COVID-19 and the mental health of health-care workers

We read Jo Billings's Comment on our paper about the prevalence of post-traumatic stress disorder and common mental disorders in health-care workers in England during the COVID-19 pandemic with interest.[1] We thank her for her thoughtful engagement.

Billings rightly notes the limitations of our data collection periods, with screening measures completed from April 23, 2020, to Jan 15, 2021, and clinical interview data from March 1 to Aug 27, 2021. The suggestion is that because the interview data were collected after the initial peaks of the pandemic, they might show a lower prevalence of mental disorders than the screening measures, owing to natural remittance of symptoms as staff entered a recovery phase. If excess mortality were used as a proxy for the pressure experienced, this criticism might be appropriate. However, as Billings touches on, evidence suggests that instead of pressure easing after the pandemic peaks, it actually intensified as backlogs of referrals and large numbers of staff resignations occurred.[2] Our own data (in preparation) collected from more than 23 000 health-care workers across 18 NHS Trusts, via online survey as part of the wider NHS CHECK study,[3] shows remarkably little change in the prevalence of symptoms of common mental disorders (measured via the 12-item General Health Questionnaire) when compared with substantial differences in excess mortality for the same periods. For example, from April 1 to June 30, 2020, there were 53 389 COVID-19 deaths and prevalence of common mental disorders was 55% (95% CI 52–58), while from July 1, to Oct 31, 2020, there were 7157 COVID-19 deaths but prevalence remained high at 47% (46–48). Similarly, from Nov 1, 2020, to March 31, 2021, there were 88 211 COVID-19 deaths and prevalence of common mental disorders was 55% (53–56), while from April 1 to Aug 31, 2021 there were 6969 COVID-19 deaths and prevalence again remained high at 51% (48–54).

We agree with Billings about the limitations of having considered only three mental disorders (anxiety, depression, and post-traumatic stress disorder). Evidence from multiple sources (including our own NHS CHECK study) has found constructs such as moral injury to be highly salient for many health-care workers, despite not being a formal mental health diagnosis.[4,5] There is a strong argument for further research of the predictors of moral injury, and into interventions that could prevent, reduce, or mitigate the effects of morally injurious events.

Finally, we concur that our findings pose important questions about how local, regional, and national NHS and government organisations should respond to substantial proportions of staff meeting diagnostic criteria for mental disorders. It also raises questions about how health-care workers can, or should, hold those in decision-making positions to account. Arguably, the recent industrial action by nurses, ambulance staff, and junior doctors suggests that, for many, a line has been crossed. While it is beyond the remit of this research to dictate solutions to these problems, we hope the evidence we have provided, as well as ongoing data collection and intervention testing, contributes to the discussion.

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Management of suicide risk in mental health practice

In their Personal View in *The Lancet Psychiatry* Article, Keith Hawton and colleagues[1] describe a well thought through approach to suicide risk. The authors postulate not only how suicide prediction measures are ineffective, but also how assessment and formulation of suicide risk allows for an explicit and systematic approach. Hawton and colleagues outline essential steps to reduce suicidal ideation. These steps are clearly and effectively addressed by the Collaborative Assessment and Management of Suicidality (CAMS) Framework and its guiding clinical tool, the Suicide Status Form, which is a comprehensive medical record and multipurpose roadmap for guiding the assessment, stabilisation-planning, and suicide-focused treatment of patients, with additional documentation for all interim care through to disposition.[5]

For more on the **CAMS Framework** see https://cams-care.com/

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