psychologie.uzh.ch

Report

Positivity through adversity in the race to the BSc finish line – Reflections on the impact of the COVID-19 Pandemic on final year studies

Kelly Murray-Hodcroft
University of Northumbria, UK

In January 2020, the UK watched from afar as the City of Wuhan in the Hubei Province, China, became an area that was to be the epicentre of the original outbreak of COVID-19. At that time, I was a third year BSc Psychology (Health psychology) mature student at University of Northumbria, with three school aged children and dealing with a lengthy mystery illness. My dissertation, a lab study titled: "An investigation of the effect of Resveratrol on 'Remembering to Remember' in healthy adults" was something I was very passionate about as my husband has Attention Deficit Hyperactivity Disorder (ADHD) and I have personal awareness of the impact it has on family life. The objective of this double-blind study was to examine whether Resveratrol could increase Prospective Memory (PM) in healthy adults who show increased symptoms of ADHD.

Enduring two lab visits, healthy participants all completed the ADHD diagnosis tool ASRS-v1.1 solely on visit one to obtain ADHD symptom severity. Thereafter, 500mg trans-Resveratrol and placebo were administered at least 7 days apart. A non-stimulating TV program (Grand Designs) was shown for 45 minutes to allow for absorption and participants then took part in a Prospective Remembering Video Procedure (PRVP) task to test prospective memory. The study began under a thin veil of awareness that COVID-19 was gathering pace and I was becoming more depleted of energy. The study ran for several weeks but could not continue. Due to the requirement of administering Resveratrol, moving the study online was also not an option and the five participants data was enough to write my dissertation but not enough to provide clarity on effect and I was left feeling defeated and deflated.

By March 2020, I was home-schooling my three children, university teaching had moved online, and the world was becoming a very different place. My health was rapidly deteriorating due to the pressure I was under and having my children at home full time left me with little time or energy to do anything else. I had already been rushed to hospital twice, with May 2020 thankfully being the final time and I was facing total UK lockdown and an ambulance ride alone. With a heart rate of over 220BPM at rest and atrial fibrillation (AF), I had loss of taste that was embodied in a strong metallic sensation, my cognition was in decline, rapid weight loss due to a non-existent appetite and my anxiety and insomnia were increasing. Not only myself, but most of my family were struggling with health issues that included loss of smell and taste, continuous coughs, high intermittent temperatures, joint issues, post viral facial rash, migraine, pneumonia, and nausea. Although it would be pertinent not to give this mystery illness a label due to lack of early testing, in reference to a study by Watson et al (2020) titled 'Altered Smell and Taste: anosmia, parosmia and the impact of long Covid-19', a participant quoted "Four months into recovery the rancid/metallic taste and smell hit me." And "It's really quite debilitating – physically, mentally and professionally. I'm 6 months in and losing hope." As a family, we have had the struggle of what could be classed as long

COVID-19 symptoms and I am thankful to report in January 2021, that after a lengthy battle with ensuring the right nutrition, rest, supplementation and exercise aplenty, myself and most of my family are almost back to full health.

The lengthy interruption took a toll on my BSc, and at times I was ready to quit, my cognition, emotional and mental wellbeing were just not capable at taking on such an enormous task. I had submitted my dissertation with success in June 2020, but I had other modules to complete to get my final degree classification. I decided to compartmentalise my module work and utilise small sections of the assignments rather than feel the pressure of the whole requirement. I was very slow and pragmatic but finally in September 2020 I was able to submit all the required modules and I gained my BSC Psychology (Health Psychology) on 2nd October 2020. Emerging from this trying time has made me look to post-traumatic growth (PTG) and what I could do to empower myself to grasp a positive outcome. Although past research on PTG has left questions on limitations of methodology, it remains to be an intriguing topic that I felt could enable me to find self-improvement through adversity (Jayawickreme et al, 2021). I decided to start by making one small change in my routine and that was to alter the very first thing I do on waking. Historically, like many, I would reach over to my mobile phone, turn off the alarm and begin scrolling through my emails, social media and world news. I applied some self-analysis to this and realised that the content was at times very stressful and before I had even started my day, I was elevating my stress levels. This led me to doing one thing differently and although I still reach for my mobile phone, I now go into my notes and write down three things that I am grateful for in my life. Personally, this helps me to start my day with a positive mindset and due to this I tend to have dominant positive thoughts diurnally rather than negative.

As I write this on the evening of 4th January 2021 although I am pleased to report that I am now thriving on the MSc Health Psychology course and thoroughly enjoying the content matter. England has again been put into lockdown and I feel a sense of déjà vu as I am again assigned the role of home school Mum. Covid-19 has affected so many students and their quest for knowledge and success in subject matter they are passionate about. As for me, I will strive and struggle to pave a career path that will enable me to potentially be able to help others live a happier and healthier life because I can hold my hand up and say, I have walked some of my journey in your shoes.

References

Jayawickreme, E., Infurna, F. J., Alajak, K., Blackie, L. E., Chopik, W. J., Chung, J. M., ... & Zonneveld, R. (2021). Post-traumatic growth as positive personality change: Challenges, opportunities, and recommendations. *Journal of personality*, 89(1), 145-165.

Watson, D. L., Campbell, M., Hopkins, C., Smith, B., Kelly, C., & Deary, V. (2020). Altered Smell and Taste: Anosmia, parosmia and the impact of long Covid-19. doi:10.1101/2020.11.26.20239152

Kelly Murray-Hodcroft
Student of MSc Health Psychology, University of Northumbria, MBPsS
kelly.murray-hodcroft@northumbria.ac.uk