PMS0008

Written evidence submitted by Professor Ann Luce, Bournemouth University

About

1. I am a Professor of Health Communication at Bournemouth University. I have been researching in the area of suicide prevention for 18 years. I am the UK National Representative to the International Association of Suicide Prevention. I am the Research and Media Lead on the Pan-Dorset Multi-Agency Suicide Prevention Strategy Group. I also work across Real Time Surveillance, the Suicide Response Team (cluster response), Communications, Bereavement, Training and Community working groups. I have written several sets of media reporting guidelines on suicide prevention for the World Health Organization. I also sit on the World Media Task Force for the prevention of suicide.

Summary

2. My evidence is based on my research into mental health/illness and suicide among healthcare staff in an NHS Trust in the South of England between 2019 and 2021 (and accompanying Literature Review). My **findings particularly relate to the area of the Committee's Inquiry which aims to understand how well-placed the healthcare service is** to overcome risks and challenges, including the impact of Covid-19, in order to achieve its future ambitions.

3. My research demonstrates that:

    a) Supporting the mental health of the healthcare workforce itself is a critical aspect of any wider objective to improve mental health service provision.

    b) There are failings in mental health support for healthcare professionals, and barriers to seeking it, which, although my research focuses on one NHS Trust, are likely to be widespread. Therefore, it could be argued that **the healthcare service is not as well-placed as it should, or could, be and that action must be taken** to address these issues in order to achieve the ambitions identified.

    c) The actions needed are **organisational-level interventions to address these gaps and barriers.** The creation of a systematic and consistent method of care is necessary, including the use of resources such as training and toolkits. There is also a need to encourage wider cultural change within workplaces, with **workplace culture currently acting as a further barrier**. I have made specific recommendations to address all of the above in this submission.

    d) Implementation of these recommendations will not only benefit the health of employees themselves, but **improving the efficiency of the workforce** will have a trickle-down effect on patient care and, ultimately, on patients.

My research

4. I have recently completed research, commissioned by an NHS Trust in the South of England, to review how it responded to the suicides of 11 current or recent healthcare employees between 2019 and 2021. Each directorate within the Trust was affected.

5. Where no reference is given, I am drawing on my own research, which is due for publication in 2023. The research is currently in peer review.

6. Alongside the forthcoming research publication, I worked with NHS England to create the following practical interventions:

    a. a Support Seeking Framework
    b. a Postvention Communication Strategy Model and
    c. a Healthcare Workforce Postvention Toolkit.

Employee wellbeing: why healthcare staff are so at risk

7. Suicide rates in the UK have risen in recent years, with healthcare workers found to have elevated risk of suicide. While no single indicator alone can predict suicide, high prevalence rates in this population may be symptomatic of several factors, including psychosocial job stressors, such as low social support and high job demands; burnout and emotional exhaustion; job uncertainty; and more recently, traumatic stress and anxiety in light of the Covid-19 pandemic. Other risk factors include depression, mental health issues, and other personal problems (NCISH, 2020).

8. Nurses experience burnout due to many factors, including fluctuating workloads, reduced staffing, complex procedures, and working in intense 'life and death' situations. Staff have reported feelings of exhaustion, mental distance, and negative feelings about the job, with excessive workload being a key predictor of staff stress and intentions to resign (Lacobucci, 2021).

9. Beyond stress, trauma exposure is common among healthcare workers and has been shown to have negative mental health effects, including vicarious trauma, secondary traumatic stress, traumatic countertransference, burnout, and compassion fatigue (Finklestein et al., 2015).

10. Experiencing the suicide of a friend or colleague can further result in associated trauma or reopen past trauma. Inconsistent organisational response to a suspected staff suicide can compound the trauma felt across the workforce (Waters & Palmer, 2021; Luce et al., forthcoming).

11. Workplace trauma can also act as a barrier to seeking mental health support. Trauma is associated with decreased preventative health care and perceived barriers at the institutional and clinical levels for mental health care practices.

12. In addition to the intrinsic job-related stress factors and trauma, Covid-19 has had far-reaching impacts on healthcare professionals. Staff shortages have increased, in turn increasing staff burnout and mental health concerns (Deakin, 2022). Worryingly,

despite the crisis point of the pandemic being passed, only one in four people working in the NHS in 2022 felt their organisation had enough staff for them to do their job properly (Waters, 2022).

13. Given the heightened exposure to trauma, and the staffing impacts of Covid-19, it is not surprising that since the pandemic, healthcare professionals have been shown to be at even greater risk of mental health problems (Søvold et al., 2021). The healthcare workforce was struggling before the pandemic. It is now worse. At a time when we know that the demand for mental health services will continue to significantly outstrip provision, unprecedented pressure is being placed on patients, staff, staff-as-patients, and people trying to access services.

14. The mental health of the workforce itself therefore needs to be at the forefront of Government and agency mental healthcare policy aimed at the wider population. However, as the next section will show, this is not currently the case.

Institutional response: how healthcare staff are forgotten

15. My research found three broad categories of healthcare staff who need mental health care support:

    - **Those who reach out for support when they need it.** Individuals in this group report that support provided is "*adequate*" and "*helpful*".

    - **Those who do not reach out for support, despite recognising that they may need it**. This is a much larger and more significant group identified. Reasons for not seeking support are explained below.

    - **Those who do not recognise that they need support, nor reach out for help.** It was identified that these individuals are likely desensitised to their own vicarious trauma, so much that they do not recognise it.

16. Within the NHS, there is rightly a strong focus on patient care. What is alarming, however, is that **the specific risks to healthcare staff, as outlined in Paragraphs Seven to 13, are often not recognised**. As a result, staff are prone to being dealt with as part of the general population and do not always seek and/or receive the mental healthcare they need.

17. My research found that there is a particular tension within the healthcare workforce between *"being a patient and an employee and being an employee and not a patient".* This leads to barriers for staff in reporting any mental health problems they may be experiencing. Their concerns, predominantly reported by staff who work in clinical directorates, fell broadly into three categories. These concerns related to:

    - others accessing their records
    - a culture of gossip in the workplace and
    - how they might be subsequently treated by colleagues.

18. This is in line with previous research findings which suggest that **staff perceive a variety of barriers to seeking support**, including mental illness-related stigma,

workplace trauma, organisational culture, confidentiality concerns, and access to support (Sweeney et al., 2016; Mannion & Davies, 2018; Søvold et al., 2021).

19. Perceived mental illness-related stigma, especially of **being a healthcare worker with a diagnosis of mental illness, was viewed by many to be a particular barrier to seeking support which may not be experienced by the wider population**. Participants in my research stressed the underlying stigma attached to mental health problems and how this negatively impacts help-seeking behaviours. Given that mental illness-related stigma in healthcare settings is considered a barrier to care (Pellegrini, 2014), addressing the stigmatisation of mental health within healthcare settings is essential (Zaman et al., 2022). By raising awareness of mental health and utilising postvention services, it is hoped that individuals may reach out for help before reaching crisis point.

20. Career concerns were also identified as a barrier to seeking support. Participants raised concerns around responses from co-workers, and the perception that if they sought support then they might be viewed as professionally, as well as personally, inadequate. These findings are in line with previous research relating to workers' perceptions of the duty to work (Damery et al., 2010), and how **stigmatising attitudes from colleagues in relation to mental health can influence job performance** (Tulk et al., 2021), with healthcare professionals actively hiding mental health problems due to fears of being perceived as vulnerable or weak (Smith et al., 2022).

21. Increasing understanding, use of appropriate language, and reducing mental illness-related stigma through training might benefit the normalisation of discussion relating to mental health and suicide (Peters et al., 2015; Schlichthorst et al., 2020). Given that **organisational culture can impact the willingness of staff to self-disclose and access support** (McCann et al., 2015), developing a shared organisational culture can be fundamental to creating a safe healthcare system, encompassing openness, and learning, and allowing staff to safely feel they can voice their concerns (Nightingale, 2018).

22. Also in terms of workplace culture, there is a general perception that staff should always be working above and beyond their limits, an expectation that predates Covid-19. Healthcare staff reported not being able to cope with the *"extreme pressure"* and the *"normalisation"* of daily trauma as part of the job role. Overwhelmingly, **there appears to be a culture of toxic resilience, with targets and KPIs, rather than patient care, at the centre of the workplace environment**. The findings show that, especially for the group who do not recognise they need help, this culture is a particular barrier, in which staff are expected to *"just get on with it"* because **pressure and trauma are considered an everyday part of the role**. This then encourages staff to *"suppress any need for support."*

23. Some progress has been made; for example staff mental health and wellbeing hubs have been set up nationwide to provide healthcare staff access to mental health services and support. However, there is a general belief that these are lacking, with some reporting that clinical supervision is not always available within the hubs.

24. All of the above means that **to meet the ambition of ultimately improving service standards, supporting the mental health of the workforce itself is vital**. If the support provided remains at the current levels demonstrated by my research, this

ambition can be considered vulnerable. In fact, **it could be argued that progress is at risk of being undone, and the gap widened.**

Recommendations

25. ***Recommendation 1: The Government should commission an independent review to fully understand the specific mental health risks to healthcare staff, the particular barriers to support they experience, and to assess current institutional responses.***

26. The specific risks to healthcare staff, as outlined in Paragraphs Seven to 14, are often not well understood, or acknowledged. Nor are the barriers to seeking support recognised or effectively addressed. Getting to grips with the scale of the problems facing the healthcare workforce requires a comprehensive, multi-agency approach. That is not to say that other policy designed to improve mental health services should be de-prioritised, but that these are at risk of being undermined if the mental health of healthcare professionals is neglected.

27. While it may be a difficult and sensitive topic, the parameters of the review should not shy away from including a better understanding of the impact of the suicide of a colleague on healthcare workers, and how services might be developed to support co-workers following such an event. Research suggests that when employed effectively, postvention services can provide positive support to a community following a suicide (Dransart et al., 2017).

28. ***Recommendation 2: Informed by such a review, agencies should then put in place a framework for improvement that is applicable across healthcare settings. This framework should aim to implement a systematic and consistent method of mental health care to the health workforce.***

29. In recognising the importance of addressing and increasing support for healthcare staff within the NHS, both prevention and postvention strategies should be one of the top priorities for organisations. This is particularly necessary considering the strain on healthcare professionals following Covid-19 when there is 'a clear need for the development of structured guidance on how to identify barriers to help-seeking and implement early prevention strategies' (Awan et al., 2022). Yet not all organisations are engaging.

30. Part of the problem may be that literature does not often present adaptable, structured guidance on how to implement changes within a workplace. There are some resources available aimed at reducing death by suicide, including the 'Toolkit for Employers' developed by Public Health England (2016) and the NHS Employee Suicide Postvention Toolkit (The Samaritans, 2022). Yet many Trusts across England do not know that these are available.

31. By not only identifying the perceived barriers to support seeking and provision, but also providing a framework for action, it is hoped that workplaces can recognise and address any existing barriers before a crisis occurs. If a crisis does occur, more formalised pathways are needed here too. This was further supported by managers in the Trust used in the research. One noted that tension arises when *"you want to protect the anonymity of your staff. You also need to be able to provide a responsive service and you don't want care to be compromised".*

32. ***Recommendation 3: The 'Support Seeking Framework', the 'Postvention Communication Strategy Model' and the 'Healthcare Workforce Postvention Toolkit', which have already been developed for one NHS Trust, should be considered as helpful examples of interventions which could be adapted for other healthcare settings.***

33. Developed in the post Covid-19 context, and in collaboration with NHS England, the interventions, tools, and resources from our 'Seeking Support Framework' are practical and implementable. They include:

    a. A staff-only mental health pathway, which incorporates a staff crisis pathway.
    b. A computer systems audit to identify if staff-as-patient confidentiality breaches have occurred.
    c. A review of occupational health roles within the Trust to ensure they are functioning correctly.
    d. Training for team leaders, managers, and HR staff, ensuring this is consistent across all Directorates. This should include training on staff support and referral process, confidentiality, and available pathways of support.
    e. Better appreciation of, and support for, lived experiences of mental illness among health professionals.
    f. A process to become a trauma-informed organisation by reviewing operational processes, providing regular support following a traumatic event, providing regular supervision/debriefing, and providing general trauma awareness training.

34. Such a trauma-informed approach would benefit healthcare organisations, as noted by Dawson et al., (2021). A trauma-informed approach is guided by four assumptions: realisation about the trauma and how it can affect people and groups, recognising the signs of trauma, having a system that can respond to trauma, and resisting re-traumatisation (Haung et al., 2014). Implementing a trauma-informed approach requires a whole-organisation approach and change at every level. The 'Seeking Support Framework' includes practical suggestions for a Trust to do so (see f. above).

35. ***Recommendation 4: Further guidance should be developed and provided to support all healthcare staff, at all levels of seniority, to improve workplace culture in the area of mental health – raising awareness, reducing stigma, and encouraging help-seeking. This guidance, and accompanying awareness-raising materials, should be designed to show understanding of the particular nature of healthcare work and its associated pressures. It should also seek to break down the workplace-specific barriers which prevent healthcare staff a) recognising the need for mental health support and b) seeking that support (notably those barriers raised by the difficulty of being simultaneously both employee and patient).***

36. My research, and the work of Awan et al., (2022), found that there is a clear need for the development of structured guidance to not only provide pathways for help-seeking, as mentioned above, but to ensure a supportive workplace culture. Workplace culture cannot be expected to improve without encouragement and effort made at all levels, including 'from the top'.

Conclusion

37. My research has identified both barriers to accessing mental health support and gaps in services for healthcare workers. It is of fundamental importance that these are addressed. Without action, and the close collaboration of Government and healthcare agencies in doing so, **progress towards improving mental health services for the wider population is at risk.** The good news is that improving our understanding of the breadth and depth of these issues (Recommendation One) and working together to develop a framework for improvement (Recommendations Two, Three and Four) will **give healthcare professionals the mental health support they need and deserve**. Not only this, but it will **improve overall health service efficiency and have a positive impact on patients and their care.**

I am happy to provide further detail on the information submitted and/or to give oral evidence to the Committee.

References

If the Committee needs access to non-hyperlinked/non-open access resources below, please let me know and I will share these with you

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April 2023