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Re thinking systems of support in healthcare: What do our staff groups *really* need?

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Occupational distress in healthcare: Do we have the right models offering the right service design

- Services and initiatives to improve clinician wellbeing is a significant area of growth within healthcare
- The speed and development of these services has not been driven by data or evidence
- Current models and services for staff support are based on a number of assumptions about how we can improve wellbeing:
    - That distress in the workplace reflects workplace origins and not previous adversities or current life stressors
    - That the trauma in the room '***is*** the trauma in the room'
    - That psychological support is the most efficacious approach to address the challenges faced in healthcare
    - Psychological models that dominate services include
        - Depression
        - Anxiety
        - Secondary trauma
        - Burnout
    - BUT: Data reporting high levels of mental health needs in healthcare professionals typically only explores and reports symptoms, not whether they impact on functioning (e.g. not based on diagnostic thresholds
- Common features of staff wellbeing and specialist trauma support services
    - Psychologically driven
    - Based on short term intervention frameworks - typically up to 6-8 sessions
    - Designs not driven by NICE guidelines for the conditions they seek to treat or NICE guidelines for workplace wellbeing stress organisational approaches rather than a focus on individual treatment

Non Occupational Sources of distress

“Is the trauma in the room, the trauma in the room”

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Occupational distress in healthcare

- Elevated rates of adverse childhood experiences (ACEs) are reported by staff in the health and social care sector, compared to the general population, with a recent systematic review (Mercer et al., 2023) indicating that…

Between 44.5% and 86.5% of staff in this sector report exposure to at least one ACE, with the highest rates noted in mental health professionals

Exposure to multiple ACE types is the norm, with as many as 31% being exposed to 4+ different ACEs, and some reporting up to nine ACE types.

Common ACEs reported in this population include:

Parental separation (**23.5%**, Maunder et al., 2010; **31.8%**, La Mott & Martin, 2018; **32.4%**, Senreich et al., 2020).

Parental mental illness (**34.1%**, Esaki & Martin, 2013; **35.9%**, Senreich et al., 2020; **44.5%,** La Mott & Martin, 2018)

Household substance abuse (**27.4%,** Maunder et al., 2010; **30.7%,** Senreich et al., 2020; **30.8%**, La Mott & Martin, 2018)

Emotional abuse (**30.3%,** Senreich et al., 2020; **44.3%**, Maunder et al., 2010)

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The current study: Non occupational sources of distress and theoretical frameworks

About the study

- Online survey comprising several self-report measures assessing various frameworks of distress (diagnostic and non-diagnostic).
- Staff currently working in public sector roles (health and social care, police, fire services), with at least 6 months experience, were eligible to participate.
- Initial recruitment drive primarily focused on healthcare workers (in any sector)

Participants

261 health and social care staff:

Primarily **female** (72.8%)...

...of a **White** ethnicity (66.7%)...

... and in a **frontline** role (75.9%)

AGE

Between **19-68 years old**, with an average age of 41 years

Most (95.4%) **had social support**, in line with the national average

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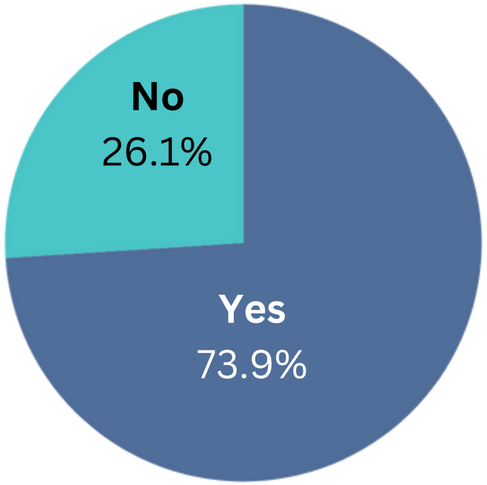
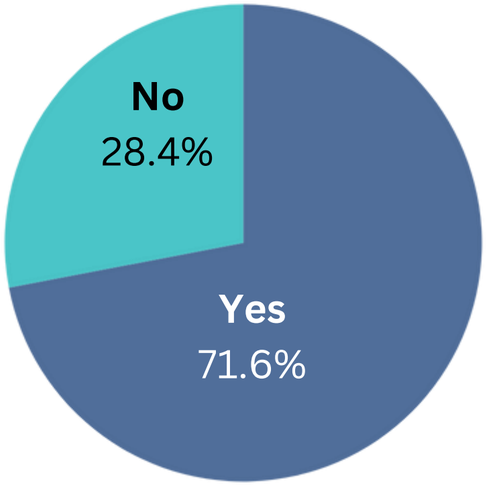
Non-occupational sources of (dis)stress



Reported any problem on the IADQ



Reported any non-work problem on the IADQ

Staff reported an average of **2** problems (both work and non-work) on the IADQ

Staff reported an average of **2** **non-work** problem types on the IADQ

Of those who reported any problem....

3%

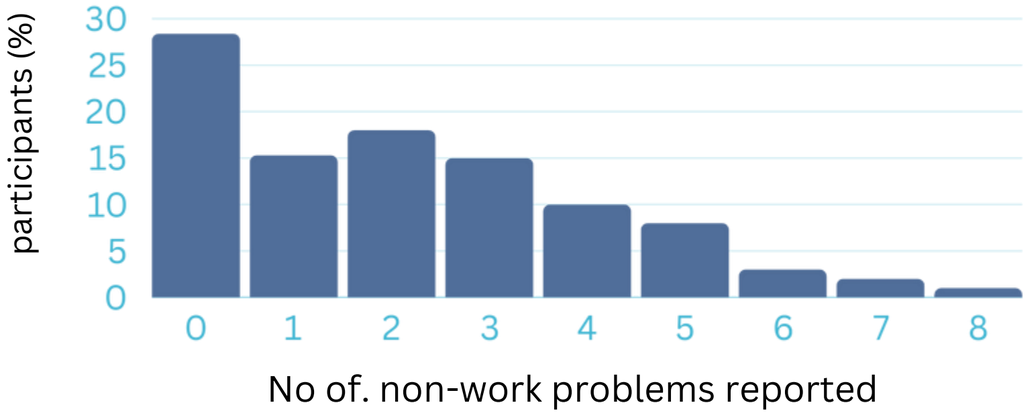
reported work problems only

67%

reported non-work problems only

30%

reported both problem types



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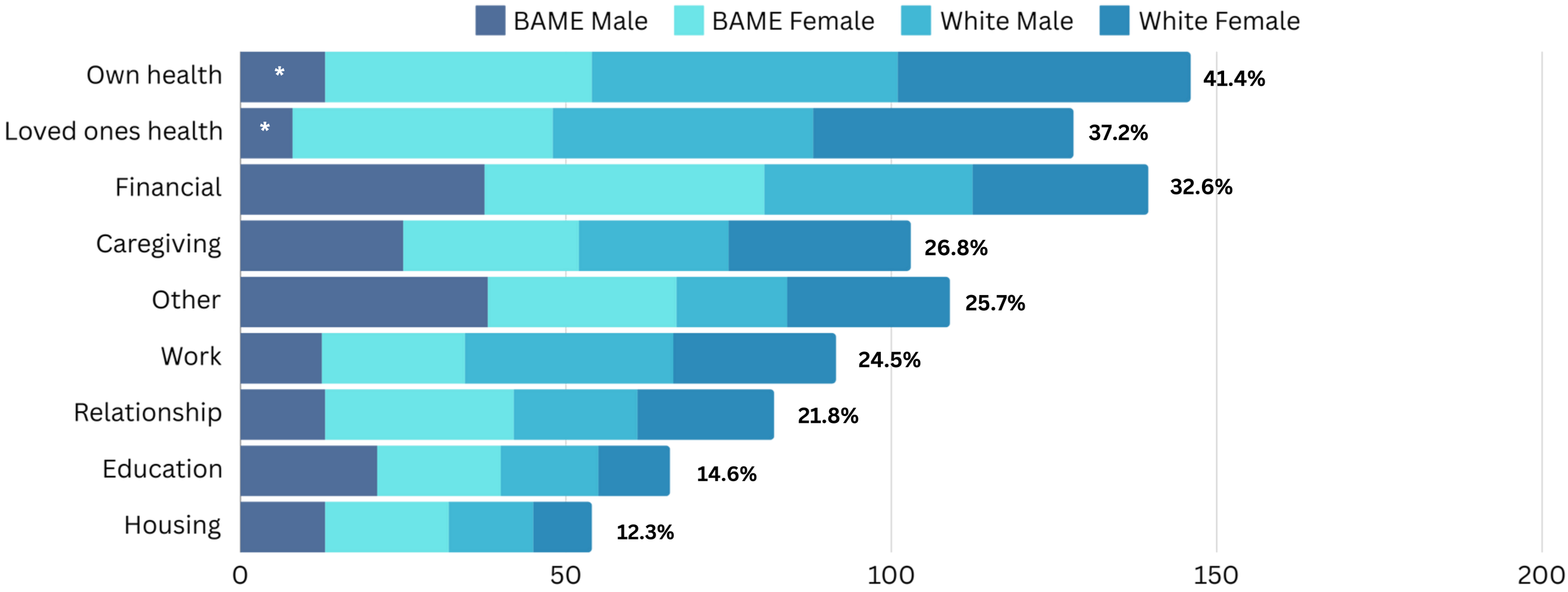
Current Non-occupational sources of (dis)stress



Percentage of participants per gendered ethnic group

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Prior use of mental health services and presence of distress

Almost half (48.3%) reported a history of **accessing mental health treatment**

Approximately half (46.7%) reported a history of **exposure to a trauma that still troubles**. Commonly, these were personal (non-work) events.

59.0%

Non-work related traumatic experience that still troubles

41.0%

Work-related traumatic experience that still troubles

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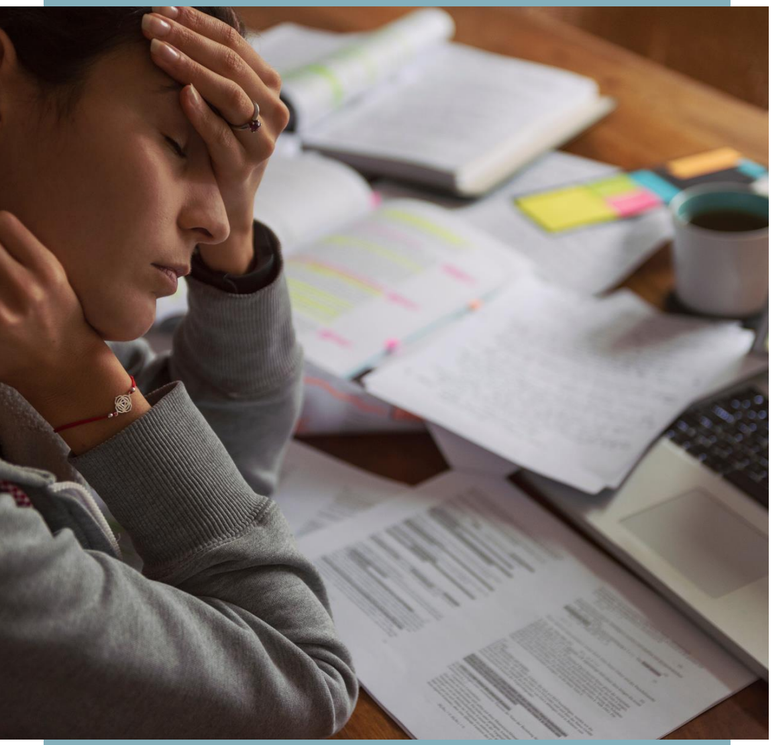
A workforce with multiple sources of challenge: What is the scope of responsibility of healthcare providers to meet the mental health needs of their staff ?



- Key debate: Is it the role of healthcare providers to provide Mental Healthcare to its staff for non work related distress?
  - Do we have responsibilities in this area?
    - Do we risk assuming responsibilities for individual employee welfare, disempowering the individual, and stepping outside of the responsibilities of an employer
  - At the same time…
    - we ask healthcare professionals to work in areas that present with a higher risk of exposure to secondary and direct trauma , as well as risk of physical injury.
    - Access to (statutory) mental health services is challenging
  - Do higher risks of exposure and problems with accessing support outside of the workplace create a different level of responsibility for healthcare providers

- **NB: NICE guidance (Mental wellbeing at work)**

“Ensure that systems are in place to provide support for employees for whom external factors are influencing their mental wellbeing”

- Acknowledges responsibility towards, “organisations, workplaces or workforces where employees are likely to experience traumatic events in the normal course of their work (such as the emergency services).

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Policy and practice implications: Non-occupational sources of (dis)stress

- Healthcare professionals, in particular, mental healthcare professionals, experience levels of ACE exposure that are higher than general population and similar to the levels of service users in mental health services, yet the learnings of this data is not integrated into our staff wellbeing systems
- Healthcare professionals experience higher numbers of non work place problems than workplace problems
- There are intersectional qualities to the non work related problems experienced by our staff groups
- Current service models that do not attend or acknowledge non-occupational sources of support will likely have limited longer term impact on the wellbeing of staff groups
- Many of the non work related problems encountered by our staff groups are better managed by social work frameworks / professionals rather than psychological

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Types and prevalence of mental health needs in healthcare professionals

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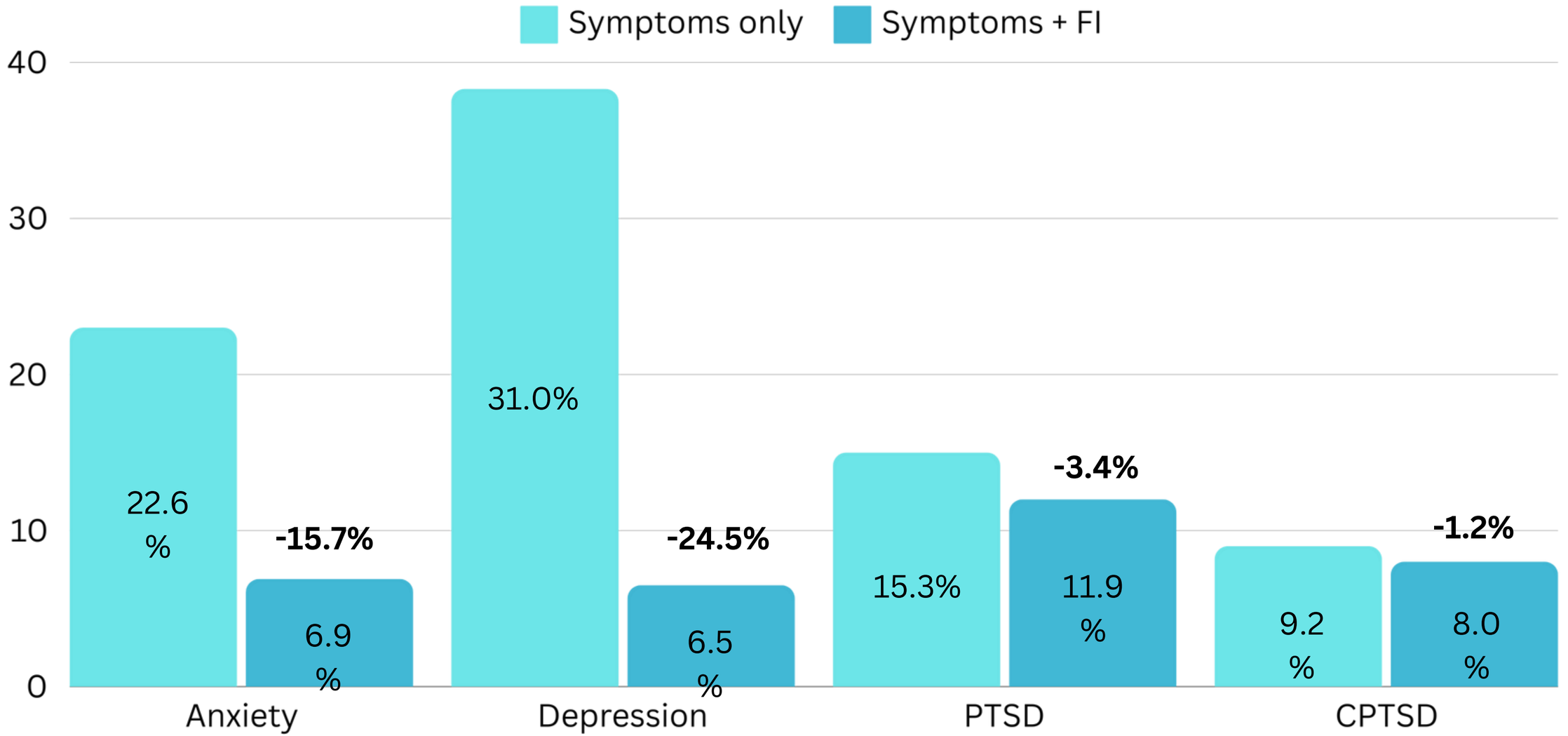
Prevalence of pathologies (diagnostic)



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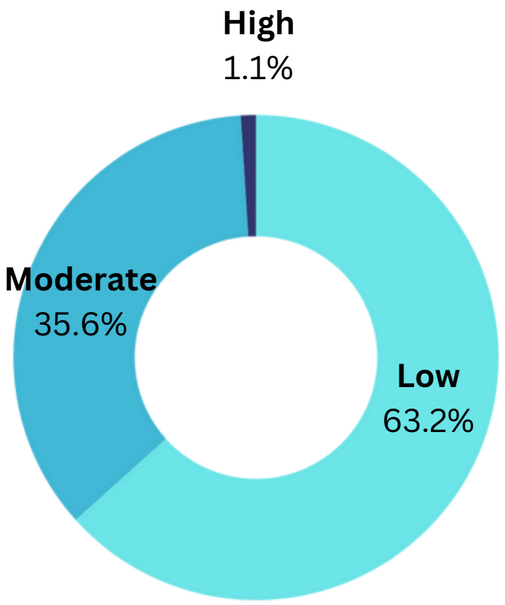
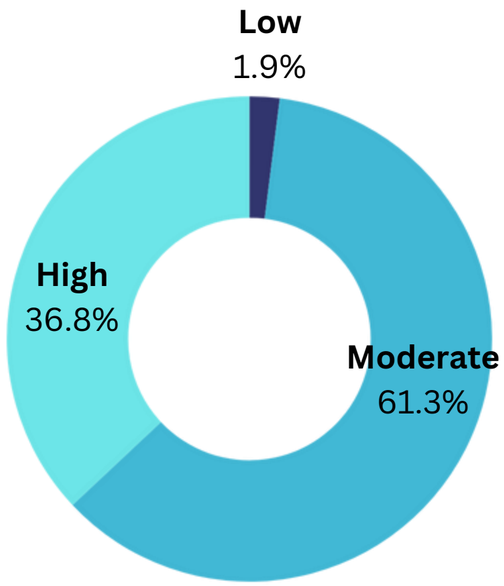
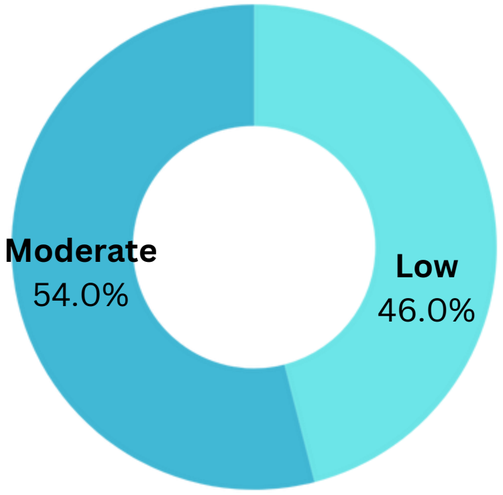
Prevalence of pathologies (non-diagnostic)



Secondary traumatic stress



Compassion satisfaction



Burnout

Almost three quarters (72.8%) of staff reported symptoms (anger, shame, guilt, loss of trust, existential conflict) related to a morally injurious experience in the workplace

Most staff (88.1%) reported experiencing at least one somatic symptom in the past week, with **over half (57.5%)** reporting at least moderate symptoms

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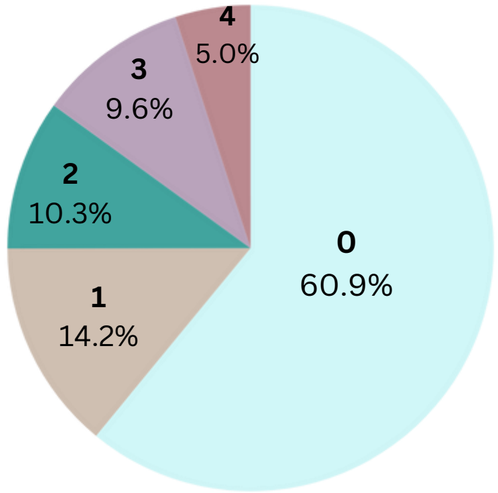
Number of pathologies (diagnostic)

- **Not meeting diagnostic threshold** for any of the pathologies assessed (Anxiety, Depression, Adjustment Disorder, PTSD/CPTSD) **was the norm (60.9%)**

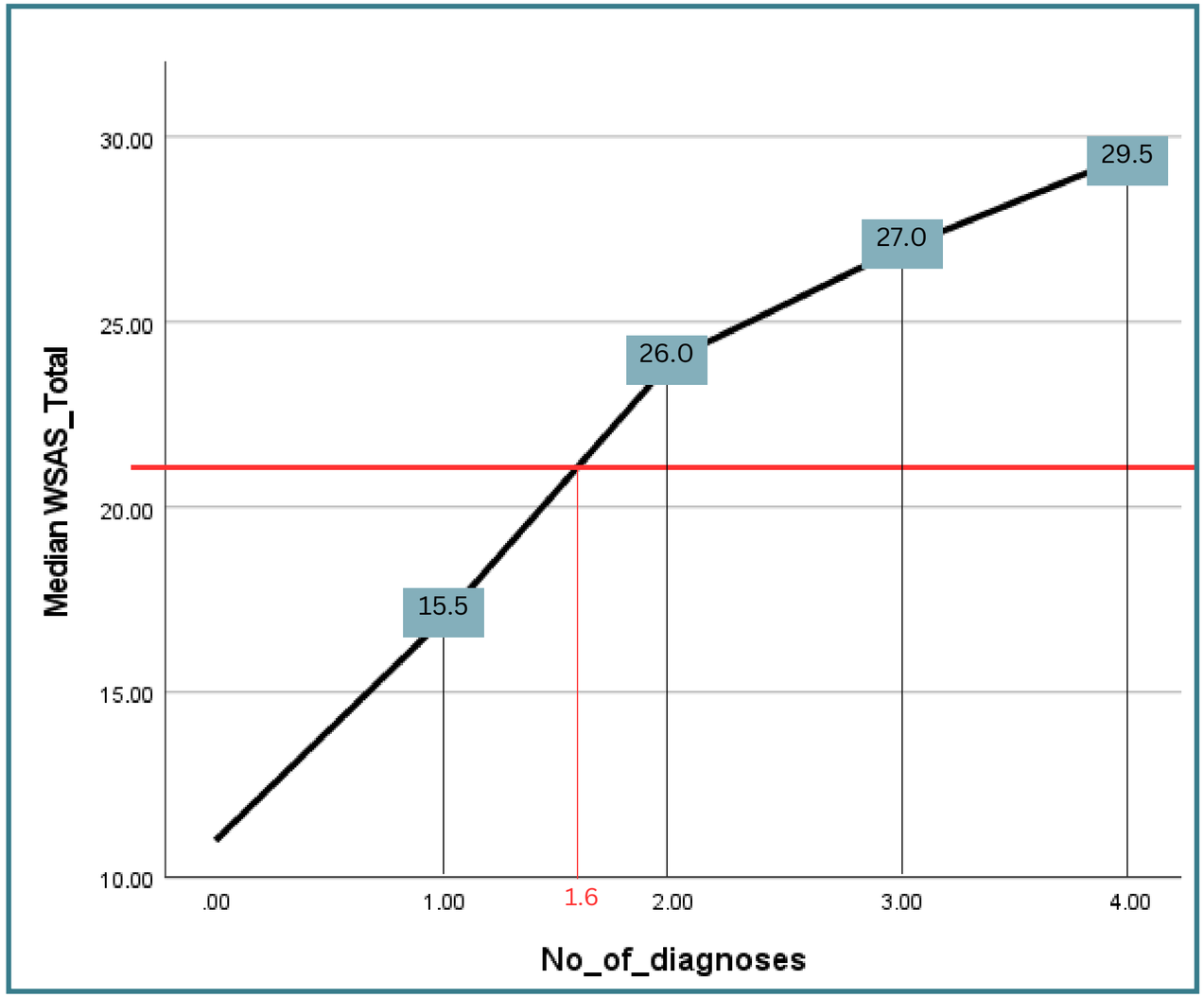


Of those who **did meet** diagnostic threshold for any pathology, **most (65%) met threshold for multiple pathologies**

(Median = 2.0, IQR = 1-4).

- Participants who met threshold for at least one pathology were **twice as likely** (RR=2.00, 95% CI 1.44 - 2.79) to meet threshold for 'moderate to severe functional impairment'.

- Participants who met threshold for multiple pathologies (2+) were **three times as likely** (RR=3.09, 95% CI 1.85 - 5.16) to meet threshold for 'moderate to severe functional impairment'.



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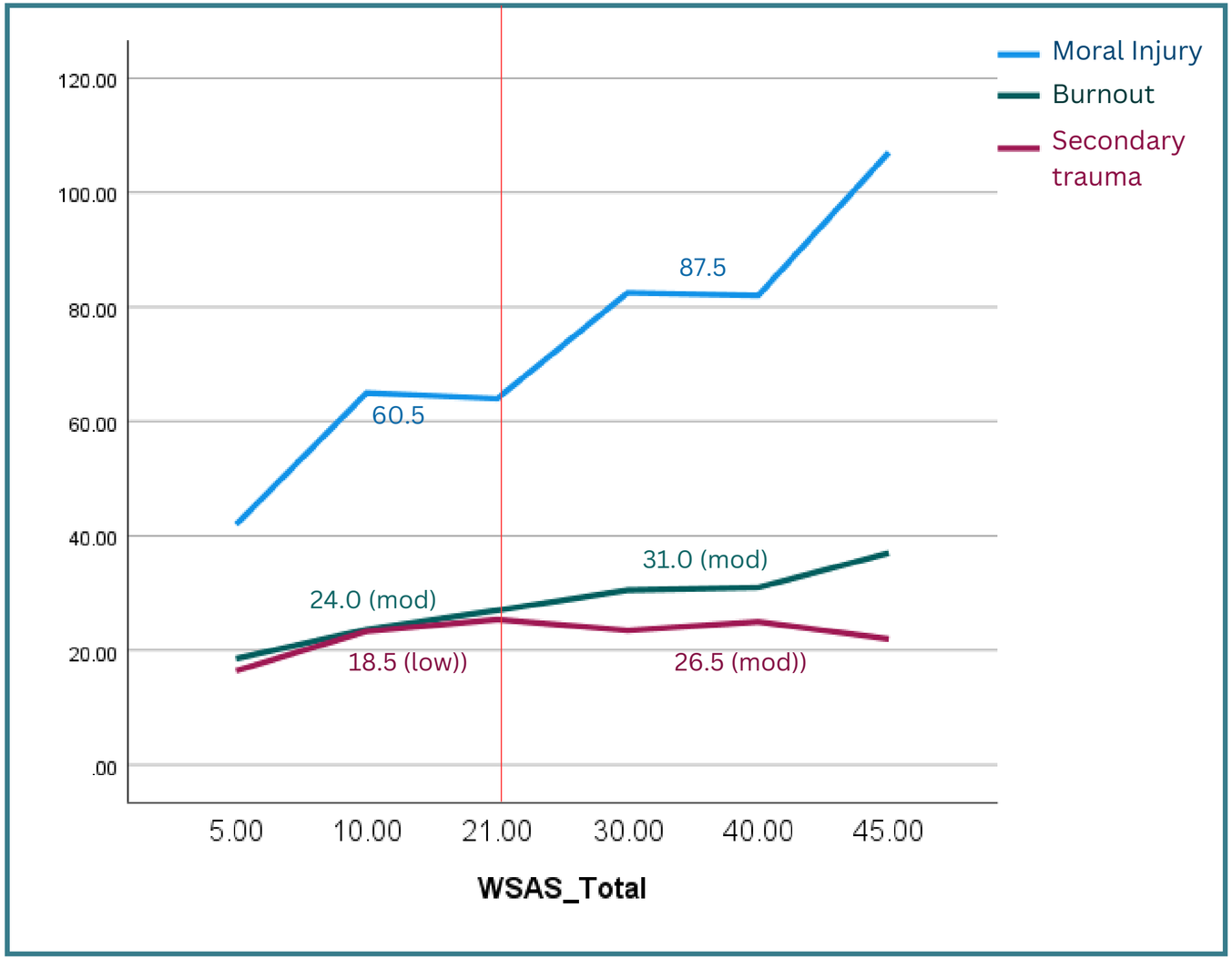
Number of pathologies (non-diagnostic)

- Participants who met the 'moderate to severe' FI threshold on the WSAS (score >20) reported:
  - Significantly higher moral injury (p<.001)
  - Significantly higher burnout (p<.001)
  - Significantly higher secondary traumatic stress (p<.001)
- Severity of FI was significantly, positively correlated with severity of moral injury (rs=.46. p<.001), burnout (rs=.55, p<.001), and secondary traumatic stress (rs=.51, p<.001).
- Risk for moderate to severe FI was 1.5 times higher in those with moderate (vs. low) burnout, and 2 times higher in those with moderate (vs. low) secondary traumatic stress.



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Non-occupational sources of (dis)stress

	Depression	Anxiety	PTSD	DSO (complex PTSD symptoms)	Moral Injury	Burnout	STS	CS	FI	Somatic symptoms
Work										
Own health										
Education										
Financial										
Relationships										
Housing										
Other										
Caregiving										
Loved ones' health										

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Service and Policy implications: Diagnostic / pathology frameworks

Take home message

- Current approaches to measuring occupational distress are likely inflating figures and risk mischaracterising the relationships between distress, impact and functioning. BUT - if staff groups did meet a probable diagnosis, also likely to meet criteria for more than one.

- Healthcare professionals are more likely to not meet criterion for probable diagnostic threshold than to meet thresholds.

- Current data suggests that direct trauma, rather than depression and anxiety are the more dominant diagnoses, yet staff wellbeing services are not set up to offer specialist PTSD or Complex PTSD support to staff.
- Direct (PTSD or CPTSD) were more prevalent than secondary trauma - yet secondary trauma dominates narratives relating to occupational distress

- Going forward, evidence suggests more specialist trauma support needs to be embedded in services

- Non occupational sources of (dis)tress are also related to levels of psychopathology and functional impairment

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Non diagnostic theoretical models that underpin healthcare vocabulary

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‘Everyone is just so burnt out’

- Burnout has dominated language in healthcare for the last 40 years.
  - High levels of emotional exhaustion
  - high levels of depersonalisation
  - Decreased sense of accomplishment

- Burnout is not a diagnosis, but is often talked about in diagnostic terms. It is coded in ICD-11 for ‘reimbursement’ purposes

- Burnout arises as a consequence of chronic inequalities (imbalance) between demands placed on individuals and the resources to meet such demands (Transactional model)

- Many current models and interventions in healthcare are based on the findings of burnout research
  - yoga, cognitive coping strategies,
  - compassion fatigue program, systematic clinical supervision, meditation,
  - stress management programs, autonomy / caseload management
  - Work-life balance

- Yet, 30 year review in US found that interventions derived from burnout make minimal impact’

- Burnout fails to address ‘the meaning we attach’ to events and focuses on transactional imbalance

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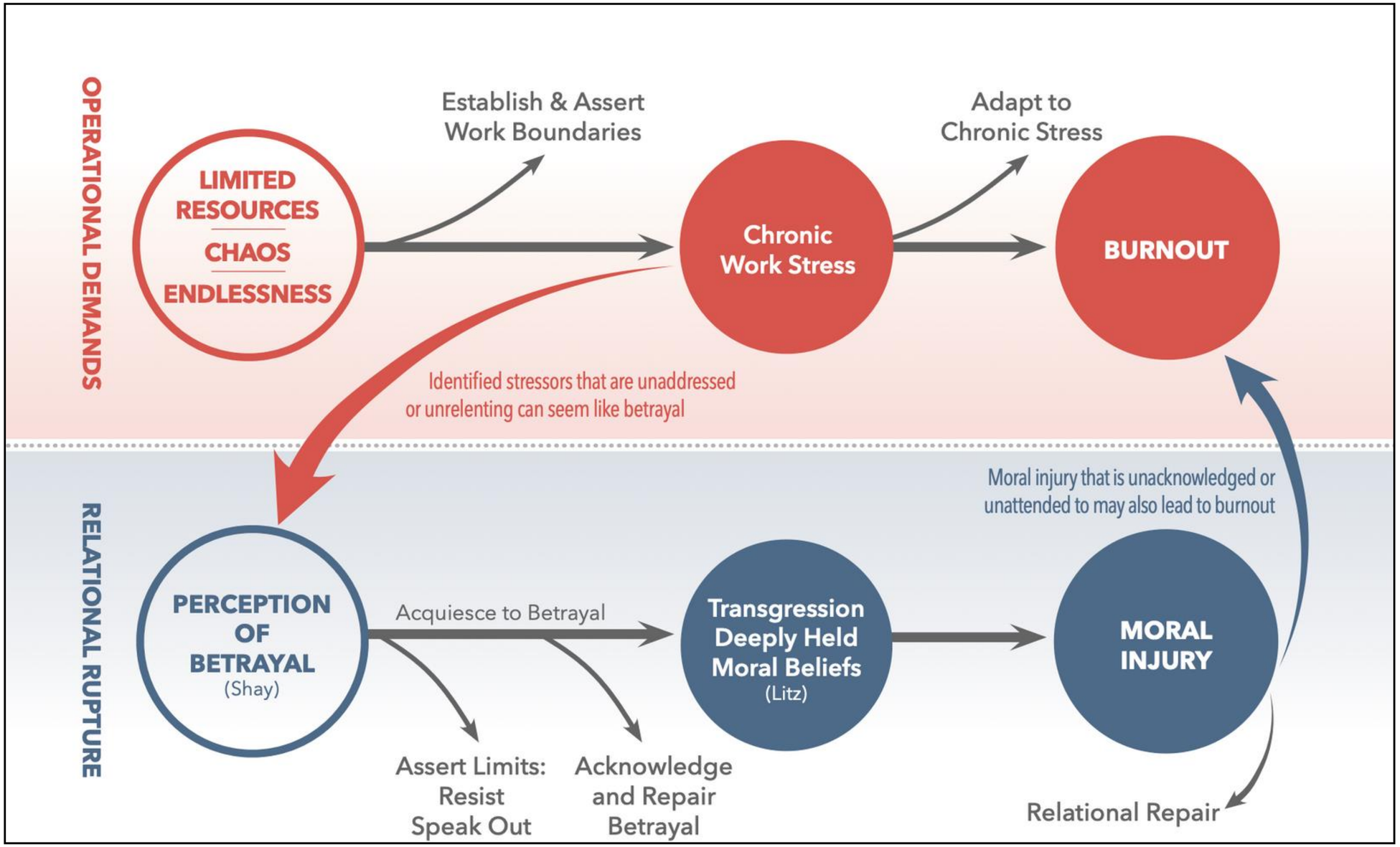
The relationship between moral injury and burnout

- A key debate in healthcare is the relationship between burnout and moral injury, specifically whether moral injury is a more valid framework for describing the experiences of clinician distress
- Debate is critical as the different frameworks have very different intervention pathways and service designs
- The 'burnout' industry is a huge and growing (profitable) healthcare industry, and healthcare is heavily emotionally invested in the language of burnout
- Growing literature from 2019 - are we experiencing moral injury - not burn out (Dean et al., various)
- Debate has focused on establishing dominance of one framework over the other rather than the relationship between them.
- Initial data suggests Moral Injury and burnout represent separate and dual pathways to clinician distress (Morris & Webb, various)



Dean, Morris, Manzur & Talbot (2024) Federal Practitioner

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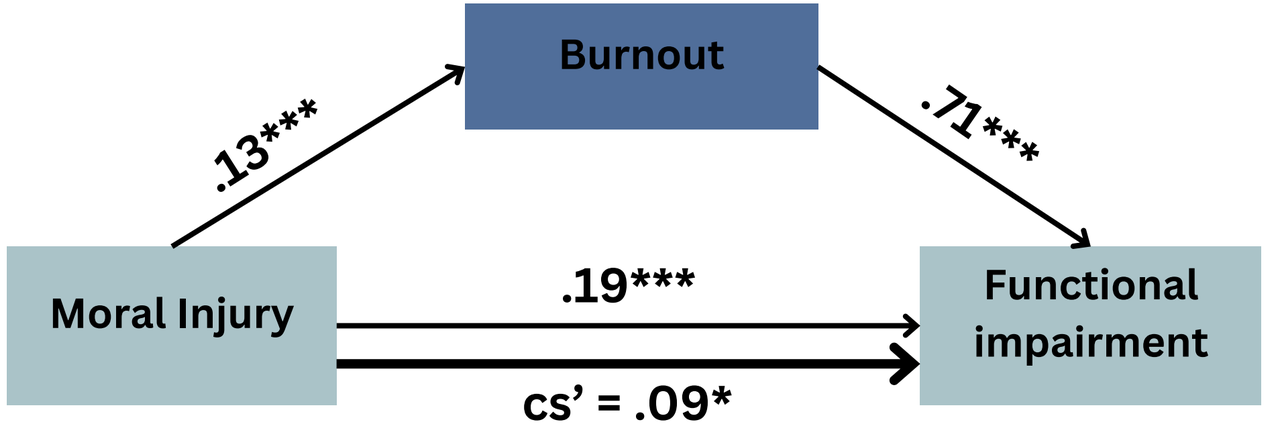
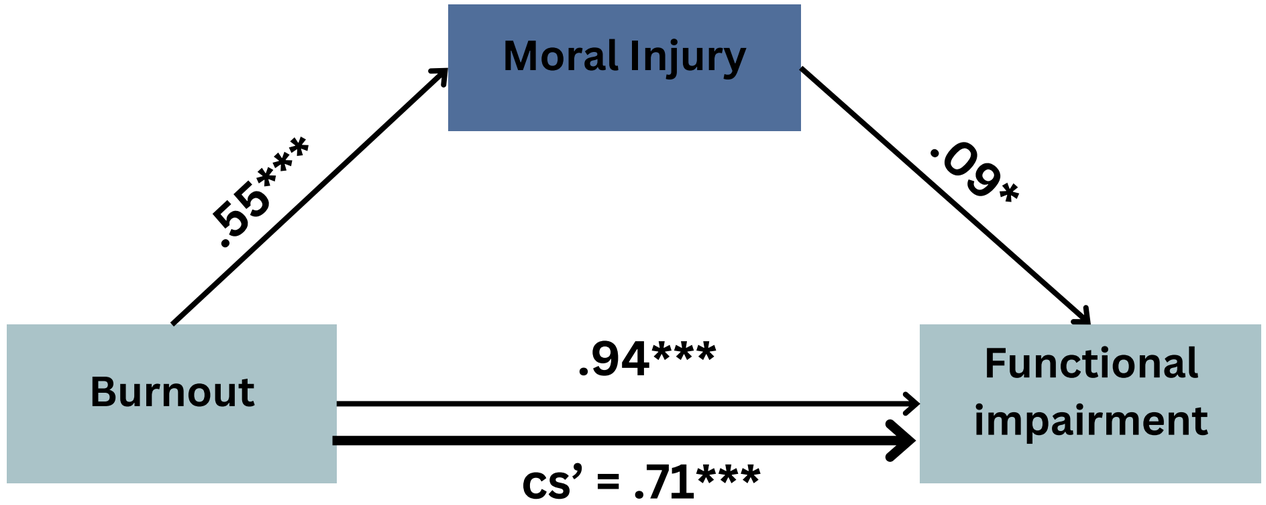
Non occupational sources of (dis)stress



- Moral injury predicts functional impairment
- Burnout predicts functional impairment
- Moral injury predicts burnout, and vice versa



Summary of models

- The effects of burnout and moral injury on functional impairment could be *partially* explained by one another (there was a partial mediating effect).
- However, both moral injury and burnout offered unique contributions to determining a person's ability to function, irrespective of each other.

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Implications for service design

Service design

- Services based on, or dominated by, burnout and its derived interventions, will have a limited impact current levels of occupational distress.

- Attention to relationship ruptures and perception of betrayal (moral injury) is also critical.

- The role of moral injury indicates the need for **organisational focused interventions** rather than the individually focused interventions promoted in the burnout framework

- Moral injury framework allows for preventative approaches rather than management of distress

NB: NICE Guidelines for workplace wellbeing, 1.6.1 “Do not use individual-level approaches to replace organisational strategies for reducing work stressors, or for the main purpose of increasing productivity.”

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Summary

- Occupational distress is likely to reflect multiple factors including potentially historical and current non work related stressors.
- Higher than expected prior use of mental health services and exposure to potentially traumatic events that continue to trouble, most notably from non work sources, were reported
- Non work related stressors were prevalent, with challenges suggesting that purely or dominant psychological frameworks having limitations - social work skill sets also need to be considered within our workforce planning.
- Current approaches to measuring occupational distress are likely inflating figures due to the focus on symptoms (syndromes) rather than diagnoses (consideration of functional Impact)
- Whilst the most common outcome for healthcare professionals is ***not*** meeting criterion for any psychiatric condition, where criterion is met, it is most commonly for more than one diagnosis.
- Direct trauma, in the form of PTSD and CPTSD are currently the most frequently endorsed, yet in healthcare we more commonly think about trauma as a secondary or vicarious trauma.
- Non diagnostic frameworks were also endorsed (burnout, secondary trauma and moral injury)
- Moral Injury and burnout represent both separate and overlapping pathways to account for functional impairment
- indicating that both addressing resource imbalance and relational ruptures need to occupy central positions in our service models to reduce distress and work towards the goal of healthy organisations.

Questions and Contact Details

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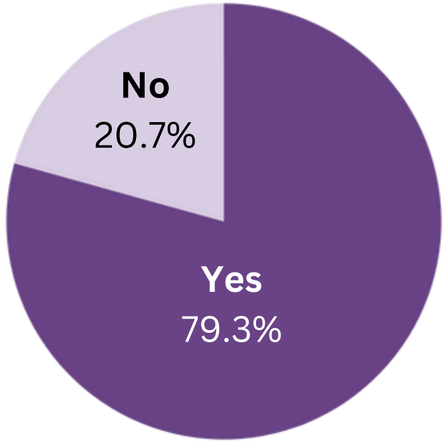
Non-occupational sources of (dis)stress

Sample 1: 323 secure mental healthcare staff

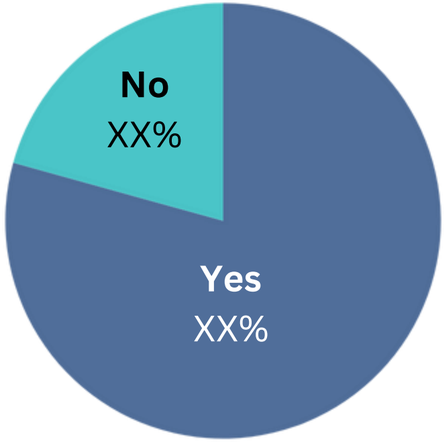


Reported non-work problems

Across the sample, staff reported an average of **2** **non-work** problem types on the IADQ

Almost a third **(31.3%)** of staff reported that experiencing **both** work & non-work problem types

Sample 2: 261 public sector workers



Reported non-work problems

Across the sample, staff reported an average of **X** **non-work** problem types on the IADQ

Almost a third **(XX.X%)** of staff reported that experiencing **both** work & non-work problem types

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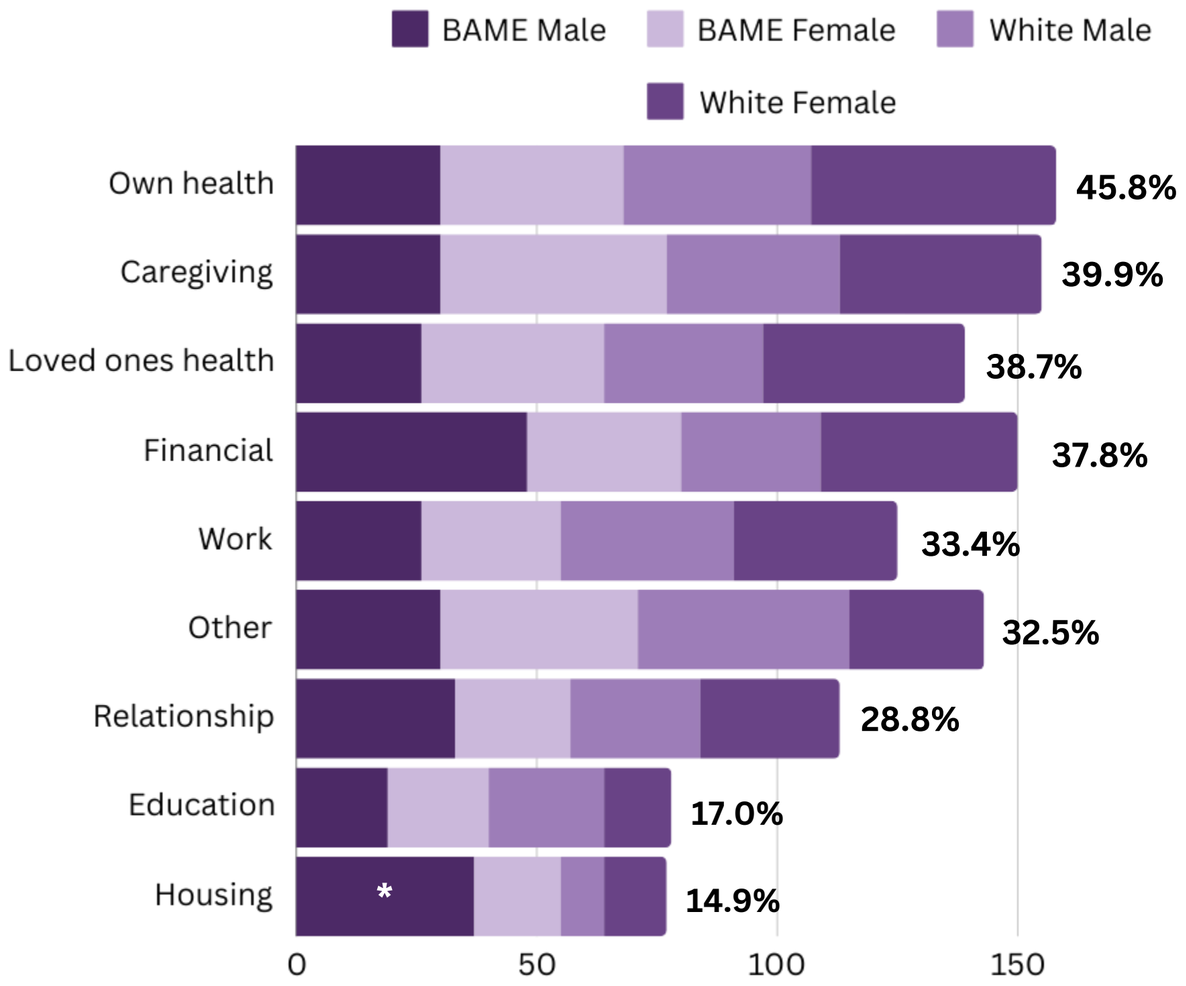
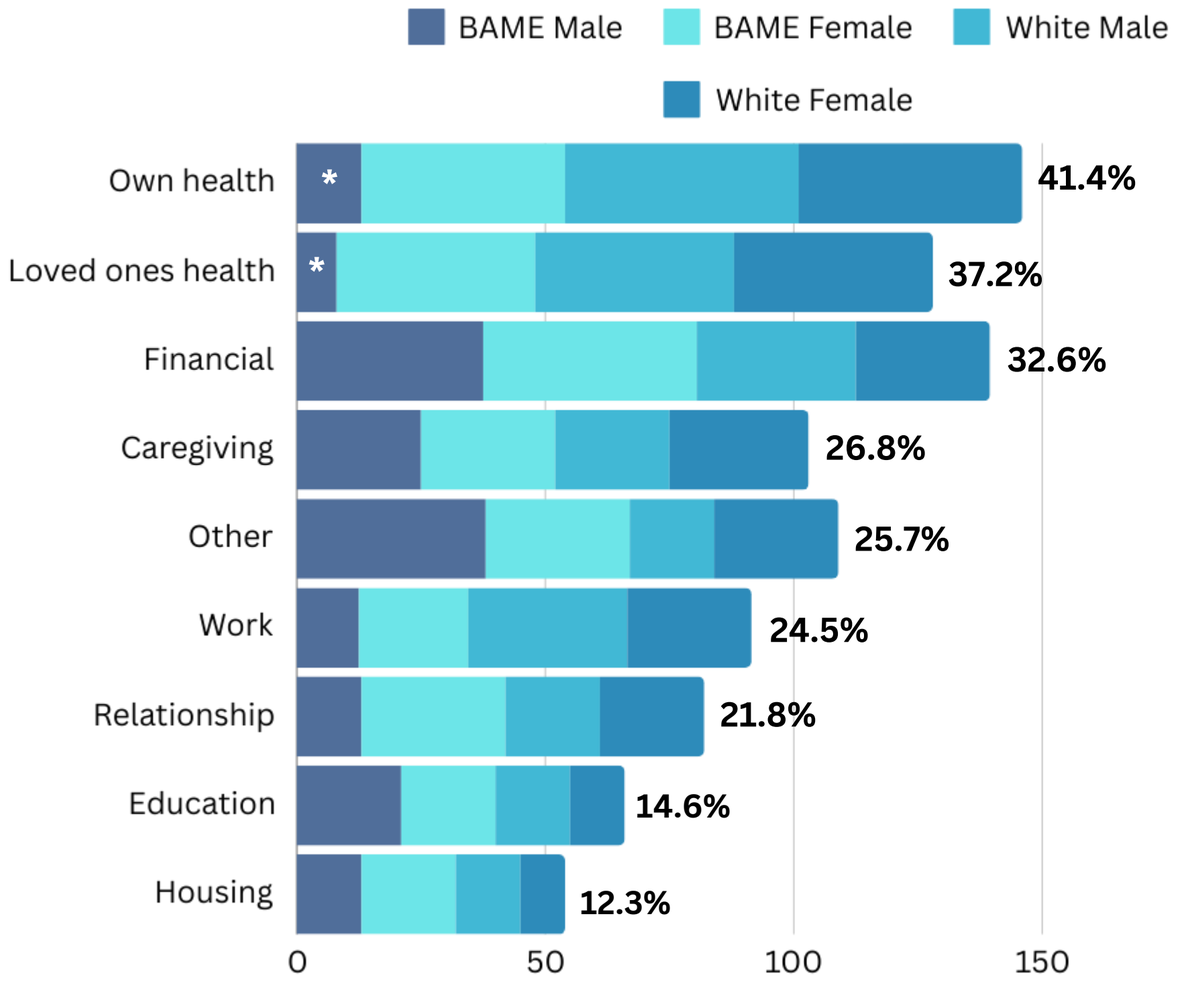
Non-occupational sources of (dis)stress

Sample 1: 323 secure mental healthcare staff



Percentage of participants per gendered ethnic group

Sample 2: 261 public sector workers



Percentage of participants per gendered ethnic group