the british
psychological society
division of health psychology

Health Psychology Update

Volume 29 Special Issue

ISSN: 2396-8729 (Online)

Health Psychology Update

is produced by the Division of Health Psychology (DHP) of the British Psychological Society and is designed to serve as a forum for discussion of issues related to the scientific analysis of psychological processes of health, illness and health care and the development of professional skills in research, practice, consultancy and teaching/training.

Health Psychology Update aims to:

- disseminate information to the membership on behalf of the DHP relating to the training and continuing professional development of health psychologists at all levels of competence;
- stimulate debate among the membership and provide a forum for the discussion of issues relating to teaching, research, consultancy and the practice of health psychology;
- disseminate information, which may impact on members with respect to changes in national and regional practice and policy.

Submission to *Health Psychology Update*

Health Psychology Update contains regular features, such as forthcoming event reviews, training updates, student issues, interviews, readers' letters and opinions and book reviews. Other features will also appear over each volume, such as themed issues, 'How to…' brief guides, research articles and current debates. Suggestions for themed issues and debates are particularly welcome. Papers should be submitted in accordance with the 'Notes for contributors' on the inside back cover, to the appropriate editor.

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Contents

Editorial

Pippa Tollow

WELCOME to a *Health Psychology Update* (HPU) special issue. As you may have heard, or even attended, the division recently hosted a webinar in lieu of our sadly cancelled BPS Division of Health Psychology Conference 2020 to demonstrate how health psychology has responded to Covid-19; and here, in lieu of our special conference issue of HPU, we hope to provide you with a lasting record of that webinar, as well as an insight into the broad range of work that health psychologists are conducting in relation to Covid-19.

Within these pages you will find: a detailed report of the DHP webinar; an insight into the work of the BPS Covid-19 co-ordinating group; two fantastic short articles exploring the theory behind adherence to non-pharmacological interventions, such as quarantine, and the publics emotional response to such guidance; as well as short summaries from health psychologists all over the country (and abroad) giving a fascinating insight into the work that has emerged in response to the global Covid-19 pandemic. Much of this work is being conducted from makeshift desks and home offices, much like the one that I'm writing at now, and I like to think that this further demonstrates the dynamic and responsive nature of the featured work.

Whilst the past six months have represented huge personal sadness for many of us, I hope that this issue can also demonstrate the power of our profession in the face of adversity.

Thank you for reading.

Pippa Tollow
Editor

Health psychology, behavioural science and Covid-19 disease prevention

Angel Chater, Ellie Whittaker, Lesley Lewis, Madelynne Arden, Lucie Byrne-Davis, Paul Chadwick, John Drury, Tracy Epton, Jo Hart, Atiya Kamal, Emily McBride, Daryl O'Connor, Gillian W. Shorter, Vivien Swanson & Christopher Armitage

In March 2020 the president of the British Psychological Society (BPS) reached out to member networks to join forces on a BPS Covid-19 co-ordinating group. Members of this group were tasked to lead different work-streams highlighting psychology's role during the pandemic. One workstream focused on 'Behavioural Science and Disease Prevention'. It was clear that understanding behaviour and anticipating public responses to changes in policies, public messaging and guidelines would be key to improving health outcomes. This workstream focused on developing clear guidance to prevent the spread of Covid-19 and identifying psychological evidence to promote best practice in the design of sustainable behavioural interventions. This includes both immediate infection control behaviours aimed at reducing virus transmission, such as hand washing, physical-distancing and self-isolation, and behaviours that may have been influenced during the pandemic, such as physical activity, eating behaviour, substance use and healthcare use, which will have far reaching impacts on future health. This article provides an overview of the core guidance and practical examples of its application in a public health setting.

Psychology's role in behavioural science

WE HAVE frequently been asked, 'Aren't behavioural science and health psychology the same thing?'. The short answer is: 'No'.

Behavioural science is an umbrella term that covers disciplines that deal with human actions, including psychology, sociology, anthropology, epidemiology, biology, economics, and political science (Public Health England, 2018). Psychology focuses on understanding human behaviour and is fundamental to behavioural science.

Health psychology training covers many behavioural science disciplines and enables the ability to understand, predict and change behaviour using psychological theory and modelling. Health psychology theories explain how thoughts, feelings and automatic processes, alongside the environment and physiological factors, influence behaviour.

The development of UK health psychology was driven by a co-ordinated response to requests from other fields such as medicine, public health, pharmacy and biomedical science, to help understand behaviour to optimise health, reduce ill health and premature death, and enhance health care systems (Johnston et al., 2011; Quinn et al., 2020).

Health psychology and Covid-19

The strength of health psychology can once again be seen, shining brightly during the Covid-19 pandemic with its ability to under-

stand behaviour. As a discipline we have collectivised. Our collegiate nature, and already strong relationships with those in health and care sectors, has enabled us to offer rapid support to the pandemic response. Covid-19 came from a new virus, with many 'unknowns'. Yet our science has been consistent in offering solutions. Without a vaccine or cure, the focus to save lives must be on behaviour and disease prevention.

The virus itself does not move from place to place; the host moves. Therefore, the prevention of Covid-19 centres round behaviours which are both conscious:

- washing hands with soap and water;
- physical-distancing;
- carrying, using and disposing of tissues;
- self-isolation.

And unconscious, such as:

- touching the face.

We need to continue to bring to the attention of policy makers, public health teams and communicators to the things that they 'don't know they don't know' to help understand and adapt human behaviour. The science of health psychology can help to create a 'behavioural vaccine', with a set of behavioural rules and actions, such like the 'Green Cross Code' (e.g. think, stop, look and listen; wait, look and listen again, arrive alive). Creating such behavioural rules and actions can prevent transmission and support a zero Covid-19 strategy.

The British Psychological Society's (BPS) Covid-19 Behavioural Science and Disease Prevention Psychological Guidance (Chater et al., 2020) highlighted nine points for consideration to optimise policies and communications:

1. Minimise the 'I' and emphasise the 'we'.
2. Deliver messages from a credible source in relatable terms to the target audience.
3. Create worry but not fear.
4. Identify what influences each preventive behaviour and ensure policies, messaging and interventions target all relevant drivers.
5. Clearly specify behaviours and their effectiveness.
6. Avoid unintended negative consequences.
7. Create clear channels of access for health literacy.
8. Use behavioural scientists and the psychological evidence base to support the Covid-19 response.
9. Make a pledge to work together, through a multidisciplinary approach.

Embedding behavioural science and health psychology into public health

Public Health England's *Improving People's Health: Applying behavioural and social sciences to improve population health and wellbeing in England* strategy (Public Health England, 2018) acknowledged the importance of a multidisciplinary approach. The Behavioural Science and Public Health Network (BSPHN) hosts this strategy (www.bsphn.org.uk/352/Foreword), and a community of practice, with access to online resources and regional 'hubs' (www.bsphn.org.uk/398/Regional-Hubs) to support the translation of behavioural science into local public health teams. Supported by Health Education England regionally, these hubs have been using health psychology to build capacity to optimise policies, campaigns, programmes and their outcomes.

Deviating from behavioural science principles can lead to chaos and confusion. A good example is the change in messaging from 'Stay home' (a behaviour), 'Protect the NHS', a reason for that behaviour, and 'Save lives' an outcome from that behaviour; to 'Stay alert', not a behaviour, 'Control the virus', this reason lacks clarity as the virus lacks sentience, and 'Save lives', it is not clear that staying alert will lead to saving lives.

Enabling access to behavioural science and health psychology

To support the knowledge transfer and mobilisation of health psychology during the acute phase of the Covid-19 response, members of the BPS Division of Health

Psychology (DHP) and the Behavioural Science and Public Health Network formed a collaborative, named the Health Psychology Exchange (HPX). A link to volunteer psychologists within this collaborative was provided as part of the BPS Behavioural Science and Disease Prevention Psychological Guidance (point 8). This enabled those who could benefit from behavioural science expertise (such as local authorities and central government), access to health psychologists who could provide it.

Some of the early requests were from health psychologists working in local authority, closely linked to Directors of Public Health, who were being asked how to implement Covid-19 disease prevention messaging in their regional areas. To support them and others, members of the BPS Behavioural Science and Disease Prevention taskforce, HPX and DHP (led by Whittaker, Lewis and Chater) held regular public health forums to assist the translation of the BPS guidance into public health practice. Below we unpack the psychology behind the guidance and examples of how those in public health have been using it.

Overall use of the guidance

Public health teams have been using the guidance as a regular reference point and ensuring that all team members are aware of it.

> *The guidance is included in both the public health and corporate Covid-19 communications plan, meaning that all members of staff who have responsibility for communications across our council have had access to the guidance, and we have discussed how we can use it to make our communications more likely to change behaviour. Our communications staff have found the guidance invaluable and welcomed the way that it was accessible, easy to follow, and 'not too academic'.* (North Yorkshire County Council)

1. Minimise the 'I' and emphasise the 'we'

Social psychology research (Reicher & Drury, 2020) highlights the need to collectivise rather than personalise. Evidence on past emergencies (Drurt et al., 2019) shows that when people think in terms of 'we' rather than 'I', reflecting a sense of shared social identity, they are motivated to give support to others. This is important during a pandemic such as Covid-19, when individual self-sacrifice (such as self-isolation) benefits others. Emphasising a collective approach can facilitate adherence to shared and accepted norms of behaviour, and evoke collective self-regulation around such social norms (e.g. hand hygiene, physical distancing). Messaging should highlight how we can look after each other rather than how you can look after yourself.

> *We focus on a community approach throughout our 'Stay Safe, Be Kind' campaign which reinforces the idea that individuals should look after each other by minimising the 'I' and focusing on the 'we'.* (City of Wolverhampton Council)

2. Deliver messages from a credible source in relatable terms to the target audience

Credibility of the source of a message can influence whether the message is received, and its intended consequence (e.g. changes in behaviour) achieved (Ghio et al., 2020). Much of this is harnessed on trust, and the messenger needs to be deemed credible. Trust declined in both the UK government (April 67 per cent; May 48 per cent) and news organisations (April 57 per cent; May 46 per cent) during the Covid-19 lockdown (Fletcher et al., 2020a). Evidence suggests that those who do not trust the government are less likely to act on advice – such as from the test and trace service to self-isolate (92 per cent who trust versus 83 per cent who do not trust the government would self-isolate if called; Fletcher, Kalogeropoulos & Nielsen, 2020b). Local authorities using our guidance have used senior leaders in the local area, and the

local community, including school-children as credible sources to share the message in relatable terms to their target audiences.

> *A number of senior leaders (Chief Executive, Director of Health and Adult Services, Assistant Directors, Public Health Consultants) in our council have provided videos to reinforce key messages or update our residents on progress or our current work. All of these direct people to a single point of contact if they require further information. We also let primary school children explain social distancing and how it might work in schools with a 'two metre check' video.* (North Yorkshire County Council)

Other local authorities, along with clinical commissioning groups (CCGs), have used celebrities such as athlete Paula Radcliffe to send a message in areas where localised infection rates are higher than the national average (e.g. Bedfordshire). This helps to take the national message and instil it at a local level. Luton Borough Council and Luton CCG have used a local Bedfordshire General Practitioner to speak directly to the black, Asian and minority ethnic (BAME) communities through social media.

3. Create worry but not fear

Lessons have been learnt (Bish & Michie, 2010; Rubin et al., 2010) from the public response to previous pandemics such as swine flu (H1N1) and SARS (severe acute respiratory syndrome). Past research has shown that during these types of pandemics, uptake of protective 'mitigating' behaviours such as hand washing; carrying, using and disposing of tissues; buying hand sanitiser; and avoiding using public transport, were low and linked to a relative lack of public worry (Rubin, et al., 2010). Generating higher levels of public worry may therefore be needed to promote behaviour. However, a delicate balance is needed, as too much worry can lead to anxiety and fear, causing a 'fight or flight' response. Fear can lead to denial and avoidance behaviours unless supportive communication is given (Chater, 2018).

Threat appraisals (linked to perceived vulnerability to a threat and its severity) and coping appraisals (linked to beliefs of whether behaviour change will lead to a better outcome (response efficacy) and confidence in the ability to engage in said behaviour (self-efficacy) are common features in psychological models such as Protection Motivation Theory (Rogers, 1975) and the Health Action Process Approach (Schwartzer et al., 2003). While worry caused by a threat to health is important to consider the need to change behaviour, to facilitate behaviour change, people need to believe that what they do will be beneficial and is within their control to do so.

> *Our messages do not create fear as our communications umbrella phrase of 'Stay Safe, Be Kind' acts as a way of balancing the messages.* (City of Wolverhampton Council)

4. Identify what influences each preventive behaviour and ensure policies, messaging and interventions target all relevant drivers (COM-B)

The COM-B model at the hub of the Behaviour Change Wheel (Michie et al., 2011; Michie et al., 2014) suggests that for behaviour to occur the target population must have three things:

- capability to enact the behaviour that relies on both psychological (e.g. knowledge and skill) and physical (e.g. ability and strength) capability factors;
- opportunity to enable the behaviour that considers both social (e.g. norms, support) and physical (e.g. resources, environment) opportunity facilitators; and
- motivation to perform the behaviour that involves both reflective (e.g. attitudes, confidence, intentions) and automatic (e.g. emotion, habit, identity) motivational processes.

Accordingly, the capability, opportunity and motivation of public health teams to

use the COM-B model (Michie et al., 2011; Michie et al., 2014) may differ. Reaching out to academic partners and local psychologists has helped.

> *There are good links between the local authority, health care providers and health psychologists/ academics at the university in Bedfordshire enabling public health strategies and services to be co-developed, delivered and evaluated using behavioural science.* (Luton Borough Council/Total Wellbeing Luton/University of Bedfordshire collaboration)

5. Clearly specify behaviours and their effectiveness

The Behaviour Change Wheel (Michie et al., 2011; Michie et al., 2014) stipulates in its first of three stages the importance of:

- defining the problem in behavioural terms;
- specifying the behaviour; and
- identifying what needs to change (COM-B diagnosis).

When considering the problem – for example, premature death from Covid-19 – there is a need to specify the behaviours that can go towards mitigating risk (e.g. handwashing; physical distancing; self-isolation, avoiding touching face, and using and disposing of tissues appropriately).

Simply telling people what to do will not be enough for effective behaviour change. They need to know why certain behaviours are important, how they lead to optimal outcomes and guidance on how, when and where to perform them. They may also require environmental support. To maintain trust and clarity, and to avoid confusion, when official messages need to change over time, it is important to provide a clear rationale for this change, and a new set of actions that relate to and are achievable by the target population. These should also be clearly linked to effective outcomes (Ghio et al., 2020; Bish & Michie, 2010).

> *We are ensuring that our initial communications, which are very much focused on preparing the public for the launch of contact tracing, provide clear behavioural actions and their related outcomes. One example of this is asking people to answer phone calls they receive from an unknown number (whilst also providing assurances that the person they are speaking to is not a scammer), because by speaking to the contact tracing team in a timely way will keep strengthening the process and help to reduce onward transmission of the virus. We hope by doing this we will elicit a positive response and mitigate confusion amongst the population.* (Aneurin Bevan Local Public Health Team)

6. Avoid un-intended negative consequences

Reviewing past responses to a number of viral respiratory infections (Bish & Michie, 2010) research showed a need to consider demographic differences when communicating the level of perceived threat during any future pandemic, with a focus on enhancing the belief in the efficacy of protective measures suggested by health officials.

Policies, information and messaging may have un-intended consequences, such as increased anxiety, widening social deprivation, inequality and exclusion. It is important to acknowledge that while we are all in the same storm, we are not in the same boat. In fact, some may not have a boat.

> *Public Health Wales' 'How are you doing?' campaign targets groups who are digitally excluded or have not received Covid-related information from usual channels by developing a range of resources in Welsh and English that are easy-read and easy share. The campaign is focused on maintaining good health behaviours during lockdown and overcoming social isolation.* (Public Health Wales)

7. Create clear channels of access for health literacy

Information from multiple channels can be overwhelming, and even more so when

feeling anxious, experiencing social isolation or unable to access usual places for health messages. There are many who are digitally excluded from online sources of information due to digital poverty. Others, such as those with visual or hearing disabilities, cognitive difficulties or language barriers, may be excluded due to a lack of consideration given in the channels used to provide information. Clear channels of access to health information must be a priority for the whole population. Co-creation with members from different groups can facilitate this.

> *Our messages are clear and brief to support health literacy and we offer communication in British Sign Language, easy read versions and our website can easily be translated in other languages and has a read aloud function. We have also developed a local monthly newsletter to be circulated within our food parcels. We are now in our second edition of the newsletter and have been working with our regional newspaper through a collective approach.* (City of Wolverhampton Council)

8. Use behavioural scientists and the psychological evidence base to support the Covid-19 response

We've identified throughout the importance of accessing and using behavioural science and psychological evidence. There has been good representation of behavioural science in informing government, local authorities, organisations, and in the media. However, deterring from the science could lead to a lack of clarity and transparency, which may have a negative impact on population level trust. While scientists are not (usually) politicians, it is recognised that science is only one slice of the pie when decisions are made and messages are communicated. However, our science is needed to optimise outcomes.

> *I was asked to contribute behavioural science expertise to inform the local communication strategy for Covid-19. I worked alongside members of the public health and communications teams to develop messages for social media.* (Sheffield Hallam University/ Doncaster Council collaboration)

9. Make a pledge to work together, through a multidisciplinary approach to #COMBATCOVID19TOGETHER

The engagement with the guidance and public health forums facilitated by the BPS Behavioural Science and Disease Prevention taskforce, HPX and BPS DHP has been excellent. We hope the practical examples provided can support organisations to draw from behavioural science to work together towards a zero Covid-19 strategy.

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Acknowledgements

All authors are members of the BPS Covid-19 Behavioural Science and Disease Prevention Taskforce (www.bps.org.uk/coronavirus-resources/coordinating-group/behavioural-science). We would like to thank Shanara Abdin, Shareen Ali, Cheryl Williams and Alex Wood for providing some of the examples of how the guidance has been used in public health settings.

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Non-pharmacological interventions for Covid-19: How to improve adherence

Maria Gialama, Periklis Papaloukas & Sinead McGilloway

Non pharmacological interventions (NPIs) have been widely recommended in the battle against Covid-19. Numerous NPIs, including personal protection, social distancing, and environment and travel measures, have been implemented globally to reduce Covid-19 incidence and mortality. Adherence to these measures is crucial in determining their effectiveness. This article discusses some important barriers and facilitators to adherence, based on existing knowledge and mainly recent literature in the area. We propose three ways in which adherence may be improved, including: (i) targeting individual-level barriers; (ii) addressing structural and societal factors; and (iii) facilitating healthy social norms/social emotions. Collectively, these highlight the important role of individual behavior (and adherence) in containing, and mitigating the impact of, Covid-19 now and into the future.

THE CORONAVIRUS pandemic is rapidly spreading across the world, posing a new and unprecedented challenge to public health and the global economy. In May 2020, the European Centre for Disease Prevention and Control (ECDC) reported that 210 countries had already been affected, with over 3 million confirmed cases (ECDC 2020; WHO 2020).

Due to the limited availability of antiviral drugs and as yet no vaccine, the World Health Organization (WHO) (2019) has recommended a wide range of non-pharmacological interventions (NPIs) or public health measures relating to:

(i) (i) personal protection (e.g. hand hygiene, respiratory etiquette, face masks);
(ii) (ii) social distancing (e.g. contact tracing, isolation of sick individuals, school/workplace closure, quarantine of exposed individuals); and
(iii) (iii) environment and travel measures (e.g. entry/exit screening, travel restrictions and border closures) (WHO, 2019).

The need to implement such measures has, in effect, created a global 'social experiment' in which health psychologists have a unique opportunity to assess the nature and extent to which populations are complying with the health-related behaviours required for NPIs to be effective and to identify potentially influential factors.

During the 1918 influenza pandemic, it was reported that cities in which multiple NPIs were implemented early, showed lower cumulative excess mortality, had less-steep epidemic curves and peak death rates which were 50 per cent lower than those that did not implement such measures (Hatchett et al., 2007). The researchers concluded that the early implementation of multiple NPIs in a population in which immunity had not yet developed, would slow progression of the epidemic.

Quarantine – undoubtedly the most restrictive of measures – may be defined as the 'separation or restriction of the movement of persons who may be infected' (WHO, 2019). This is one of the oldest methods to control infectious disease outbreaks, dating

back to the 14th century when Europe endeavoured to prevent the spread of plague epidemics (Sundwall, 2019). Quarantine has been found to be very effective in limiting the spread of infection (Rothstein & Talbott, 2007) and especially when implemented early (Nussbaumer-Streit et al., 2020).

Quarantine responses to the current pandemic have varied considerably. For example, Italy and Greece, despite having a similar demographic, emerged from 'lockdown' with dramatically contrasting numbers of infections and deaths. In Greece, mobilisation was immediate, with lockdown and social distancing measures imposed earlier than the rest of Europe, and with heavy penalties for lack of adherence, all of which resulted in rapid disease suppression (Magra, 2020). This speaks to the importance of both the timely implementation of NPIs and of high levels of adherence, especially with quarantine measures. A recent Cochrane review indicated that quarantine, in the context of Covid-19, is important in reducing incidence and mortality (Nussbaumer-Streit et al., 2020). Thus, it is crucial that NPIs are accepted by communities and that the public co-operate insofar as possible to contain the spread of the disease (Aelio et al., 2010). However, this is a much less straightforward goal than it might first appear.

Adherence: Facilitators and barriers

According to a recent review by Webster et al. (2020), the most commonly identified factors affecting adherence to quarantine and other protective health behaviours are: levels of knowledge (in the general population) about the disease outbreak and quarantine protocol; social norms; perceived benefits of quarantine; risk of disease; and the practicalities of being quarantined. Research conducted with people quarantined during the SARS outbreak (2003), indicated very high levels of adherence amongst participants, all of whom complied with quarantine protocols (Cava et al., 2005). This appeared to be due to ethical, legal and/or social factors, with the first of these reportedly the most common; participants often stated that they adhered with quarantine to be 'good citizens'. Those who perceived themselves to be at greater risk, demonstrated greater vigilance in maintaining the quarantine protocols than those with lower levels of perceived risk (Cava et al.,2005).

Similarly, DiGiovanni et al. (2004) reported that, during the 2003 SARS outbreak, the general population was generally found to comply with the quarantine and were motivated primarily by a desire to protect 'the health of the community'. Adherence rates were unaffected by penalties. Other macro-level factors considered key to non-adherence include loss of income and employment (Rothstein & Talbott, 2007). Additional barriers include inconsistencies in the application of quarantine measures between various jurisdictions and patchy monitoring of adherence, as well as challenges due to a lack of communication between governments and the public regarding the rationale for quarantine (DiGiovanni et al., 2004).

Three ways to improve adherence

This paper aims to identify barriers to, and facilitators of, adherence with NPIs based on: (i) a general review of the literature (mainly during the last decade) on the role of human behaviour in determining virus spread and suppression; and (ii) an overview of recent policy guidance on how we should respond to the pandemic. We have identified a number of simple yet effective evidence-based approaches/strategies to enhance adherence, and therefore help mitigate the spread and impact of the disease. These approaches/ strategies should preferably target multiple levels including: (i) individual level barriers; (ii) structural and societal factors; and (iii) social norms/ social emotions. Each of these is discussed below.

1. Individual level barriers: Improve knowledge and understanding of risk through timely and high-quality information

According to the ECDC (2020), it is important to develop a comprehensive risk communication strategy which involves conveying to the public, the rationale and justification behind public health measures. The WHO (2015) defines risk communication as 'the exchange of real-time information, advice and opinions between experts and people facing threats to their health, economic or social well-being to enable people at risk to take informed decisions to protect themselves and their loved ones'. The effective transmission of knowledge is, of course, central to risk communication and adherence can be improved through enhanced knowledge, thereby promoting a greater understanding of the rationale for quarantine measures (Reynolds et al., 2008). For example, adherence levels were higher during the 2003 SARS outbreak in Canada when people correctly identified the rationale for quarantine (Reynolds et al., 2008). This is in line with Webster et al. (2020), who argue that people who perceive quarantine to be beneficial, and disease outbreak to be risky (in terms of disease transmission/severity), are more likely to adhere to quarantine. Conversely, those who believe that the pandemic is not serious, are less likely to be compliant.

On a related point, a recent Lancet review on the psychological impact of the Covid-19 quarantine, indicates that the public should be provided with sufficient information to properly understand the situation and the reasons for quarantine (Brooks et al., 2020). Poor public health information and insufficiently clear guidelines about appropriate actions, can cause fear and confusion about the purpose of quarantine, all of which may negatively impact adherence rates (Brooks et al.,2020). However, information and messages from multiple channels, albeit necessary, can be overwhelming and difficult to process (BPS, 2020). Paradoxically, this may also be the case amongst those who might be considered more likely to comply with NPIs. For instance, Carthey et al. (2011) found that NHS healthcare staff may have difficulty in keeping up-to–date, and complying with, a large number of work-related policies/guidelines. This was compounded by difficulties in distinguishing essential from irrelevant information, thereby further reducing adherence.

Reynolds et al. (2008) also suggested, as in the current pandemic, that due to our rapidly changing knowledge of the virus, simple instructions about quarantine requirements should be developed and supported by, for example: telephone contacts from health staff to the public; publicly available and reliably-sourced web-based information; targeted messages; and more coercive measures such as adherence hotlines and/or the immediate issuance of legal orders. Consistent and targeted communication from both traditional (e.g. public health departments, media) and non-traditional sources (e.g. childcare centres, businesses) and clear delineation of responsibilities/lines of authority, have also been found effective in improving NPI acceptability (Aiello, 2010). The WHO (2020) suggests that authorities must provide the public with clear, up-to-date and consistent guidelines, and with reliable information about quarantine measures. For example, Webster et al. (2020) suggest that public health teams should regularly check in with those under quarantine and provide clear information.

The ECDC (2020) argue that an effective risk communication strategy encourages action at a personal level as a means of self-protection, whilst also allowing public health officials to monitor and appraise perceptions of, and responses to, the outbreak. This is consistent with recent guidance on optimising policies, which suggests that while it is important to generate a sense of urgency to encourage the uptake of protective behaviours, it is equally important to recognise that heightened anxiety

may cause fear and a 'fight or flight' response which can lead, in turn, to denial and avoidance behaviours (BPS,2020).

2. Structural and societal factors: Help tackle inequalities through the provision of psychosocial and practical support for socially vulnerable populations

It is crucial to ensure continued structural and societal support – both practical (e.g. food and healthcare access) and psychosocial – to people affected by Covid-19 in order to facilitate adherence and effective implementation of NPIs (ECDC, 2020). However, this also applies to socially vulnerable populations (e.g. in poverty, mental health service users) who disproportionately experience pandemic burden, including differential virus exposure and disease susceptibility, unequal access to treatment and excess morbidity and mortality rates (Quinn & Kumar, 2014).

In April 2020, it was reported that one third of critically ill Covid-19 patients in the UK had black, Asian, and minority ethnic (BAME) backgrounds (ICNARC, 4 April 2020). Research indicates that BAME communities in England are more susceptible to Covid-19 due to systemic racism, lower socio-economic status, and poorer experiences of healthcare, all of which create barriers to quality healthcare provision (Public Health England, 2020) and which can also negatively impact adherence.

Thus, socially vulnerable groups need additional supports and arrangements, including help to comply appropriately with NPIs (ECDC, 2020; WHO, 2020). Sundwall (2019) argues further that public health policies must be inclusive and target disenfranchised subgroups, such as homeless people, migrants/refugees and mental health service users. For example, most refugees and migrants live in inadequate/overcrowded accommodation which undermines their ability to follow public health advice, including quarantine and self-isolation (Kluge et al., 2020). A failure to prepare for, and respond to, these needs can lead to continued population-specific transmission chains, hampering global transmission control efforts, with potentially disastrous consequences (Quinn & Kumar, 2014). Therefore, it is crucial that governments adopt a more inclusive approach to meet the needs of such socially vulnerable populations (Kluge et al., 2020).

3. Facilitate positive social norms and 'social emotions' – increase a sense of collective responsibility by fostering empathy, altruism and solidarity

During the SARS outbreak, social and ethical pressures to comply with quarantine, were notable factors in influencing adherence (Cava et al., 2008). The importance of reinforcing social norms and moral values around quarantine was also highlighted in Webster et al.'s (2020) recent review, a key recommendation of which, was the need to emphasise the importance of altruistic behaviours, such as the protection of public health (DiGiovani et al., 2004) and the need for citizens to call upon their 'civic duty' to save lives (Cava et al.,2005).

A sense of duty is found to derive mainly from interpersonal empathy (Harper et al., 2020), and altruism, more broadly, may be facilitated and maintained by empathy (Brooks et al., 2020). Pfattheicher et al. (2020) showed that empathy for those most vulnerable to the coronavirus is a basic motivating factor with regard to physical distancing and may be harnessed to promote greater adherence in the general population. The researchers concluded that information alone cannot result in behaviour change and that informational material imbued with emotional content should be used to foster a shared sense of altruism, empathy and solidarity. Such human values are not to be underestimated at a time when our humanity is being tested like rarely before.

Moreover, a recent review (Brooks et al., 2020) suggests that regular reminders by public health officials, on the bene-

fits of quarantine to wider society and self-isolation as an altruistic choice, can be beneficial. For instance, public health messaging focused on duties and responsibilities toward family, friends and fellow citizens, may facilitate the development of positive 'social emotions' and provide a promising approach to help slow the spread of Covid-19 (Everett et al.,2020).

Conclusion

Ultimately, human behaviour has been an important determinant, not only in the spread of the current pandemic (Michie, West & Amlot, 2020), but also in its effective suppression and/or mitigation. If the general public can be encouraged and supported to comply with NPIs - and to maintain their adherence to them in the longer term – we will be better able to reduce our risk of infection and suppress any possible waves of infection into the future.

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Feelings towards physical and behavioural adaptations during the Covid-19 pandemic

Mark Forshaw, Victoria Blinkhorn & Lucy Galvin

THE COVID-19 pandemic has elicited universal uncertainty, alongside large-scale behavioural and social changes. These modifications have ranged from changing our daily routine to how we engage with others and the environment around us. The impact of these adaptations to our day-to-day lives is, in part, determined by individual appraisal (Taha et al., 2014). The perception of severity, as noted during previous outbreaks (Lau et al., 2007; Rubin et al., 2009) has an impact on engagement in behaviour (Janz & Becker, 1984) and perceptions can be influenced by a number of factors (Joffe, 2003). For example, being older has previously been associated with higher ratings of severity and adoption of recommended behaviours during pandemics (Bish & Michie, 2010), emotional influence is also a crucial factor in decision-making and behaviour change (Hartley & Phelps, 2010), and eliciting differing emotions has been associated with active coping and positive influences on behaviour, negative impact of engagement and associated avoidance (Restubog et al., 2020; Tannebaum et al., 2015). In order to mitigate Covid-19 and maintain engagement in protective behaviours, it is integral that we make efforts to understand feelings and beliefs that may in turn impact on behaviour (Mukhtar, 2020). As such, this study aimed to take stock and investigate the positive and negative emotions experienced in relation to environmental and behavioural adaptations during the Covid-19 pandemic and determine what role age and perceived pandemic severity has on these.

Method

Participants

The sample consisted of 131 participants (80.3 per cent female); 105 had no symptoms of Covid-19 and had not been tested, 25 had symptoms but had not been tested, one had tested negatively, and no one had tested positively. Nine participants lived on their own, 103 lived with between one and three others, and 19 lived with four or more others. Only 122 participants disclosed their age (M = 40.15), which ranged between 20 and 81 years. Participants were recruited by advertising the study via the authors' social networks, across other academic intuitions, and also on psychology research participation websites.

Materials

Participants' views, thoughts, and actions concerning the Covid-19 pandemic were measured using a purposely constructed online survey. Participants were first presented with six behaviours they might have experienced during the pandemic (specifically: someone wearing a face mask outdoors, someone wearing gloves outdoors, seeing someone walk away to avoid them in the street, someone avoiding something they have touched, speaking to someone behind a screen, and someone they do not know walking very close to them). Each behaviour was presented alongside six potential feelings and participants were asked to rate the extent to which they agreed with each. For example, the first behaviour was 'If I see someone wearing a face mask outdoors, I feel…', and the six feelings were 'annoyed', 'scared', 'insulted', 'pleased'

Table 1: Correlations between variables

	Annoyed/ Scared/ Insulted (ρ)	Pleased/ Reassured/ Safe (ρ)	Perceived Severity of Pandemic (ρ)	Following Rules (ρ)	Age (ρ)
Annoyed/ Scared/ Insulted					
Pleased/ Reassured/ Safe	–.34***				
Perceived severity of pandemic	.17	.36***			
Following rules	.12	.24**	.32***		
Age	.09	.00	.29*	.08	

* p < .05; ** p < .01; *** p < .001

"reassured" and 'safe', and participants had to state to what extent they agreed using a five-point Likert scale (1 = Strongly disagree; 5 = Strongly agree). Next, participants were asked to state how serious they felt the pandemic was using a visual analogue scale (0 = Not at all; 10 = Extremely). Finally, participants were asked to summarise how much they have been following the rules around social distancing, staying indoors, staying away from people they don't live with, shopping only when necessary and so on, using a 5-point Likert scale (1 = Not at all; 5 = As much as possible).

Procedure

The first page of the online survey contained the participant information sheet and other relevant ethical information. Participants completed a selection of demographic questions, continued to answer the six behaviour-based questions, and then the final questions concerning the extent to which they had been following the rules during the pandemic. After completing the survey, participants were thanked for their time and presented with a full debrief.

Results

Within each of the six behaviours, reliability analyses were calculated for each of the six-items regarding feelings and were grouped into two sets of three items (annoyed/scared/insulted and pleased/reassured/safe). The reliability of the six behaviours for the annoyed/scared/ insulted trio and for the pleased/reassured/safe trio were high (α = .79 and α = .88 respectively). As such, a mean was calculated across the trios of items for annoyed/scared/insulted, and for pleased/reassured/safe. These two new variables were used for the remaining analysis. Spearman correlation was used due to small deviations from normality in some of the variables.

In Table 1, we report the correlations between four variables. Predictably, the two trios of feelings were significantly negatively related to each other due to their opposite natures. Perceiving of pandemic severity was significantly correlated with feeling pleased, reassured, and safe in consideration of the six observed behaviours. Interestingly, there was no relationship between the strength of the other trio of feelings and the perceived

severity of the pandemic. In addition, individuals who stated they were following the rules significantly perceived the pandemic as more severe. Finally, and also understandably, the higher the age of the individual, the more severe they perceived the pandemic to be.

Discussion

The purpose of this study was to take stock of emotions related to behavioural and environmental adaptations during the Covid-19 pandemic. Based on our findings, these adaptations elicited more positive emotions, and were also associated with higher perceived severity of the virus. This complements the other finding, that individuals who stated they were following the rules closely perceived the virus as more severe. It could be that a combination of perceiving the virus as severe, and following the rules, creates a sense of safety and reassurance. It is interesting that there was no relationship between more negative emotions towards adaptations and behaviours and severity of Covid-19. This suggests an acceptability of these behaviours. What will be intriguing to discover is whether this acceptability has an impact on personal engagement in these behaviours, and the type of coping utilised.

With older individuals being more susceptible to the severe consequences of Covid-19 (World Health Organization, 2020), it is not surprising that the higher participants' age, the higher the perceived severity of the virus, and this mirrors previous pandemic findings (Bish & Michie, 2010). Whilst of course, there are limitations to this study, namely the relatively small sample, it still offers a useful snapshot of understanding behaviour during the global pandemic, and highlights a sense of openness to adaptation and change.

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'Celebrating Health Psychology' webinar: Event review and reflections

Sarah E. Golding

IT IS the 23 June 2020, and I – like many of you – am supposed to be in Bristol for the Division of Health Psychology's (DHP) annual conference. Instead, here I am at home, with good coffee and no soggy conference food, having just experienced my very first 'Zoom conference'. The conference theme 'Celebrating Health Psychology' has been retained as the title of today's replacement event – a webinar dedicated to showcasing some of the incredible ways in which health psychologists are responding to the Covid-19 pandemic.

In this review, I outline the speakers and the broad variety of topics they covered. The speakers have each submitted an overview of their presentations for this special issue (including two longer reflective pieces); these will follow this review, so read on for more detail.

Session 1: Health psychology's contribution to the response to Covid-19

In the first session, presentations were focused on contributions from health psychologists to Covid-19 policy and research. Chris Armitage and Maddy Arden discussed the work of the Behavioural Science Consortium, highlighting some of the rapid research underway, as well as efforts to engage policy makers. A collection of media appearances by Susan Michie were presented, during which she called for (and demonstrated by example) the need for clear, consistent messaging from leaders during public health crises. Finally, Marie Johnston provided an overview of rapid research being conducted in relation to Covid-19 in Scotland. Her review of lay summaries highlighted an emphasis on the mental health of those affected by Covid-19, with only a small number of projects focusing on psychology and behaviour relating to virus transmission.

Session 2: New ways of working due to Covid-19

In the second session, presenters reflected on how Covid-19 is driving health psychologists to adopt new ways of working across practice, research, teaching, and consulting. First, Eleanor Bull considered how health psychologists delivering psychological interventions have had to adapt to lockdown, social distancing, and increased infection control measures. Next up, Neil Coulson discussed the potential pros and cons of conducting research online, given that more of us will be exploring this route. He especially highlighted the need for ethical considerations in the online world. This was followed by reflections from Michael Smith and Mark Wetherell on the challenges (and hopefully opportunities) of delivering engaging, interactive, and practical teaching sessions during lockdown and beyond. Angel Chater and Emily McBride then discussed some of the work that health psychologists, along with other psychology colleagues, have been collaborating to advise policy makers. They outlined the work of the British Psychological Society's Behavioural Science and Disease Prevention Taskforce and the role of the Psychological Government Programme, which aims to amplify the voice of psychologists in government. Finally, Jo Hart and Lucie Byrne-Davis emphasised the value of the collective. They discussed the work of the Health Psychology Exchange, which has brought health psychologists together and enabled collaborative, voluntary action

to translate psychological evidence and raise the profile of health psychology with bodies such as councils and health care providers.

Themes and reflections

From my perspective, there were five key themes that cut across the webinar.

1. Uncertainty

There is uncertainty everywhere you look for it in relation to Covid-19. Will we find a vaccine or successful treatment, and what happens if we don't? How will many people cope with the crippling recession that is looming? How will we, as practitioners and researchers, respond to help mitigate the growing health and social inequalities? How will we manage as teachers, to keep students engaged and motivated? How will we manage as humans as cases and suffering continue to rise? Adapting to this uncertainty is even more challenging as we don't fully understand the situation we face.

2. Clarity

Clarity and consistency of messaging and guidelines is crucial if we expect the public to remain engaged with governmental advice, and more importantly adhere to it. Where there is ambiguity in messaging, people will look to others for normative cues, and those individuals with lower motivation to adhere will be less likely to do so.

3. Habit

Successfully responding to Covid-19 must include an understanding of the role of habitual behaviours. It is vital that we ensure these are not overlooked when designing behaviour change interventions to reduce transmission. As health psychologists, we need to bang the drum for non-reflective drivers of behaviour.

4. Community

We need to emphasise the collective and encourage as much collaboration as possible, between professionals but also between members of the public. We need to work together to understand and raise awareness of our shared interconnections, both personally and professionally, as well as at the local, regional, national, and international levels. The virus isn't fussed about borders or disciplines, so why on earth should we be?

5. Opportunity

I am a natural pessimist, so I am doing my best to look for the positives in this situation. Today's webinar gave me cause for hope. There are many challenges linked to the Covid-19 pandemic, which were acknowledged by the speakers; however, they also highlighted the potential for opportunity. For example, the pandemic is providing us with the impetus to reach out to policy makers and strengthen the links between different areas of our own profession and the wider psychological community. We are also adapting to remote working, with potential benefits in terms of increased inclusivity and accessibility, improved work-life balance, and reduced carbon emissions.

Joining the webinar today reinforced the pride I feel for my profession and the health psychology community. We might be a relatively small Division of the British Psychological Society, but collectively we can amplify our voice. The efforts being made to contribute to the Covid-19 pandemic, both large and small, across research, teaching, and practice are hugely impressive. Even if we are not directly involved in these efforts, we can all make a contribution by celebrating health psychology with those around us. Let's embrace and share our community spirit, the incredible knowledge and skills we possess, and have faith that our discipline can and should be part of the solution to Covid-19.

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Acknowledgments

I am hugely grateful to all the webinar presenters for agreeing to submit summaries and reflections of their presentations for inclusion in this section of this special issue.

'Celebrating Health Psychology' webinar: Speaker summaries

Covid-19 Research in Scotland: A review of recently funded projects

Marie Johnston, Professor Emeritus of Health Psychology, University of Aberdeen

The Scottish Government's Chief Scientist Office invited universities to bid for Rapid Research funding on Covid-19 in five identified priority areas. More than half of the 55 funded projects address the two psychological and behavioural priorities and the lay (but not scientific) summaries are available at www.cso.scot.nhs.uk/covidcalloutcome. Eleven projects investigating 'the resilience and mental health of frontline health and care staff' priority will study mental health, wellbeing and burnout in frontline health and social care staff and informal carers. The second relevant priority area concerns the impacts of interventions, including social distancing and other behaviour changes, to reduce the spread of infection in the population. Ten projects examine their impact on groups at particular risk, due to health (e.g. post ICU), social factors (e.g. low income), or behaviour (e.g. drug users). A further 10 studies examine effects on the wider population, investigating an extensive range of impacts including adherence to the recommended behaviours, trust in government, loneliness, health and health behaviours. Overall, a large variety of research designs are proposed, and several investigators aim to develop interventions. This review indicates strength in the assessment of psychological, especially mental health, states, but shows a surprising dearth of studies investigating the behaviours which transmit the virus. However, the review is limited by relying on the lay summaries and prompts consideration of what these abstracts should include for effective dissemination.

Behavioural Science in the spotlight during the Covid-19 pandemic: A montage of media interviews with Professor Susan Michie

Susan Michie, Professor of Health Psychology and Director of the Centre for Behaviour Change, University College London

Behaviour is at the heart of managing the global threat from the Covid-19 pandemic. Behavioural science helps us to understand the systems within which behaviours occur and to identify key influences in relation to capability, motivation and/or opportunity. This understanding of behaviour provides interventions and policies with a stronger framework with which to be built. Covid-19 has shown that no person, community or nation is an island. We are all inter-connected and solutions must take a collective approach. Translation of behavioural science can occur on many levels, such as via collaboration with government, science, the media and the public. It is important this this translation is clear, concise and trustworthy. This montage of clips shines a spotlight on the clarity and consistency of a selection of interviews, strengthened with fundamental principles from health psychology and behavioural science, with the core focus on the need to understand and intervene with behaviour.

The Behavioural Science Consortium's research on Covid-19 related behaviours

Christopher J. Armitage, Professor of Health Psychology, University of Manchester & Madelynne A. Arden, Professor of Health Psychology, Sheffield Hallam University

In the absence of a vaccine or cure for Covid-19, changes in behaviours such as hand cleaning, self-isolating and physical distancing are crucial in preventing the spread of - and speeding recovery from – the Covid-19 pandemic. As the Behavioural

Science Consortium, we have been providing behavioural science advice to national and local government for several years. When Covid-19 and lockdown hit, we were able to draw on the strong health psychology evidence base to provide sound behaviour change advice to policy makers at pace. We also moved quickly to learn all we could about Covid-19-related behaviours, undertaking research using existing theoretical frameworks and multiple methodologies. Just as was the case at the beginning of the Covid-19 pandemic, we do not know what behaviours will need to change in the future, but our strong scientific base will enable us to move quickly. It is more important than ever to continue to build this evidence base proactively, not just reactively, and we are working hard to anticipate the future needs of national and local government in changing people's behaviours.

Website
http://behaviouralscienceconsortium.org

Online research: Opportunities and issues

Neil S. Coulson, Professor of Health Psychology in the School of Medicine, University of Nottingham

Online research methods have been used by health psychologists for many years, however the Covid-19 pandemic has led many others to reflect on how they undertake and deliver their research projects. The pandemic has created the opportunity to consider new ways of working and in order to get started, I offer this short summary of key issues when considering online research methods. Starting with the potential benefits, online research methods provide unique access to participants. For example, approximately 93 per cent of UK households are digitally connected, with 4.6 billion people globally having Internet access. Typically, online methods are much less costly in terms of cost, time and travel. Indeed, they can be used flexibly by both researcher and participant alike. Despite many benefits, online methods are not without their problems and researchers should reflect carefully on issues around representativeness, participant anonymity and deception, response rates and levels of control. Each of these issues will need to be considered in relation to the research aims of the study as well as the specific method being considered. A range of data collection methods exist including online interviews, online focus groups, online surveys and social media. Many platforms have been created which can support our work, but I would urge consideration around institutional preferences for certain platforms (e.g. data leakage and user privacy). Regardless of which method(s) are used, our work should be considered in relation to the British Psychological Society *Code of Human Research Ethics* (2014) and *Ethics Guidelines for Internet-Mediated Research* (2017).

Health psychology for the political landscape: Policy guidance and the Psychological Government initiative

Angel Chater, Professor of Health Psychology and Behaviour Change, University of Bedfordshire & Emily McBride, Senior Research Fellow, University College London

Our aim is to build a strategy to engage policymakers and communicators in the complexity of human behaviour, highlighting the things that they 'don't know they don't know,' and the pitfalls in the translation of policy to real-world practice. We hope to build capacity to use, or at the very least consider, behavioural science and health psychology in policy and public health. As part of the work of the British Psychological Society's Behavioural Science and Disease Prevention Taskforce (Chater et al., 2020), we set nine core points for consideration in policies, programmes and communications related to the prevention of infection and disease management during Covid-19. Our recommendations were: (i) Minimise the 'I' and emphasise the 'we'; (ii) Deliver messages

from a credible source in relatable terms to the target audience; (iii) Create worry but not fear; (iv) Identify what influences each preventive behaviour and ensure policies, messaging and interventions target all relevant drivers; (v) Clearly specify behaviours and their effectiveness; (vi) Avoid unintended negative consequences; (vii) Create clear channels of access for health literacy; (viii) Use behavioural scientists and the psychological evidence base to support the COVID-19 response; and (ix) Make a pledge to work together, through a multidisciplinary approach. Our guidance can be considered as a road map of key points to consider, that we know from the evidence, or pre-emptively suggest are important, based on theoretical mapping from a health psychology perspective. We highlight the importance of scientists and politicians working together with a primary common goal, to save lives, acknowledging that research is only one slice of the pie that influences policy decision making.

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Health Psychology Exchange (HPX): A time for collective efficacy

Jo Hart, Professor of Health Professional Education, University of Manchester & Lucie Byrne-Davis, Professor of Health Psychology, University of Manchester

At the point of lockdown, we were aware that many of our colleagues and friends were directly supporting the Covid-19 crisis, as doctors, nurses and other key workers. As health psychology professionals, we realised that there were ways in which we could support the country's efforts. Nationally, we were aware that the profile of health psychology was being raised, as behavioural scientists were playing key roles in government advisory groups and in the media.

With Professor Angel Chater, we invited colleagues on Twitter to join us in a collaborative and set up a resource sharing group on the Open Science Framework. We contacted NHS and public health organisations, explaining a little about the work of health psychology professionals, explaining that 'we are creating a pipeline from research, through rapid evidence review and support for evidence-based policy making and practice to delivery of psychological interventions'.

We have been really busy, including working with 17 organisations, liaising with the BPS Behavioural Science and Disease Prevention Taskforce, producing two rapid reviews (Thorneloe et al., 2020; Rodham et al., 2020) with a further two in progress. Groups have put on two webinars with two further being planned, and two articles from our colleagues in HPX have appeared in The Psychologist (Redsell et al., 2020; Watson, 2020). We think that we have achieved and learnt a lot – the importance of being interconnected with each other, of informal mentoring, about making science policy ready. We feel that the work has raised the profile of health psychology – and that people want to work with us longer term and pay us.

We strongly believe that we can achieve much more together – and hope that there is a positive legacy from this work to a new way of working – of collective efficacy.

Flyer about the work of health psychology professionals

www.nwppn.nhs.uk/index.php/resources/news/2706-a-message-from-dr-lucie-bryne-davies-of-university-of-manchester-re-the-health-psychology-exchange

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Reflecting on the 'corona coaster': The impact on health psychology interventions (based on DHP 'Celebrating Health Psychology' webinar talk New Ways of Working in Practice)

Eleanor Bull, DHP Practice Lead.

The Covid-19 pandemic has been a rollercoaster for us all, radically affecting every part of our lives. In this article, I summarise some ways those working in practice have been adapting to Covid-19, with a focus on psychological interventions. My thoughts are based on conversations with colleagues working across the UK in different areas of practice. I could not hope to cover everyone's experiences but wish to spark further discussions and highlight health psychologists' diverse contributions at this time of great challenge and opportunity for our community.

Business as usual

For some, the pandemic has ostensibly meant business as usual. One example is our inpatient psychologists, including health psychologists, who deliver interventions to people in acute hospital settings, helping people cope with stress, anxiety, pain, medical and health behaviour issues whilst in hospital. This one-to-one work is more important than ever with late presentations of health emergencies, an increase in patients in intensive care and 'no visitor' rules affecting people's usual coping resources.

An extra challenge comes when conducting bedside psychological interventions whilst swaddled in a full-face mask, plastic shield, gown and gloves. Encouraging deep breathing is also tricky – meditation is not relaxing if you believe every 'in-breath' contains a cloud of Covid! Psychologists are responding creatively to this 'business unusual', developing new ways to offer empathic psychological practice to inpatients despite PPE, including drawing on lessons from the Ebola crisis.

New ways of connecting

Many health psychologists practise in community services supporting people with long-term conditions (LTCs). We've seen many outpatient clinics starting to operate remotely, via telephone or online appointments, with enormous variation in organisational readiness to change. Some organisations and teams are bounding towards a digital healthcare revolution, whilst others have had to rapidly invest in basic IT and telephone infrastructure. Equally, some psychologists are used to working virtually, while others have understandably worried about client safety, confidentiality and therapeutic relationships. Despite these challenges and fears, emerging PPI work suggests patients appreciate even our imperfect efforts to reach them in this time of crisis.

Remote interventions can be effective and offer convenient access for people with LTCs. Covid-19 has brought extra stressors for those with LTCs, summed up excellently by Professor Rona Moss-Morris and colleagues in their recent NHS England webinar. Connecting remotely, psychologists have been helping people interpret guidance and symptoms, stay active and connected to those they love whilst shielding, and cope with the impact of worsened conditions, uncertain or cancelled medical procedures.

Many clients are managing better than we might have anticipated, seeming open and responsive to psychological interventions for their LTCs at this time. Why could this be? Changes to work and home life may have offered a chance to slow down

and refocus: on health, on wellbeing, on family. For some, clinic cancellations have been empowering – one lady told me that without healthcare people 'interfering' she felt freed up to manage her pain the way she wanted. Other practitioners have commented on positive effects of 'online disinhibition' – people expressing emotions more freely online. Some with LTCs may feel positively about the recent national sense of comraderie and focus on looking after the vulnerable.

Whether we like it or not, connecting remotely is probably here to stay. However, for clients who may struggle with technology, remote psychological interventions can be impractical or impossible. To avoid intervention-generated health inequalities going forwards, psychologists must ensure that 'digital is not dogmatic', nor adopted as a 'one-size-fits-all' solution.

New frontline roles

Some health psychologists' usual roles have been paused and they have been redeployed. Trainee and qualified health psychologists have been on the frontline, working with distressed healthcare workers in the staff room of intensive care units, manning emotional wellbeing hubs and mentoring senior health service leaders as they make tough decisions about provision. These roles have been challenging but a huge opportunity to develop new skills and build confidence.

Others are putting immense time and energy into volunteering. Amongst the activities of the Health Psychology Exchange, our Psychological Interventions group have been working with eight health and social care organisations who asked for help to ensure workers stay well. Meeting weekly online, we translated various guidance documents into a simple Psychological Needs Assessment Conversation Tool for use in consultancy discussions with leaders. We have offered written psychology resources, and provided direct support such as reflective practice groups for staff. We have also run webinars for care home managers. It has been great to come together, build capacity and see our trainees leading work, supported by more experienced psychologists.

New roles with the public

Finally, our community had been deeply involved in psychological interventions for prevention of Covid-19. Some psychologists have been redeployed into test and trace efforts or manning public advice lines, using their data analysis and communication skills to provide information effectively and encourage healthy infection control behaviours. Health psychologists are doing a tremendous job to specify guidance behaviourally and apply psychological knowledge to develop effective prevention messages. Looking ahead, work underway to gather evidence on the effectiveness of public health messaging and vaccine uptake interventions will be crucial.

Reflecting on the corona coaster

In reflecting on the rollercoaster of the past few months, perhaps we can all relate to ups and downs, including frustration, anxiety, sadness, and guilt, but also excitement, pride and confidence at opening up to new possibilities, creativity and optimism. Seeing our field's leaders shape the national Covid-19 narrative and increase health psychology's visibility has been fantastic, as is how we've managed to draw together, even as the virus keeps us apart.

In all cases, our theories, methods, values and guidelines have helped us practice safely and ethically in these challenging times. The next challenge for our health psychology community may be how to sustain and build on these new relationships, skills and roles. We know health psychology will be needed more than ever in the coming months and years. We must have confidence in our collective voice and the connections we have made which will help us deliver stronger, better interventions for the future.

Alternative delivery of health psychology teaching during Covid-19: Challenges and potential opportunities

Michael Smith, Associate Professor of Psychology, Northumbria University & Mark Wetherell, Professor of Psychobiology, Northumbria University

Dr Michael Smith and Professor Mark Wetherell (Northumbria University) aim to employ innovative methods in their teaching and like to offer their students lots of practical experiences that facilitate learning. Here, they reflect on the challenges and opportunities presented by the Covid-19 lockdown on their health psychology teaching practice.

Michael

On 12 March 2020, I delivered a practical workshop with my final year undergraduate health psychology students. We played some games with the Cards for Change (see www.mcrimpsci.org/change-exchange/cards-for-change) to familiarise the students with behaviour change techniques. A couple of hours after this very practical and interactive workshop ended, I received an email from our Vice Chancellor stating that the campus was closing and that all teaching was to take place online. With just a couple of days to prepare for online delivery, it was clear that a rapid shift would be needed in my approach to teaching, given that such practical activities as the one I delivered that day wouldn't be possible. Given that online delivery (or at least blended learning) will be the new normal mode of teaching in the next academic year, here are a couple of reflections on my online teaching experience.

Firstly, it's important to foster student engagement and maintain/establish a student community. I am a big fan of student led activities; for example, with my MSc Health Psychology students I facilitate a student led journal club. This type of student led activity worked less well in an online format. However, allowing students the opportunity to debate and discuss topics in virtual breakout rooms did seem to be an effective way of engaging students. A challenge for programme directors moving forward will be to promote student engagement, programme identity and a student community if the cohort is only able to 'meet' virtually.

Secondly, we all must work hard to not simply replicate what we would do in a classroom environment on an online platform. New and innovative methods will be required to engage students and to maximise student learning. One potential opportunity here is the increased use of digital media. Typically, I would deliver some lectures on health inequalities, but there have been substantial excellent digital resources produced and available online relating to health inequalities during the pandemic. In the new academic year, I intend to make these available to students and then substitute a lecture with some informed, student led discussion on the topic via virtual breakout rooms.

Mark

Many of us are lacking certainty about what future teaching delivery might look like. Various terms such as hybrid teaching and mixed learning are being bandied around; it seems we are all in the same 'blended learning' boat.

I am particularly proud of the practical experiences we offer that contribute to the uniqueness of our programme at Northumbria. Given my research, some of these experiences involve stress induction and measurement. I run an acute stress session, measuring heart rate, blood pressure and mood, whilst investigating the effects of social evaluation and social support. I also have students measure their own diurnal cortisol at home and then learn about analysis and interpretation. These practicals offer great first-hand experiences of the techniques themselves but also help students to see things from participant and patient perspectives which should make

them more considered researchers and practitioners. The sessions are logistically challenging and time consuming but the positive feedback from students encourages me to continue. Then Covid-19 came along, forcing me to reconsider.

For the next cohort, we are being advised to prepare for a blended approach of online delivery and socially distanced on-campus sessions where possible. What does this mean for my practical sessions?

In terms of the diurnal cortisol sessions, many participants and patients carry out these activities remotely, so arguably these sessions would have even more ecological validity. Standard lab procedures and regulations should be sufficient in terms of handling and analysing the samples. Running this activity remotely will certainly require more preparation and organisation and I have concerns about running the analysis sessions online as students typically find this very difficult and are facilitated by lots of over the shoulder tuition. A major concern, however, is the provision and transporting of the samples. Although I would give clear instructions for this, I would have no control over whether these instructions were adhered to, and as such, risk assessing would be difficult. As the situation stands, I am unfortunately not optimistic that I will be able to run this practical.

How about the acute stressor sessions? One-to-one or group testing cannot work with social distancing and there are significant issues relating to the use of shared equipment. I have considered developing sessions on how to run acute stress studies using an online platform. Although this is possible, it would require students (and me) dedicating more time and effort to the processes and issues related to setting these tasks up online. Although this may be a useful skill, this focus doesn't really tap into my learning objectives for these sessions. I also remain optimistic that in the future we can resume face-to-face testing, so this is not an appealing option for me.

Obviously our content aligns with the BPS competencies for Health Psychology, but I need to consider whether removal of these activities would impact this. In reality, the answer is no as I will still deliver content that aligns with the knowledge competencies related to stress, physiological and psychosomatic processes. However, removal will impact the uniqueness of our programme – of which I am extremely proud.

As a researcher I do work on the process of benefit finding - finding positive consequences even amidst adverse situations. As a proponent of applied research, I hope the current situation will evoke some benefit finding and the development of different, maybe even improved, ways of working.

Teaching, training, consultancy and practice: Summaries of work relating to health psychology and Covid-19

Forming a collective in practice: The joint effort of volunteer HPX health psychologists delivering psychological interventions during a crisis

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In 2020 the coronavirus pandemic swept the globe, mobilising international medical and public health responses, including support for frontline workers experiencing significant psychological strain (Chen et al., 2020; Wang et al., 2020). In response to the pandemic, health psychology professionals formed a collective, the Health Psychology Exchange (HPX), led by Professors Hart, Byrne-Davis and Chater (@HealthPsychX, Health Psychology Exchange, 2020). Health psychologists are knowledgeable in public health, epidemiology, behaviour change and psychological health and well placed to bridge the gap between psychological professionals and those in need. As such, HPX members volunteered their expertise in a number of key areas: public health messaging, evidence synthesis, rapid reviews and psychological consultancy. From the HPX, a working group with over 60 years' combined experience in psychological practice and intervention was formed and coordinated by E. Bull and Dr R. Brady (Watson, 2020).

This HPX working group comprised health psychology professionals and trainee health psychologists working in research and practice. The team have developed, refined and evaluated a conversation tool, the Psychological Needs Assessment Tool (PNAT; Brady et al., 2020) summarising the published guidance on psychological wellbeing for health and social care workers (BPS Covid-19 Staff Wellbeing Group, 2020; Smith, 2020; World Health Organization, 2011). The PNAT has been used to help organisation leaders co-identify areas of good practice and psychological need to support social care and health workers, college students and third-sector organisations to keep psychologically and physically well during the pandemic. The working group have then collaboratively developed psychological interventions, including reflective practice group facilitation, experiential training materials and public health messaging; or signposted to existing evidence-led resources. Furthermore, to demonstrate successful psychological intervention in times of global crisis the group plan to disseminate their work in webinars, peer-reviewed articles, case-studies and social media (Brady et al., 2020; Byrne et al., 2020).

The opportunity provided through HPX to share knowledge and experiences has increased our capacity in several ways. Within the group, our trainee and early career health psychologists have been able to connect with and shadow those who are experienced in consultancy, to deliver publications, psychological interventions and consult with third parties, outside of their usual working roles (Byrne et al., 2020). For more experienced health psycholo-

gists, the HPX working group has helped us build peer networks and share best practice, with new connections with organisations to build upon going forward. Through support from the group, client organisations have acquired new knowledge and been able to apply psychological and behavioural change practice and research.

To date, the group has focussed on organisations' need to support the well-being of workers and developed interventions to target specific groups. However, this group of professionals remains ever cognisant of growing waiting lists of patients whose 'non-essential' healthcare has been put on-hold. The group, with clinics in rheumatology, pain management, weight management, cardiology and life-limiting illness, continue to develop individual level interventions for patients whose healthcare has been disrupted. Future directions will utilise the groups' effort to deliver individual level interventions to maintain psychological wellbeing and reduce physiological detriment as a result of Covid-19.

Acknowledgements

Ainslea Cross, Eleanor Bull, Jacqueline Lavallee, Roseanna Brady

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Gloucestershire Hospitals NHS Trust Psychology Service contribution to the Trust's Wellbeing Offer

Dr Polly Ashworth, Gloucestershire Hospitals NHS Trust & Dr Emma Phillips, Gloucestershire Health and Care NHS Trust

As the pandemic started, the Health Psychology Department considered how best we could support staff through the unfolding crisis. The Mental Health Liaison Team (MHLT) were keen to collaborate and we formed a COVID staff support steering group with Leadership and Organisational Development. Our response included two elements; the Psychology Link Workers and an Enhanced Individual Staff Support Service.

The Enhanced Individual Staff Support Service included easier access to therapy for staff (appointments available within 48 hours including evenings and weekends), delivering high quality therapeutic support for staff members, rapid staff access to psychiatrist review if indicated.

The Psychology Link Workers proactively forged links with teams in the hospital, trying to connect with every team, from Maternity to Mortuary. Where psychologists or MHLT staff were already embedded in teams these

staff took on the link work, maintaining relationships. We appointed a temporary WTE Psychologist dedicated to Critical Care towork intensively with that team.

The role of the link worker evolved to:

- Raise awareness of general psychological wellbeing messages and normalising staff experiences: 'It's ok not be ok', 'Our strength is between us not within us', 'Distress is a normal response to abnormal events'.
- Deliver and explain Trust documents about the Wellbeing Offer.
- Identify key challenges in each area and co-develop tailored interventions.
- Support the senior staff to support their staff; messages such as 'You don't need to have a solution.'
- Provide light touch support to individual staff and signpost to other services if needed.

Each area used the psychology link work input differently. Some examples:

- Supporting senior staff to implement ward huddles.
- Identifying common complaints (e.g. 'I can't sleep') and signposting to free apps.
- Ward drop-in sessions for staff to talk.
- Facilitating referrals to staff support service for additional input.
- Helping analyse data about staff redeployment patterns reported to be causing distress.
- Being a visible presence, in scrubs, alongside staff, and also working remotely.
- Providing supervision for staff offering helplines.
- Providing feedback to Leadership and Organisational Development about common themes.
- Identifying areas who could be helped by other people in the organisation (e.g. suggesting a Chief Executive visit).
- Responding to staff concerns about developing PTSD, educating about 'debriefing' and a webinar on trauma.
- Offering group sessions for staff returning from redeployment.

Our reflections

We had opportunities to work with new teams and contacts across all levels of the trust and to integrate psychologically-informed ideas into their work. The contribution of psychology was widely embraced and welcomed throughout the Trust, indeed the role of staff support and the psychologist link worker was put forward as being a significant contributory factor explaining why the absence rate of staff due to stress during the pandemic was amongst the lowest of neighbouring trusts. We were honoured to be included in a Royal Visit by the Trust, highlighting how our response was valued. As we face a future including Covid we are hopeful of new opportunities to contribute to psychologically-informed care for staff and patients as part of new care pathways.

Coronavirus, health psychology and clinical practice: trainees' experiences of a shared mission in the Health Psychology Exchange

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The coronavirus (Covid-19) pandemic has placed health and healthcare provision at the forefront of public consciousness in 2020 (WHO, 2020). Health psychology has contributed to the Covid-19 efforts through research, epidemiology, public health messaging, behaviour change interventions & wellbeing provision (Chater, et al., 2020). Health psychology professionals have formed a voluntary network entitled the 'Health Psychology Exchange' (HPX; Watson, 2020). The HPX is composed of a large network of

trainee, early career researchers and experienced chartered Health Psychologists. The trainees within HPX have various training routes including the independent, PhD and taught doctorate route, and are involved within several working-groups including one concerning psychological interventions. Like the wider group, this Psychological Intervention working group is powered by a variety of clinical skills, knowledge and experience possessed by its experienced practitioners and trainee members alike.

Trainee members of the Psychological Interventions working group have had the opportunity to enhance their existing competence through multiple projects in consultancy, psychological intervention, and clinical skills. Trainees contributed to the development and evaluation of a consultancy tool used to support the assessment of wellbeing and psychological needs of staff across multiple health and social care contexts (Brady et al., 2020; Armstrong et al., 2020). Trainees have had the opportunity to lead or co-lead in assessment consultations. In some instances, assessments have informed the design and delivery of tailored intervention and consultancy undertaken by trainees. One project involved supporting a local authority with appropriate and targeted public health messaging by applying health psychology resources (Bonell et al., 2020; West et al., 2020) and expertise in Public and Patient Involvement and Engagement (Redsell et al., 2020). Another case involved facilitating peer review support groups for care home managers to support psychological wellbeing. Undertaking this involved negotiating with the client organisation to become a training placement to provide trainees the ability to provide safe, ethical practice with continued access to supervision from their training provider.

The process of delivering consultancy in timely, unpredictable circumstances due to Covid-19 has involved skilful negotiation of terms and offers. Assessment and contracting skills become particularly pertinent in a pandemic, guided by the iterative process of trainees' engaging in self-reflection and awareness of professional competence and boundaries (BPS, 2018; HCPC, 2016). Moreover, the process of having conversations both in the assessment, development and delivery of effective interventions with clients has involved great care in effectively building rapport, relationships and trust.

Health psychology training varies considerably across training routes and between individuals. These differences have been controversially regarded as unstandardized and problematic (Hilton & Johnston, 2017). This view perpetuates a misconception about Health psychologists' ability to demonstrate practitioner competence and the application of health psychology in practice (Hamlet et al., 2017). It is arguably the combination of the differences in experiences of practitioner roles and the shared values that have been integral in this working group's shared success. In working together, we have fostered openness, empathy, warmth and rapport building as a group and with clients, key interpersonal skills for the change process (Martin et al., 2000). Moreover, in doing so, it has not only encouraged collaboration, development and engagement in new experiences for our clients, but has empowered us as trainees to feel we have achieved this for ourselves too.

Acknowledgements

Ainslea Cross, Roseanna Brady, Eleanor Bull, Jacqueline Lavallee, Atiya Kamal

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A Health Psychology perspective on Palli Covid Kerala's palliative care in Covid-19: A resource toolkit for low and middle income countries e-book

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Looking at the Indian scenario, as on 18 July the Covid-19 pandemic has affected 1,003,832 patients and has killed more than 25,602 people. The priority of the health care system and governments have been forced towards fighting such an unprecedented emergency. Formerly accessible and feasible opportunities of care that had been evolving have come to a halt. This results in severe complication during and post-pandemic era. Further, the pandemic and the efforts to curb it, such as nationwide lockdown and home isolations also possess various threats, especially for patients with other severe and acute health care needs, along with Covid-19 patients. Appreciatively there has been rethinking on how to deal with and to help those who are most vulnerable. Palliative care or specifically palliative home care establishes itself as an effective mechanism in these circumstances. The state government of Kerala, India has taken a huge leap by forming the Palli Covid Kerala team. The task force was formed in the last week of March 2020, with 22 palliative care professionals that consisted of national and international level faculties, oncologists, anaesthetists, and psychiatrists, to create a palliative care e-book for low and middle income countries. The comprehensive toolkit developed, can effectively be incorporated in dealing with both Covid-19 and other illness care. The present paper tries to summarise the critical elements of the toolkit with relevance to health psychology. The aims of the e-book include:

- Goals of care, ethics and communication.
- Symptom control.
- Management of distress.
- End of life care.
- Healthcare worker support.

The e-book encourage active support of health psychologist to patients with Covid-19 and those suffering from other illness, who are unable to access healthcare unlike normal circumstances. The role of health psychologists is particularly important in two major domains of the e-book, management of distress and end of life care. The management of distress grief, bereavement and loss domain deals with how psychosocial interventions and spiritual care can help patients and

their families to pull through the chaos. It is identified that the presence of a psychologist on the field is highly recommended, especially professionals skilled at psychoeducation, addressing stress, promoting daily activities, identifying distress and grief, ruling out depression and suicidal tendencies. Similarly end of life care is a very delicate area where patients and their families need at most support. In the case of Covid-19 scenario where grief and rituals of mourning have been ruled out by social distancing, isolation and quarantine, the process of bereavement is challenging and prolonged. Psychologist should make efforts to reach out to the families and to ensure support with the help of technology and other alternate means.

Critical care consultancy during Covid-19 – Stage two training

Sarah Keith, University of Stirling

Covid-19 presented a unique opportunity to conduct a piece of consultancy in line with my Stage 2 training requirements. The Critical Care team where I work (in the North East of England) approached my department looking for someone to conduct a service evaluation. I was fortunate to have the support of my department and time to put myself forward to conduct this.

Background: Many operational changes have been made in Critical Care in order to cope with the increased demand due to Covid-19, including an increase in personal protective equipment (PPE), staffing changes, and the presence of psychologists in the department. I was asked to conduct a qualitative exploration of the attitudes and experiences of Critical Care staff during the Covid-19 pandemic. We wanted to establish how staff experienced these changes, what they felt had worked particularly well, and any areas that they felt had not worked well. We were particularly interested to see how they had found practical and procedural changes as well as impacts to their own wellbeing. With this information, the service could make appropriate adjustments to improve patient care and staff wellbeing should a second peak occur.

Methods: After discussion with the client I conducted focus groups with key staff teams including consultants, nurses, allied health professionals and secretaries. Each focus group occurred face to face in groups of varying sizes, but no larger than eight people due to social distancing. The groups were led by a facilitator and an assistant psychologist was present who was able to take notes on any non-verbal cues that occurred. Such cues observed included eye contact with one another indicating encouragement and support to speak, as well as emotion not picked up on the recording. The focus groups were recorded and then transcribed. We are now in the process of analysing the results with thematic analysis in order to draw out the key themes. In addition, a survey was designed for staff to complete with questions based on those from the focus groups. This ensured that all staff in Critical Care had the opportunity to express their views, even if they were unable to attend a focus group. This provided us with the best opportunity to capture a broad range of views.

Impact on practice: The findings will be fed back to Critical Care management to aid decision-making regarding which further changes, if any, would need to be made as they prepare for a potential 'second peak'. It will also aid decisions in relation to any changes that may be kept as they come out of the pandemic and go back to 'usual work'. This piece of consultancy could impact practice, patient care, and improve staff wellbeing. Although this was commissioned to aid their Covid-19 response, the findings could also be transferred to non-Covid work.

Acknowledgements

I would like to thank my supervisors, Dr Graham Dyson and Dr Lesley McGregor for their support. Further thanks to Dr Kristy O'Hare, Hester Bowers and Natalie Roberts for their help with data collection and transcription.

Covid-19 in prisons

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March 2020 was a scary time to be in a prison. As Covid-19 spread across the world, prisons were at risk of serious outbreaks due to the large amounts of people living closely together.

As the government started to publish guidelines aimed at reducing the spread of Covid-19 I realised that much of the advice was not applicable to prisoners. A salient example of this is the instruction to 'stay at home', which is not something prisoners could do, despite that being the place they would probably rather be.

As a trainee health psychologist, I wanted to develop an intervention aimed at reducing the spread of Covid-19 which contained information and techniques that were achievable in prison. Inspired by blog posts by Susan Michie and colleagues (*BMJ Opinion* blog; Michie, West & Amlot, 2020; Michie et al., 2020; West et al., 2020) about behaviour change to reduce the spread of Covid-19, I used the behaviour change wheel (Michie et al., 2014) to design an intervention.

The intervention was a leaflet detailing behaviour change techniques for four target behaviours: washing hands, social distancing, coughing/sneezing into a tissue, and avoiding touching of the face. Examples of behaviour techniques include 'habit formation' where it was suggested that they keep tissues with their prison ID card that they always take with them, and 'action planning' where they were advised to plan how to communicate with others whilst maintaining a two metre distance.

The leaflet was approved by offender care senior managers and reviewed by a group of prisoners who gave feedback on the design and the information included. Following some minor changes, the leaflet was ordered and distributed to seven prisons and 1 immigration removal centre with a total of 4800 leaflets sent out.

The leaflet was evaluated in one prison using questionnaires. The results showed that the leaflet helped the prisoners understand what they needed to do, and why doing these behaviours would reduce transmission. There was a 10.3 per cent increase in hand washing, a 6.5 per cent increase in social distancing, a 4.3 per cent reduction in sneezing into a tissue, and a 9.9 per cent increase in face touching. However, these were self-reported, so should be taken with caution, especially when we are not always aware of these behaviours (West et al., 2020). The increase in face touching may be due to increased awareness of it rather than an actual increase.

The questionnaires also measured the components of the COM-B model for hand washing and social distancing based on Keyworth et al.'s (2020) questionnaire. There was little change in these components for handwashing, although they were high initially. There were however improvements in the prisoners' psychological capability, reflective motivation and automatic motivation to social distance (11.0 per cent, 10.6 per cent, 10.5 per cent respectively).

Prisoners are often a forgotten group, and interventions and services are frequently not applicable for prisoners, particularly with an increase in the use of technology. I was therefore pleased to offer something targeted uniquely for prisoners to help them during this difficult and dangerous time.

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The Health Behaviour Change Research Group's response to the Covid-19 pandemic

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The Health Behaviour Change Research Group (HBCRG) at NUI Galway in Ireland is a national hub and internationally-recognised centre for excellence in health behavioural intervention, development, evaluation and implementation. The following article outlines the HBCRG's response to the Covid-19 pandemic.

Expert contribution to public health policy

Professor Byrne, Director of the HBCRG has been appointed to the Behaviour Change Sub-Group to the National Public Health Emergency Team (NPHET) for Covid-19 in Ireland (www.gov.ie/en/collection/3008f6-the-national-public-health-emergency-team-nphet-covid-19-subgroup-be). Professor Byrne brings health psychology expertise to this sub-group who meet weekly to provide important insights and evidence to support the public health communications strategy and the wider work of NPHET.

Evidence synthesis for researchers, policy makers, practitioners and members of the public: HBCRG members have joined the Emergency Evidence Response Service at Evidence Synthesis Ireland (https://evidencesynthesisireland.ie/covid-19) to respond to pressing COVID-19 evidence gaps. Dr Noone, Dr McSharry and Dr Morrissey recently published a Cochrane rapid review on the effectiveness of video calls for reducing social isolation and loneliness in older adults (Noone et al., 2020). Further details of this review are available in this issue. Dr Toomey has contributed to several reviews, including an updated Cochrane review of personal protective equipment for reducing disease transmission amongst healthcare staff (Verbeek et al 2020). Dr Noone is currently leading a rapid review of the evidence on the behavioural determinants of physical distancing behaviour.

In response to general practitioners' (GPs) needs for reliable Covid-19 information, the 'Irish Covid-19 Evidence for General Practitioners Project' was developed and is being evaluated by Dr Lisa Hynes. This work is a partnership between the Irish College of General Practitioners, the Academic University Departments of General Practice in Ireland and the Health Research Board Primary Care Clinical Trials Network Ireland. A group of GPs and researchers meet regularly to review questions submitted by GPs to a Covid-19 hub on the Irish College of General Practitioners website. Using up-to-date evidence, national guidelines and expert input, answers are rapidly drafted and uploaded to the website.

Responding to the need for members of the public to have reliable information on Covid-19, Dr Morrissey, Dr Noone and Dr Toomey are also contributing

evidence synthesis expertise to ihealthfacts (i.e. a resource where the public can quickly and easily check the reliability of a health claim (including claims about Covid-19) that are circulated on social media.

Original research and international collaboration: HBCRG members (Professor Byrne, Dr McSharry, Dr Meade and Dr Noone) are working on a new research project led by Dr Gerry Molloy (www.hrb.ie/success-stories/all-success-stories/a-success-story/article/why-don-t-we-keep-our-distance-evidence-for-more-effective-communication-in-the-pandemic) to identify and address psychosocial determinants of physical distancing during the Covid-19 pandemic. The project will use a mixed-methods approach to identify potential barriers and facilitators to physical distancing and will also analyse how public health communications about Covid-19 could be tailored to be more effective in encouraging this practice in the general public.

Group members are also collaborating on multiple international Covid-19 projects, including the 'International Assessment of Covid-19-related Attitudes, Concerns, Responses and Impacts in Relation to Public Health Policies' (iCARE) study (https://mbmc-cmcm.ca/covid19). This survey study led by Professor Lavoie and Professor Bacon aims to assess awareness, attitudes, and adherence to Covid-19 prevention measures related to hygiene, social distancing, and self-isolation. The results will be used to enhance the uptake and effectiveness of prevention behaviours around the world.

Summary: The Health Behaviour Change Research Group's response to the Covid-19 pandemic has contributed much needed health psychology expertise to national and international evidence requirements for policy makers, researchers, healthcare practitioners and members of the public. In doing so, we hope to enhance Covid-19 preventative measures.

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An Irish acute hospital staff support response implemented during Covid-19

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Background: To mitigate potential psychological impacts on staff working in acute care during Covid-19 (Greenberg et al., 2020) St Vincent's University Hospital Department of Psychology (DoP) adopted a stepped model of staff support. A four level model was devised, informed by John Hopkins RAPID Psychological First Aid (PFA; Everly & Lating, 2017). Level 1: Online resources Level 2: Training for heads of departments (HODS) and managers Level 3: Staff support telephone line Level 4: Directing staff towards follow up support. This model was implemented from April to July 2020 with evaluation ongoing.

Implementation and Evaluation: Level 1: Dedicated Covid-19 staff support pages were added to the hospital intranet and advertised via 'all hands' email and meetings with HODs/managers. Content included brief well-being infographs, detailed mental health resources, and Covid specific information for healthcare staff. A dedicated page for HODs/managers included links to a range of information on risks to staff wellbeing

and how to mitigate these. A feedback survey reviewing the Staff Support Initiatives was disseminated in early July. 62.4 per cent of 298 respondents were aware of the DoP Online Resources available for staff and described them as 'very helpful' and 'highly recommendable'. Level 2: The psychology manager provided training for HODs/managers over 4 weekly virtual meetings. Content included an overview of the potential impact on staff wellbeing, ways to mitigate against this as well as PFA and stress management principles. Of a total of 80 invitees, an average of 80 per cent (56) attended or viewed recorded sessions. Feedback on this input is currently being planned via a survey of those invited. Level 3: The PFA informed staff support line went live on 10 April. In preparation, all facilitating clinicians completed the John Hopkins RAPID PFA training. Details of the support line were broadcast via 'all users' email, by HODs/managers as well as through posters in clinical and non-clinical areas. The line is covered by members of the DoP and Liaison Psychiatry and is operational for 48 hours per week across seven days. Over the course of the first 11 weeks, there were a total of 24 calls. This included 14 initial contact calls and 10 follow-up calls. 78.57 per cent of initial contacts were non-clinical support staff, 7.14 per cent allied health professionals, 7.14 per cent medical staff, while 7.14 per cent of initial contacts did not report their occupation. Level 4: Staff who contacted the PFA Line, and for whom further intervention was deemed appropriate, were directed towards follow-up supports. Of the 14 initial staff contacts, 10 (71 per cent) of these were provided with information regards accessing the employee assist programme/occupational health/GP or others. All callers had two or more contacts with the staff support line before being redirected.

Implications: Data from the ongoing evaluation will illustrate the effectiveness and acceptability of the staff support response and shape any future pandemic response by the DoP. Further feedback will be sought from DoP staff and will consider their views on the benefits and challenges of the approach as well as their own support, learning and supervision needs.

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Responding during a crisis: development and implementation of a Patient Triage Tool

Susan O' Flanagan, Aisling Warren, Rachel Bates, Susan Brannick, Louise O'Driscoll, Fiadhnait O' Keeffe, Niamh O'Sullivan, Julie Lynch, Lisa McGrath, Catherine McKeown, Mary Moriarty, Ruth Monaghan, Rosemary Walsh & Paul D'Alton

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Background: During the core phase of Covid-19 the Department of Psychology (DoP) at St Vincent's University Hospital Dublin, Ireland were required to rapidly and significantly alter service delivery. Transition to remote working and virtual clinics, as well as dedicating time to the development and provision of support services to the hospital staff community led to reduced clinical capacity. This necessitated triaging new and waitlist referrals, via telephone, and prioritising patients for assessment and intervention. Given the heterogeneity of services under the DoP, a consensus heuristic on how we prioritised patients for virtual assessment and intervention was required. To support consistency and shared decision making during this time of crisis, a Triage Tool was developed and implemented across all psychology services.

Triage tool: In the absence of an appropriate and validated tool, a 10-item triage tool was

developed. Tool development was based on an informal focus group with DoP team members and informed by available literature on vulnerability factors among hospital patients during Covid-19 (e.g. impact of Covid-19 on treatment provision; Dubey et al., 2020). The number of items endorsed on the Triage Tool were collated and mapped onto a traffic light system; with patients classified as presenting with mild, moderate or high priority needs.

Implementation: Eleven clinicians across specialist services (i.e. inflammatory bowel disease; neurology; cardiology; oncology and haematology; pain management; and cystic fibrosis) used the triaging tool to guide their virtual triage during the core phase of Covid-19 in Ireland (7 April 2020–12 May 2020). Inclusion of additional psychometric measures was specialism dependent; however, the majority also administered the CORE-10 (Barkham et al., 2012). Clinicians were subsequently invited to complete a questionnaire hosted by Survey Monkey to determine the helpfulness and feasibility of the tool.

Preliminary Results: Preliminary results indicate that 94 patients across specialist psychology services were triaged using the SVUH Patient Triage Tool. Some 61 per cent of virtual triage appointments lasted between 30–45 minutes. The majority, 57 per cent, of patients triaged were deemed to have a low level of need; 32 per cent had moderate needs, while 6 per cent of those screened were identified as high priority (5 per cent of data was incomplete). Scores on the Triage Tool, psychometric tests and overall clinical impression were used to guide clinical decision making. Outcome data indicated that 38 per cent of patients screened were discharged or referred to community services, 43 per cent were prioritised for psychological intervention and 18 per cent were placed on waiting list for follow up once regular services resumed. Given the heterogeneity of services, the relationship between Triage Tool categorisation and outcome will need to be evaluated on an individual service level. The clinician survey will allow us to determine the relative contribution of the Triage Tool and other confounding factors on decision making as well as clinicians' experience of using the tool.

Implications for Practice: The feasibility and usefulness, as well as required adaptations to the SVUH Patient Triage Tool, will be garnered from the clinician's survey. Results of this survey will inform future practice recommendations and the helpfulness, or not, of a shared Triage Tool should such adaptations be warranted in the future.

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Behavioural strategies for reducing Covid-19 transmission in an NHS rest and recuperation service

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Protecting the health and wellbeing of staff is critical for the NHS, in response to the Covid-19 outbreak. In March 2020, NHS Greater Glasgow and Clyde (NHSGG&C) developed a range of support for NHS frontline and support staff, which include rest and recuperation (R&R) support hubs across main NHSGG&C hospitals. Hubs are typically facilitated by redeployed NHS staff, alongside voluntary support from a 'Project Wingmen' team comprising aviation cabin crew and pilots. Overall, hubs include spaces to receive donated refreshments, comfortable seating, emotional support and quiet reflection spaces. Some hubs include active zones, with availability of table tennis, basketball, darts, exercise bikes and rowing machines.

Table 1: COM-B constructs and reducing Covid-19 transmission

Targeted behaviour	COM-B constructs	Behaviour strategies
1. Encouraging hand hygiene	Capability	Promotion, training and skill development across NHS facilities to use hand sanitizers. Increased knowledge and understanding about consequences of using hand sanitisers.
	Opportunity	Immediate and increased access to hand sanitisers across all hub areas. Funding and review to maintain access to hand sanitisers. Leadership, policies and procedures around importance of hand hygiene and regular hub cleaning.
	Motivation	Observation and modelling of use of hand sanitisers. Peer support and encouragement to use hand sanitisers. Encouraging habit formulation of hand sanitise use throughout hub use. Signs and prompts to encourage hand sanitiser use.
2. Social distancing	Capability	Promotion, training and skill development across NHS facilities to maintain social distancing. Increased knowledge and understanding around social distancing.
	Opportunity	Leadership, policies and procedures around importance of social distancing. Maximum occupancy limits to hub areas and controlling entry points and entry numbers to ensure social distancing. Floor markers throughout hubs to encourage social distancing.
	Motivation	Observation and modelling of social distancing. Peer support and encouragement of social distancing. Encouraging habit formulation of social distancing throughout the hubs. Signs and prompts to encourage social distancing.

The R&R hubs provide ample opportunities to apply behavioural strategies to reduce Covid-19 transmission, such as encouraging hand hygiene and social distancing. The Capability, Opportunity, Motivation and Behaviour (COM-B) model (Michie et al., 2014), provides insights to understanding behaviour change around improving hand hygiene and social distancing.

Table 1 outlines highlights how behaviours of hand hygiene and social distancing could be aligned to COM-B constructs, alongside examples of behaviour change strategies.

Reflections

Overall, differences in personalities, motivations and capabilities of hub facilitators, requires ongoing monitoring and review by peer hub facilitators and the hub co-ordinator management team in order to implement behaviour strategies consistently and effectively. Furthermore, in order to ensure sensitivity to diversity and inclusivity, interventions may require revisions on behaviour strategies for staff with visual or hearing impairments, along with sensitivity to staff literacy skills and competence.

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Research: Summaries of work relating to health psychology and Covid-19

Workforce impacts of Covid-19 in the UK

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The coronavirus pandemic has had significant impacts on the UK workforce. In the general population, people's work and employment has changed because of Covid-19, and this has affected their mental wellbeing. For healthcare workers, there are psychological impacts which could be sustained, and frontline health and care workers are particularly at risk. In the early stages of the pandemic, we launched a programme of studies to look at workers' experiences at different stages of the pandemic, the impacts on their psychological wellbeing and their views towards training and support.

The WoW study (1) will tell us more about work and employment nationally. The ICON study; (2) highlights the prevalence of mental health impacts of the pandemic specifically on nurses and midwives. ICON data collected before, during and after the Covid-19 peak informs the development of supportive interventions for healthcare workers. ICON findings have been reported in the national press – BBC health news – with 88% concerned about health risks to themselves and their families.

Within weeks of the declaration of UK pandemic, we rapidly developed and mobilised interventions to support workers in the NHS and social care service. Our digital package to support psychological wellbeing in health and care workers developed in the Covid e-package study (3) is being utilised in Covid-19 NHS Health and Wellbeing Offers in NHS trusts, and has been accessed by over 40,000 workers. The psychological impact of the pandemic on healthcare students is now being explored in the PoWerS Study (4), together with an exploration of their views towards the e-package to support the mental wellbeing of next generation healthcare workers. Finally, in the Covid well study (5) we are evaluating the implementation of Covid-19 supported Wellbeing Centres in an acute hospital trust and looking at the views of NHS employees towards this provision during the pandemic to ascertain how best to sustain or develop the supportive interventions rapidly initiated during this difficult time.

1. WoW Study: Wellbeing of the workforce

The WoW study is investigating how people's work and employment has changed because of Covid-19, whether this has affected their wellbeing and feelings about work, and what might be helping people to cope with the current uncertainties. We are conducting a longitudinal survey to look at recent changes (and changes over time) in how people work, health and well-being, and how people feel about the support they are getting from their employer as well as their family and friends. We will also interview people to find out more details about their experience of working or being furloughed during the Covid-19 outbreak. The findings will help us to develop recommendations and guidance for individuals, employers and policy makers on how to support the well-being and resilience of the workforce. The study is a collaboration between the Institute for Mental Health, the University of Nottingham, and Nottingham Trent University. Team members include: Louise Thomson, Juliet Hassard, Holly

Blake, Maria Karanika-Murray, Rich Pickford, Wei Choo and Lou Rudkin. Read more at www.institutemh.org.uk/research/projects-and-studies/current-studies/wow-study/wellbeing-of-the-workforce-wow-study.

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2. ICON study: The impact of Covid-19 on the nursing and midwifery workforce

This is a longitudinal national survey to evaluate the impact of Covid-19 on the UK nursing and midwifery workforce. The survey is being undertaken at three time-points: prior to Covid-19 peak, during the Covid-19 peak, and in the recovery period following Covid-19. The results from each point are being reported in real time, so the findings can be used to inform workforce strategies within the NHS and social care. Findings to date highlight the concerns raised by this workforce around health, training and workload during Covid-19. Early results from over 2,600 respondents to Survey 1 are at www.nottingham.ac.uk/news/survey-of-uk-nurses-and-midwives. Findings from over 4,000 participants in Survey 2 are at www.nottingham.ac.uk/news/icon-study. The study is led by academics and NHS staff from across the UK, including King's College London, University of Warwick (Dr Keith Couper, Project Lead), Cardiff University, University of Plymouth, the University of Nottingham (Dr Holly Blake, collaborator) and University of Surrey, in collaboration with the RCN Research Society.

3. Covid e-package study: Mitigating the psychological impact of Covid-19 on healthcare workers

We developed and evaluated a digital learning package using Agile methodology within the first three weeks of the declaration of a Covid-19 pandemic in the UK. The project is led by Dr Holly Blake, University of Nottingham. This e-package includes evidence-based guidance, support and signposting relating to psychological wellbeing for all health and care employees. A three-step rapid development process included public involvement activities (PPIs) (STEP 1), content and technical development with iterative peer review (STEP 2), and delivery and evaluation (STEP 3). The package outlines the actions that team leaders can take to provide psychologically safe spaces for staff, together with guidance on communication and reducing social stigma, peer and family support, signposting others through psychological first aid (PFA), self-care strategies, and managing emotions. Within six weeks of release, the package was accessed by over 40,000 healthcare workers. This is an open access, free, online resource available at www.nottingham.ac.uk/toolkits/play_22794. Access the full article at www.mdpi.com/1660-4601/17/9/2997. For more information, go to www.nottingham.ac.uk/news/online-resource-for-healthcare-workers.

4. PoWerS study: Psychological wellbeing for healthcare students: Evaluation of a Covid-19 digital learning package

Actions are needed to mitigate the impacts of Covid-19 on mental health by protecting and promoting the psychological wellbeing of healthcare students during and after the outbreak., particularly those deployed to support the NHS. We developed and evaluated a digital learning package using Agile methodology within three weeks of a Covid-19 pandemic being declared in the UK. The package aimed to support psychological wellbeing in health and care workers. The package has been evaluated with NHS employees and the development process is reported at www.mdpi.com/1660-4601/17/9/2997.

We are now evaluating this package with healthcare students. The project is led by Dr Holly Blake working with colleagues at the University of Nottingham. Qualitative interviews will shed insight on the emotional highs and lows of being a healthcare

student during the pandemic and perceptions of students towards the value of this resource to support their psychological wellbeing. For more information, click at www.nottingham.ac.uk/healthsciences/news/covid-19-e-package-on-psychological-wellbeing-for-healthcare-workers-and-healthcare-students.aspx.

5. COVID well study: Evaluation of a workplace intervention to implement supported wellbeing centres in a healthcare workplace during and after the pandemic

We are conducting a rapid evaluation of the implementation of supported staff wellbeing centres in a healthcare workplace during and after the Covid-19 pandemic. The project is led by Dr Holly Blake, working with colleagues from Nottingham University Hospitals NHS Trust. The 'Wellbeing centres' offer support from wellbeing buddies in a comfortable environment where staff can rest, recoup, talk and be supported. Wellbeing buddies are trained in psychological first aid (PFA). The study involves an online staff survey including measures of wellbeing and service access, the collection of service monitoring data, and qualitative interviews conducted with staff and wellbeing buddies. This will provide insights into the perceived value of these facilities during and after the Covid-19 pandemic. For more information, go to www.nottingham.ac.uk/healthsciences/news/the-covid-well-study.aspx.

For more information on these projects, contact Dr Holly Blake (holly.blake@nottingham.ac.uk; Twitter: @hollyblakenotts).

Covid-19: Investigating the relationship between coping strategies, happiness and wellbeing

Elise Burton, University of Derby

The psychology of pandemics is of the upmost importance after the new emerging coronavirus that spread globally. Health psychology is needed to gain an understanding of these unprecedented circumstances, in particular, the coping strategies used during this time of crisis. Presently, no prior research has investigated the relationship between coping strategies, happiness, and psychological wellbeing, making the current research the first to examine these important areas in health psychology. A non-experimental design was used to study the relationships between these variables. The sample included 111 adults in the general population in the UK and US. Participants completed all measures online, including a demographic questionnaire, the Coping Strategy Indictor (CSI), the Oxford Happiness Questionnaire and the Psychological Wellbeing Scale. Descriptive statistics and multiple regression analyses were analysed from the data. Results indicate that seeking social support was the most common coping strategy adopted across all participants; avoidance was the least. No significant relationships were found between problem solving and seeking social support in relation to happiness and wellbeing. However, a significant relationship was found between avoidance, happiness and wellbeing explaining 28.5 per cent of the variance ($\beta = -.129$, $p = .000$), suggesting avoidance is a significant predictor of happiness and wellbeing. Further research should explore the role of avoidance-style coping in relation to the psychology of pandemics, as these may play an important role in the psychological wellbeing of the general public during a time of crisis.

Health-protective behaviour during the outbreak of Covid-19 in the UK

Libby Chatfield, University of Derby

As part of a final year independent research project for an MSc Health Psychology course with the University of Derby, the current study is being conducted on health-protective behaviour during the outbreak of Covid-19 in the UK. This study aims to look at the way our health-protective behaviour has changed – regarding both physical and mental wellbeing – during the Covid-19 outbreak. It is important to explore and identify these

issues, especially with the longevity and high impact of some of the safety and distancing measures in place. With such massive changes and recommendations in place, there is speculation around the adoption and upkeep of these changes in behaviour, as well as how other behaviour and health-related issues may be affected in the process. Specifically, these will be areas that may not be prioritised in the initial research spree around Covid-19, which is likely to comprise of the nature, spread, and cure of the disease. As such, the findings will aim to contribute towards the growing literature about the impact of Covid-19 from a health psychology standpoint, investigating areas that are still in exploration while this virus is still being investigated.

Aims: To explore the way that health-related behaviours (doctor visits, handwashing, information seeking) have potentially changed as a result of the emergence and spread of coronavirus, incorporating theoretical underpinnings of behaviour change concerning health risks such as epidemics.

- Explore health-protective behaviours and health maintenance during the Covid-19 outbreak.
- Investigate how the health-related quality of life and illness perceptions may have been affected by Covid-19.
- Explore the effect, if any, of Covid-19 on mental health (depression, anxiety, resilience).

Method: This will combine multiple pre-made surveys to assess various areas of the impact of Covid-19 – including mental health (measured via depression, anxiety, and resilience) hygiene, and health-related quality of life This will include the use of the Brief Illness Perception Questionnaire (Broadbent et al., 2006), Hygiene Behaviour Scale (H123; Stevenson et al, 2009), PHQ-9 (Kroenke et al., 2001), GAD-7 (Spitzer et al., 2006), the Health-Related Quality of Life Scale (HRQOL-14, 2018) and Brief Resilience Scale (Smith et al., 2008). By scoring these tests individually and correlating them the aim will be to see how different areas that may be affected by the Covid-19 outbreak may relate to one another as well as seeing how prevalent they are in general. To understand any change to these areas that may have occurred throughout the outbreak, a follow-up will be conducted 2–3 weeks later due to current changing climate of the situation occurring very quickly therefore a short length follow-up period allows us to capture change as it occurs within the available period for the research. Follow-up participants will be recruited again from the general population, although those doing the initial study will be given the option to give an optional e-mail where they can be contacted for the follow-up - this will be stored separately from their answers to maintain confidentiality.

CHARIS: Covid-19 Health and Adherence Research In Scotland

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Introduction: Covid-19 Health and Adherence Research In Scotland (CHARIS) is a five-month study, funded by the Chief Scientist Office, of the Scottish Government, and involving a consortium of over 40 behavioural scientists from across Scotland. CHARIS is designed to support actionable decisions by explaining variations in: (i) adherence to each of eight Transmission Reducing Behaviours (TRBs); (ii) mental and general health status, over time and between groups. CHARIS employs three psychological theories to understand adherence to TRBs, namely the common sense self-regulation model (how people think about and respond to illness), protection motivation theory (how people respond to perceptions of risk) and social cognitive

theory (how people think about specific behaviours, in this case TRBs). CHARIS began data collection on the 3 June as Scotland was just beginning to move from full lockdown to Phase 1 of the Scottish Government's Route Map out of the crisis.

Method: CHARIS is a longitudinal telephone survey that will recruit a representative sample of adults living in Scotland (total n = 7000). Data was collected weekly for the first six weeks after which data will be collected fortnightly; each wave interviews n = 500. A core set of questions is measuring adherence to each of eight TRBs (two social distancing behaviours, four hand hygiene behaviours and two face covering behaviours). CHARIS will adapt to changes in TRBs; for example, waves 1–5 measured adherence to the TRB of only going outside for permitted purposes but this behaviour is no longer required it will be replaced with newly recommended behaviours (e.g. always carrying hand sanitiser when going out). The survey includes measures of mental health (PHQ4) and general health (one self-report item from the Scottish Health Survey), sociodemographic factors and constructs from the three theories. CHARIS is also monitoring three sources of pandemic related information: daily government briefings, newspaper headlines (print and online) and social media (Twitter). These data will be used to aid the interpretation of any observed changes in adherence, cognitions, or mental and general health. In addition to the core survey, CHARIS has a flexible component that allows modification and additions each week. This flexibility will allow CHARIS to accommodate: (i) a series of pre-planned themes designed to explore particular constructs in more depth (e.g. the impact of the pandemic on cognition); and (ii) the rapidly changing situation (e.g. a change in government advice, a second wave of Covid-19).

Research questions: Each week CHARIS will ask: (i) What are the adherence rates for each TRB and what sociodemographic and theorised motivational and behavioural factors predict adherence?; (ii) What is the mental and general health status of the population and what sociodemographic and theorised motivational and behavioural factors predict health?

Brief summary results to date (1 July 2020): Adherence to physical distancing (90 per cent adherence) and hand washing (78 per cent) behaviours is high. Adherence to face coverings is lower but rising from 30–38 per cent between 3 June and 1 July. Who and why people adhere to transmission reducing behaviours is different for each type of behaviour (keeping 2m distance, wearing a face covering, and hand washing). Having an intention (OR^2 = 5.61, ORHW = 6.67, ORFC = 13.86) to and the confidence (OR^2M = 4.22, ORHW = 4.27, ORFC = 8.94) that you can adhere to the transmission reducing behaviours is consistently significantly associated with greater adherence to all TRBs.

Dissemination: CHARIS will produce fast, real-time, evidenced based decision making for policy-makers, public health and service commissioners via descriptive weekly bulletins and three in-depth reports, as well as academic papers. The reports will present the key findings, an explanation of those findings and suggestions for government actions for population benefit.

Covid-19, lockdown and appearance

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Background: Covid-19 and lockdown are having a significant impact on people's daily lives, and physical and mental health (e.g. Vindegaard & Benros, 2020). Some groups of individuals may be facing additional challenges and consequences, and knowing more about

the experiences of these groups is important if appropriate support is to be available. Our research is examining the impact of Covid-19 and lockdown on people with facial differences (e.g. cleft lip and palate, facial scars, skin conditions).

There are a number of reasons why this group may face unique challenges in these circumstances. Firstly, lockdown has involved social distancing and self-isolation (staying at home, reducing in-person face-to-face social interaction). People living with an altered appearance or visible difference often report that the reactions of other people (including staring, unsolicited questioning, avoidance) can be particularly challenging, and lead to anxiety and social avoidance, potentially reducing social interaction (explained by Newell's (1999) Fear-Avoidance Model). Previous experience of social isolation may be beneficial when faced with the challenges of lockdown, or it may offer a reprieve from the distress that unwanted attention can cause. However, lockdown also reduces opportunities to challenge negative societal reactions, and to develop or practice strategies to manage these situations. Looking ahead, easing of lockdown and social distancing measures might be particularly challenging for those who experience anxiety around social encounters. Secondly, Online interactions (e.g. through Zoom, Skype) draw attention to the face. This might raise concerns for people with conditions that affect the appearance of their face, or it might be that these interactions are restricted to those with whom the individual is already well known and familiar, rather than with strangers. Finally, whilst face coverings are now compulsory in some settings, we know nothing about how they might impact on the experiences of people with visible differences that affect the mouth, nose or chin areas (e.g. cleft lip).

In summary, the social/behavioural consequences of the coronavirus pandemic present some potential issues that might uniquely impact the experiences of people with visible differences, particularly those affecting the face. It is important to understand these experiences and whether there is a need for additional healthcare, or psychological or social support as lockdown measures are eased, and in the longer term.

Aim of our research: to understand the experiences of adults with visible differences/unusual appearance in relation to Covid-19 and lockdown.

Methods: We are conducting two studies: (i) A qualitative study interviewing adults with facial differences about their experiences before, during and after lockdown. (ii) A survey of adults with or without visible differences, including self-report measures of constructs common within the appearance research literature that might be impacted (potentially positively or negatively) during lockdown, and as restrictions are eased and more in-person social interaction is permitted.

Participants: Adults who have joined our research centre's participant pool, meaning that we have pre-Covid-19 outcome data and can therefore chart changes from pre- to post- lockdown.

In conclusion, COVID-19 and lockdown might have a unique impact on people living with a facial difference. We anticipate that this research will provide valuable insight for healthcare providers and support organisations working with this group, and potentially guide the development of future interventions.

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Carers' experiences of caring for a friend or family member with dementia during the Covid-19 pandemic

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In the UK, an estimated 670,000 people provide unpaid care for a friend or family member with dementia (Carers Trust, 2015). This carer group report both negative (e.g. increased burden, uncertainty, isolation) and positive (e.g. sense of achievement) experiences which may impact upon their quality of life and wellbeing (Peacock et al., 2010; Shim et al., 2013). Those with high resilience report more positive carer experiences (Simpson & Jones, 2013). The literature has illustrated that, for unpaid carers of people with dementia, resilience is underpinned by factors including social assets (e.g. strong support network or frequent support from voluntary and service providers) and psychological resources (e.g. hope and positive coping strategies) (Parkinson et al., 2016). Therefore, factors such as social support are considered important in maintaining and promoting carer resilience and wellbeing (Brooke & Cooper, 2019; Parkinson et at., 2016). However, to reduce the spread of Covid-19, the UK government has implemented changes in policy, legislation, and health and social care provision, including lockdown measures which impact interaction between households. For an unpaid carer this may prevent social assets being utilised as they may be unable to draw on the support of family or services. We do not yet know how such changes have impacted upon unpaid carers of people with dementia. Therefore, the aim of this study is twofold:

- To explore unpaid carers' experiences of supporting a family member or friend with dementia through the Covid-19 pandemic.
- To investigate the role of hope and resilience during this time.

This research is underpinned by a critical realist ontological and contextualist epistemological position. Therefore, the researchers' acknowledge the existence of a real physical reality which people have their own understandings and views of (Fletcher, 2017); also that knowledge is developed through contexts and reflects the researcher's positions.

Due to the changing nature of Covid-19 guidance, it is important to try and capture data at different time-points to gain an understanding of carer's experiences. This study adopted a qualitative longitudinal research design in which carers of a friend or family member with dementia will be interviewed at two time points (eight weeks apart). Semi-structured interviews informed by a topic guide will be used. Topic guides have been created using the research aims and relevant literature and will be developed iteratively. Interviews will take place remotely using telephone or online methods (e.g. Skype), and will be digitally audio recorded, transcribed verbatim, and anonymised. It is anticipated that up to 30 participants will be interviewed. To recruit participants, this research will be advertised through carer organisations, support groups, and the researcher' social media.

Data will be analysed using an inductive, semantic, and realist approach to reflexive thematic analysis (Braun & Clarke, 2019). Though recognising that more participants may introduce new data, it is anticipated that up to 30 participants will allow the researchers to develop rich themes which provide insight to carers experiences. At the time of writing, recruitment and data collection is underway. This study will provide insight into the impact of Covid-19 on unpaid carers' wellbeing and experiences of hope. Also, their resilience, and the strategies used to support and maintain their own wellbeing over this time. The research team will work collaboratively with care providers to use the findings to inform discussions around the potential psychological impact that Covid-19 has had on unpaid carers, and the development of appropriate

support for them. This will be especially important for any further local or national measures which restrict interaction with a family member or friend with dementia.

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The importance of source credibility for recruiting underrepresented groups in health research: Insights from the Covid-19 coping survey.

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Background: The impact of Covid-19 on health and wellbeing is not yet fully understood. Behavioural and social sciences can make a substantial contribution to this understanding. Online surveys present as a quick, cost saving and wide-reaching method to capture anonymous data on behavioural responses to this novel health threat in real-time (Coulson, 2015). However, surveys are vulnerable to sampling bias (Coulson, 2012). Health psychology could benefit from and inform strategies to improve recruitment from those typically underrepresented in health research, including younger people, men and people from black, Asian and minority ethnic (BAME) groups (Bonevski, et al., 2014). Engaging these groups with Covid-19 research is important as representatives of these groups are more likely to continue working and not adhere to guidance (Weinberg, 2020). Especially relevant to this is the elevated risk of mortality from Covid-19 among BAME populations (Razaq et al. 2020). We surveyed people's thoughts, feelings and behaviours towards Covid-19 in real-time to better understand coping with the present and future health crises. Here we focus on the implications for recruiting underrepresented populations in health research and illustrate with a few of the group differences.

Method: An online survey informed by the transactional model of stress and Coping (Lazarus & Folkman, 1984) and the Common-Sense, self-regulatory model (Leventhal, 1984) assessed questions around thoughts, feelings and actions related to Covid-19 with Likert scale plus free-text responses. Snowball sampling was adopted; adults (18+) were recruited from a research database in Wales and via email and social media. Quantitative data were analysed using appropriate non-parametric statistical analyses (Coulson, 2015).

Results: 9111 people completed the survey; only 1.6 per cent of participants were young men and 4.6 per cent were from BAME groups. This underrepresentation was more pronounced where participants were recruited via the research database compared to email and social media. Young men were significantly less anxious and

reported more difficulty creating structure and concentrating than others. BAME groups were significantly less likely to believe that politicians would get us through the threat and reported less drug and alcohol use but reported greater difficulty creating structure than white participants.

Discussion: The response rate to this online survey was much lower among younger males and BAME people compared to older, female and non-BAME individuals. This is of concern as reports suggest that younger men are less likely to comply with behavioural measures to control the Covid-19 pandemic (Weinberg, 2020). These findings contradict previous research demonstrating an association between general internet use and age (Office for National Statistics, 2020), as well as the suggestion that delivering online surveys via social networking platforms could facilitate recruitment of underrepresented groups (Coulson, 2015). The use of unsolicited email invitations during the present pandemic could explain this finding (Coulson, 2012) and we will examine other similar study response patterns to compare. Earlier qualitative research advocates good engagement with minority participants they wish to sample prior to using online recruitment methods to build trust and credibility (James et al., 2017). Furthermore, studies on weight loss among men have noted the importance of engaging the target population with recruitment because of their shared experiences (Grey et al., 2013) and preferences (Elliot et al., 2020).

Health psychologists using online survey methods need to be more reflexive when developing recruitment strategies and methods of use in subsequent communication. In the context of Covid-19 research, we are reminded of key messaging factors: simplicity, consistency and credibility. Credibility is dependent on message givers being familiar with their target population and engaged with individuals from underrepresented groups in health research to be effective.

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Public responses to public health messages encouraging vaccination during pandemics or epidemics: A rapid review

Sadie Lawes-Wickwar, Daniela Ghio, Mei Yee Tang, Chris Keyworth & Tracy Epton on behalf of the Health Psychology Exchange (HPX) Public Health Messaging Review Group

Background: Trials are currently underway to identify an effective vaccine to protect

communities against the novel Covid-19 virus. Vaccination coverage rates have declined in the UK in recent years and a recent poll by the Royal Society for Public Health revealed one in five (19 per cent) respondents would not or were unsure if they would take up a vaccine for Covid-19. Health campaigns are used to advise the public about how best to reduce transmission of novel viruses (including encouraging the uptake of vaccinations); understanding the public's response to such campaigns can inform future communication strategies. A group of health psychology researchers forming part of the Health Psychology Exchange (HPX) conducted a rapid review of public health messaging about vaccinations during pandemics or epidemics, to inform public health organisations of how to approach messaging around a new vaccine for Covid-19.

Aims: To conduct a rapid review of evidence relating to how people respond to messages encouraging vaccination during pandemics or epidemics to prevent disease transmission.

Methods: Searches were performed in Ovid PsycINFO, Ovid MEDLINE and healthevidence.org for a review of public health messaging, using terms specific to public health campaigns (e.g. 'messages'), and pandemics or epidemics (e.g. 'outbreak'). PsyArXiv Preprints and OSF Preprints were searched for grey literature. A further keyword search using terms relating to vaccination (e.g. 'vaccine') was performed on the results from the searches for the main review, to identify potentially eligible studies.

Studies were included if they tested at least one type of message, measured at least one vaccination-related outcome (e.g. uptake), and participants were adults. Message delivery could include one or more of: mobile technology, news media, broadcasts, adverts, posters, social media posts, letters, websites or health alerts. All study designs were considered for inclusion. Non-English language articles were excluded.

Results: This rapid review is ongoing and the results will be reported in a future publication.

Prenatal stress, health, health-behaviours, and formal and informal supports during the Covid-19 pandemic

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Poor prenatal mental health has significant negative implications for maternal and infant outcomes. The Covid-19 pandemic, and related restrictions are likely to increase women's experiences of prenatal distress and support needs. The aims of this project are to examine pregnant women's: (i) stress, perceived social support, health, and health behaviours during the pandemic; (ii) perceptions and satisfaction with their pre-natal care during the pandemic; and (iii) stress management strategies and support needs during the pandemic.

An international online survey is being conducted, with participants recruited from forums of relevant pregnancy websites, and via social media. Participants complete quantitative measures of Covid-19 concerns, stress, health status, perceived social support, health behaviours, and perceptions and satisfaction of maternity care. Open-ended questions ask about women's stress-reduction strategies, experiences of formal and informal supports, and support needs. Findings will inform current and future supports and perinatal mental health interventions for pregnant women during a pandemic.

Funding: Ms Power is supported on this project through an Evidence Synthesis Ireland and Health Research Board (HRB) Trial Methodology Research Network Student Summer Scholarship. Dr Matvienko-Sikar is in receipt of a HRB Applying Research into Policy and Practice Fellowship.

Video calls for reducing social isolation and loneliness in older people: a rapid review

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At the beginning of the Covid-19 pandemic and lockdown in Ireland, members of the Health Behaviour Change Research Group in the School of Psychology at the National University of Ireland, Galway were invited to join the Emergency Evidence Response Service at Evidence Synthesis Ireland. At the time there was a lot of concern around social isolation and loneliness in older people due to lockdown restrictions. We saw lots of media coverage of older people talking to their families through video calls on their phones or tablets. This acted as the impetus for this Cochrane Rapid Review on the effectiveness of video calls for reducing social isolation and loneliness in older adults.

Covid-19 is spreading rapidly, so we needed to answer this question quickly. This meant that we shortened some steps of the normal Cochrane Review process. We searched CENTRAL, MEDLINE, PsycINFO and CINAHL from 1 January 2004 to 7 April 2020. We also searched the references of relevant systematic reviews. However, while two review authors checked 25 per cent of our search results for studies only one review author checked the remaining 75 per cent of our results. Normally two review authors would check all the results. Similarly, only one review author collected data and assessed the quality of the studies, and a second review author checked this work. RCTs and quasi RCTs were eligible for inclusion and older people were defined as those above 65 years.

Only three studies met the inclusion criteria for our review. The three studies had 201 participants in total and all took place in nursing homes in Taiwan between 2010 and 2020 and compared video calls to usual care.

None of the studies reported social isolation as an outcome. All measured loneliness but suggested that video calls had little to no effect on it after 3, 6 or 12 months.

Our confidence in the evidence was limited because we found few studies with a small number of participants, and they either used unreliable methods or did not fully describe their methods. Risk of bias was rated as high in all outcomes. Also, all of the participants were in nursing homes, so our findings may not apply to older people living in other places, such as their own homes. Also, some of the participants may not have been feeling lonely or socially isolated.

In conclusion, based on the current evidence, we are unable to say whether video calls help to reduce loneliness in older people. We need more studies that use rigorous methods to investigate this question, and focus on older people who are lonely or socially isolated.

If you want to read more about the methods or results of this rapid review it can be found at the Cochrane Database of Systematic Reviews:

Noone, C., McSharry, J., Smalle, M. et al. (2020). Video calls for reducing social isolation and loneliness in older people: A rapid review. *Cochrane Database of Systematic Reviews 2020*, 5. Art. no. CD013632. doi:10.1002/14651858.CD013632

The effect of antibody test result knowledge on transmission reducing behaviours

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Background: There is an assumption that previous Covid-19 infection results in immunity to reinfection, however there is insufficient data to support this assumption (Huang et al., 2020). Additionally, there is limited research to determine the prevalence of antibodies in the community, the potential for reinfection in previously infected patients and the long-term persistence of antibodies in these patients (Slot et al,. under review). Human behaviour is critical to manage Covid-19 whilst there is no vaccine, and equally to support vaccine uptake.

Aims: (i) To explore the effect of antibody test results on transmission reducing behaviours; particularly social distancing and wearing a face-mask. (ii) The project is part of a larger research study, the main purpose of which is to determine which antibody assays available in Scotland is most sensitive in detecting the presence of antibodies.

Methods: A questionnaire was designed based on the constructs of the Health Belief Model (Rosenstock, 1966). The HBM is one of the most prominent frameworks for understanding why individuals may or may not act in the face of a treat, in this case, Covid-19 reinfection and consequently infecting others. The questionnaire consists of seven sections measuring perceived susceptibility (8 questions) and severity (4 questions) of Covid infection, and the benefits (4 questions), barriers (11 questions), cues to action (8 questions), self-efficacy (4 questions) and uptake (2 questions) of transmission reducing behaviours such as wearing a face-mask and socially distancing. The individual constructs will be measured using a five-point Likert scale, ranging from 1 (strongly disagree) to 5 (strongly agree). The questionnaire will be administered to participant's pre and post knowledge of their antibody test result. Comparisons will be made between positive and negative cases and their beliefs regarding their susceptibility and severity of Covid-19 and the benefits and barriers to engaging in transmission reducing behaviours.

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Investigating habit changes in lockdown: A Covid-19 study of self-care at home in the US

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Background: On 3 February 2020, with growing concern of the spread of infectious disease, Covid-19, the United States declared a public health emergency with all states commencing some form of lockdown measures. As a result, many Americans were suddenly confined to their homes, with outings limited to only essential food shopping and medical visits. As such, the routines and daily lives of most Americans were largely changed with many external recreational and self-care options no longer available. Since habit creation is associated with the repetition of a behaviour in a stable context, these widespread changes in living environments have offered a novel opportunity to investigate potential changes in habits relating to self-care during and after Covid-19 restrictions.

Aim: To investigate whether behaviour change occurred in two habits; reducing social media use and increasing physical activity.

Methods: A longitudinal prospective design was used to observe changes in habits over time. Crowdsourcing platform, CloudResearch, was used to recruit three 'waves' of US participants (18 years and over) at different timepoints, with data collection occurring between May to July 2020. Participants were asked to choose one behaviour they had noticed a change in during lockdown: social media use ($n = 45$) or physical activity ($n = 46$). Each participant completed a baseline question-

naire comprising measures of predictor variables including (a) past behaviour, before and after lockdown; (b) habit strength; (c) planning ability; (d) self-control. Participants also indicated cues associated with the behaviour, and were asked to choose a novel cue to assist them to enact or inhibit the behaviour more regularly. Upon completion of the baseline measures, participants were asked to self-report their behaviour frequency and habit strength, and novel cue use over the previous two days, every two days for 12 weeks (42 follow-ups).

Planned analyses: A conditional growth curve analysis will be conducted using SPSS to assess the change in both habits over time. Analyses will also yield results relating to whether predictor variables can explain variation in habit change and will allow a test of the mediating effect of habit strength on the relationship between past and changed behaviour.

Anticipated implications: This may be the first study to investigate changes in self-care habits in a restricted pandemic-related environment. If predictors are shown to correlate with habit strength over time, these results can inform future interventions to improve self-care habits in changed and stressful environments.

Identifying indirect impacts of the Covid pandemic: The C-19 health behaviour and wellbeing daily tracker study

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Study summary: In rapid response to the Covid-19 pandemic and the sweeping changes to healthcare and restrictions on daily living, we set up a mixed methods UK intensive longitudinal study to understand the impact on health behaviours and mental health/wellbeing.

Background: Health behaviours such as alcohol, tobacco and substance use, dietary choices, physical activity and sleep, have immediate and long-term health and mental health impacts. The 'lockdown' and social distancing measures as a result of the Covid-19 pandemic are likely to have profoundly affected health behaviours. However, the actual impact of these unprecedented social measures are poorly understood. This includes whether such changes are likely to further widen health inequalities or affect marginalised and vulnerable groups disproportionately.

Study design: This study started in early April 2020 and uses an explanatory, sequential, mixed methods design with four components: (i) A baseline cohort of 1044 people with assessments of participants' circumstances and health behaviours before the Covid-19 pandemic. (ii) Daily surveys using Ecological Momentary Assessment (EMA) for 12 weeks (~84,000 daily data sets) among the cohort tracking health behaviours and wellbeing, including Covid-19 symptoms, smoking and alternative nicotine device use, alcohol and substance use, physical activity, diet, sleep and theory-informed psychosocial determinants of health behaviours. We will use latent class curve analysis to classify participants into meaningful groups with similar trajectory patterns (e.g. stable, increasing, decreasing) and identify predictors of these trajectories. Alongside, we are recording changes in Covid-19-related government actions. (iii) A 3, 6 and 12 month questionnaires to establish longer term changes in behavioural, health and mental health patterns and outcomes. (iv) Detailed qualitative interviews at three months to provide further insights and contextualised explanations for self-recorded behavioural and mental health changes.

Participants: We purposively targeted vulnerable and marginalised populations for recruitment and for all four study components we will have a particular focus on three priority groups: low socioeconomic status, having

a physical high-risk health condition for Covid-19 and those with a self-reported mental health issue. The baseline sample (N = 1,044) has a good mixture of characteristics:

- 72.2% female
- 21.6% net household income < £1.5k p/m
- 29.5% in a C19 at risk group
- 30.7% had change in household income
- 6.0% with a mental health issue
- 84.9% who drank alcohol in past month
- 4.3% BAME
- 8.6% current smokers
- 14.1% unemployed or furloughed
- 6.1% recreational drug users
- 26.6% key workers

Implications and potential impact of findings: The data will enable us to: robustly demonstrate associations between changed social and cultural conditions and individual level health behaviour and well-being during a critical time of the Covid-19 pandemic in UK adults; identify predictors of changes in health behaviour and well-being trajectories that will likely impact on long-term health outcomes that can be targeted through bespoke interventions or policy-based action. This will identify some of the wider determinants of poorer health outcomes due to Covid-19; inform public health modelling, future commissioning of health and wellbeing services and contribute to policy planning for future pandemics.

I don't want to hold your hand: Can Covid-19 public health messages delivered through songs?

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In response to the outbreak of Covid-19, governments around the world have published their guidelines including rigorous hand washing, respiratory etiquette, social distancing and restrictions in movements and gatherings (European Centre for Disease Prevention and Control, 2020). Songs have been used to share key advice since the start of the outbreak in many countries (Hui, 2020). In the UK, the first advice proffered concerned rigorous hand washing. The National Health Service (NHS, 2020) produced a video clip to show how to wash hands; in this video, they advise singing 'Happy Birthday' twice to ensure that hand washing continues for at least 20 seconds. One day later, Prime Minister Boris Johnson appeared on national news singing 'Happy Birthday' twice while he washed his hands (Boris Johnson sings happy birthday while washing his hands, 2020). The general public and celebrities were quick to suggest other portions of songs that could be used including the national anthem, 'I Will Survive' and 'Wonderwall'. Songs were then adapted to deliver the handwashing message. For example, the Beatles song 'I Want To Hold Your Hand' was re-written: 'I Gotta Wash My Hands'. Matt Lucas, an English actor and writer, has re-written a 20-years-old comedy song 'Baked Potato' with key messages: 'Wash your hands, stay indoors, and not to touch their faces'. Many millions have viewed this new version of 'Baked Potato' since it was uploaded on social media (Youngs, 2020). Thus, songs evolved to deliver public health messages. WHO guidelines highlight two key requirements for successful public health campaign are education and motivation (World Health Organization, 2020). We hypothesise that songs can be both. The overarching aim of our research is to examine how effective songs are for delivering Covid-related health messages.

First, we will examine the content of popular Covid-related songs using BPS Covid-19 guidance about messages to assess their clarity, influence and persuasiveness (BPS, 2020). Then, we will survey the general public to examine their reach and perceived effectiveness using open and closed questions. Specifically, we will ask participants about whether they have heard segments of popular Covid-related songs and altered their behaviour in response to them;

open questions will ask about the most important features in these songs.

Health messages have been delivered through songs for decades – for example, VD City, written by Woody Guthrie, was used by the US Government as part of its anti-venereal disease campaign. Public health authorities should consider using songs that are informed by behavioural science advice (BPS, 2020) to disseminate urgent, important and life-saving messages through songs.

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Homeworking during Covid-19 lockdown: Relationships between the physical and social environments at home, work-related burnout, and musculoskeletal pain

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Background: This study examines the impact on workers of the rapid migration to homeworking during the Covid-19 pandemic. During lockdown many workers have worked from home while managing additional demands (e.g. childcare, shared homeworking spaces) and often in the absence of adequate ergonomic equipment, such as adjustable height display screen equipment, supportive chairs, and appropriate desk space that enables workers to sit comfortably for prolonged periods. Previous research suggests poor privacy fit at work (privacy needs not being met) is associated with lower wellbeing and greater work fatigue and burnout (Laurence et al., 2013; Weber, 2019). It is also widely acknowledged that poor ergonomics of office furniture can result in musculoskeletal pain, especially if equipment is not easily adjustable or optimally set up for an individual's needs (Derjani et al., 1999; Sauter et al., 1991). As the global pandemic continues, it seems likely that many workers will continue with homeworking for some time, and it is important that we understand potential impacts of homeworking during the pandemic. This study therefore examines factors in the physical and social environment at home that contribute to privacy fit, burnout, and musculoskeletal pain while working from home during the Covid-19 lockdown.

Aims: This study explores: (i) how people's physical and social environments during lockdown affect their experiences of privacy fit during homeworking; (ii) whether differences in privacy fit, the social environment, and job-related factors predict levels of burnout amongst people working from home during lockdown; (iii) whether people working from home during lockdown report experiencing new or increased levels of musculoskeletal pain, as affected by their home-working setup

Methods: We conducted an online survey, opportunistically recruiting members of the public via social media, as well as by email to our own extended networks of colleagues, friends, and family. Power calculations for multiple regressions indicated a minimum sample size of 199 would be

needed to detect a medium effect size. We measured privacy fit, environmental factors that contribute to privacy fit (e.g. perceptions of crowding, noise, number of people present), environmental factors related to lockdown (e.g. childcare, where working at home, adequacy of equipment at home), job-related factors (e.g. job demand, job control, changes to hours worked), burnout (physical, mental, and emotional fatigue), and musculoskeletal pain.

Planned analyses: We recruited 479 people; participants were located in Germany (n = 119), Switzerland (n = 130), the UK (n = 135), and other countries (n = 95). Multiple regression models will be used to explore the impact of the physical and social environment at home on experiences of privacy fit during homeworking, the impact of privacy fit, the social environment, and job-related factors on burnout, and the impact of home-working setup on musculoskeletal pain. We will explore potential differences between countries and gender, as well as consider potential mediators and moderators between privacy fit, the environment, and burnout.

Implications: This multinational survey will provide insights into the impact of people's homeworking environments during the Covid-19 lockdown on privacy fit, work-related burnout, and levels of musculoskeletal pain. Findings will guide future interventions to support those continuing to work from home in the challenging circumstances of the ongoing Covid-19 pandemic.

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Health Psychology Update invites contributions from all areas of health psychology including experimental and clinical research, the aetiology and management of acute and chronic illness, research into health behaviours and health promotion and psychological aspects of clinical interventions and the health care system.

Articles may provide a broad overview of a particular area or issue, review the literature and may include original research, study protocols and work on teaching, training, consultancy, practical or professional issues. We would also like to encourage the submission of book reviews, short research reports, letters, news of members, work in progress and reviews of health psychology-related events. Brief, 'How to…' pieces on methodological, recruitment, ethical and practical health psychology issues are also encouraged.

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ISSN 0954-2027 03
9 770954 202003