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Helping the Helpers

Adaptation and Evaluation of Stress First Aid for Healthcare Workers in the Veterans Health Administration During the COVID-19 Pandemic

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Abstract: *Background:* Early interventions are needed to support the behavioral health of healthcare staff in the context of the COVID-19 pandemic. Stress First Aid (SFA) is a self-care and peer support model for reducing burnout and stress that is designed for use in high-stress occupations. *Methods*: We conducted a mixed-methods evaluation of an SFA program in the Veterans Health Administration (VHA). This brief, multi-session, didactic program was adapted for hospital workgroups. Program attendees completed a survey assessing implementation outcomes, burnout, stress, mood, and SFA skills at the beginning ($N = 246$) and end ($n = 94$) of the SFA program and a subgroup ($n = 11$) completed qualitative feedback interviews. *Findings*: Program acceptability, appropriateness, and feasibility were rated highly. From pre- to post-SFA, the impact of the pandemic on stress and anxiety, as well as proficiency in supporting peers increased. Qualitative findings suggest the program provided a shared language to discuss stress, normalized stress reactions, met a need for stress management tools, and helped staff feel valued, empowered, connected with each other. Staff reported being more aware of their stress, but SFA was insufficient to address many of the systemic sources of burnout and stress. *Conclusions and Applications to Practice*: While the SFA program was well received, the impact of brief programs is likely to be modest when implemented in the middle of an ongoing pandemic and when burnout arises from chiefly from systemic sources. Lessons learned during the program implementation that may guide future efforts are discussed.

Keywords: stress first aid, burnout, occupational stress, program adaptation, implementation

The COVID-19 pandemic has introduced unprecedented stress on healthcare workers (HCW) globally, such as sustained and repeated exposure to death and critical illness, as well as having to make morally difficult treatment decisions (e.g., Lai et al., 2020). Ongoing challenges such as changing job responsibilities, lack of personal protective medical equipment (Kinman et al., 2020), contracting COVID-19, and fear of transmitting the virus to a loved one have added to HCW stress (Çakmak & Öztürk, 2021; Galanis et al., 2021; Gualano et al., 2021). In addition to pandemic-related stressors, HCW are impacted by issues that predate the pandemic such as ever-increasing expectations of productivity, overload of paperwork and other administrative duties, and less time available for supporting HCW interests that ultimately improve patient care (Zhang et al., 2021).

Specifically, HCW experienced an increase in psychological distress (e.g., De Kock et al., 2021) and burnout (e.g., Chor et al., 2021; Orrù et al., 2021) since the onset of the pandemic. Furthermore, Hennein et al. (2021) found high rates of probable major depression (13.9%), generalized anxiety disorder (15.6%), posttraumatic stress disorder (22.8%), and alcohol use disorder (42.8%) among HCW with higher rates among those reporting lower levels of social support. Sinsky et al., (2021) found that one in three physicians, advance practice providers, and nurses experiencing COVID-19 related stress intended to reduce work hours and that one in five physicians and two in five nurses planned to leave their workplace. Importantly, this study found that feeling valued by their organization was linked to employee retention. Stronger organizational support, social support, and coping self-efficacy can help maintain healthcare workers' psychological health during pandemics (De Brier et al., 2020).

Early interventions have the potential to reduce burnout and stress, build resilience, and mitigate risk of mental health

Applying Findings to Occupational Health Practice

Stress First Aid (SFA) is a flexible model for self-care and peer support that can be adapted into a brief, multi-session, didactic program for hospital workgroups. Participants in Veterans Health Administration (VHA) hospitals found the program acceptable, appropriate and feasible in their work context. Qualitative findings highlighted numerous benefits of the program, such as normalizing stress reactions and helping staff feel valued and connected with each other, but the SFA program was not adequate in addressing systemic sources of stress. Implementing SFA programs systematically as part of work force training or onboarding may be most effective, ideally in conjunction with structural changes to address occupational stress.

problems before more substantial and costly treatment becomes necessary. Stress First Aid (SFA) is a self-care and coworker support model that was derived from Hobfoll et al.'s (2007) five essential elements (Supplemental Information), for use in high-stress occupations such as military, fire/rescue, and law enforcement (Watson & Westphal, 2020). Workers in these settings often have strong values such as selflessness, loyalty, a strong moral code and excellence, which give them strength but also potentially creates vulnerabilities (e.g., prioritizing other's need above one's own; Watson, 2019). SFA offers simple, practical actions to identify and address stress reactions in oneself and others in an ongoing way. It incorporates the five essential elements and includes two additional components to support ongoing stress mitigation. The resulting seven functions of the SFA model are (a) *Check*: check on self and others regularly; (b) *Coordinate*: inform and coordinate with others, including referral to additional care as needed; (c) *Cover*: increase both physical and psychological sense of safety; (d) *Calm*: reduce physiological and emotional arousal with distraction, support, soothing, and replenishing; (e) *Connect*: facilitate or restore social support; (f) *Competence*: bolstering or restoring self-efficacy in occupational, well-being, and social spheres; and (g) *Confidence*: restore self-esteem, confidence in others, meaning, and hope. SFA is designed to provide both immediate and long-term support in the context of chronic stressors. The SFA model was disseminated widely during the pandemic via journal articles (Brower et al., 2021; Conroy et al., 2021; Dowling et al., 2020; Sanford et al., 2021), webinars (Cheek, 2020; Watson, 2020; Westphal & Watson, 2021), and SFA implementation materials on the VA's National Center for PTSD website (Watson & Westphal, 2020).

Mental illness–related stigma can prevent HCW from seeking treatment, even among those experiencing distress (Knaak et al., 2017). The SFA framework (Watson & Westphal, 2020) creates a common, nonstigmatizing language to help staff identify and address stress reactions early, to protect employee well-being and foster longevity in the job. Foundational to SFA is the idea that stress reactions occur on a continuum of severity; in SFA this is referred to as the "stress continuum." The stress continuum helps staff recognize that stress reactions are a normal physiological and psychological response to a stressor and occur on a continuum including green (ready), yellow (reacting), orange (injured), and red (ill) and provides suggested actions to help people move toward wellness (green zone). The continuum aims to help reduce stigma, create a common language about stress reactions, and recognize when SFA actions are needed. The stress continuum highlights that early awareness and response can bring a person back into a less severe stress zone before the need for more formal intervention. SFA also recognizes that occupational stress and trauma are often shared experiences and that efforts to manage these experiences unfold, in part, in the context of mutual support. Perceived social support is associated with adjustment to major stressors and trauma (e.g., Griffith, 2012; Maguen et al., 2006), and group cohesion has a protective effect against the development of posttraumatic stress disorder, even at high levels of stress exposure (Dickstein et al., 2010).

Because SFA is designed for flexible application, empirical evaluation has been challenging. A 2014 firefighter study indicated that while stress indicators did not reduce significantly (possibly because initial stress levels were not substantial), the model was extremely well received, and participants felt their departments were more prepared to provide stress mitigation and support (Jahnke et al., in press). Similar implementation trials in healthcare settings are currently underway (Patient-Centered Outcomes Research Institute, 2022). SFA implementation is consistent with qualitative findings from a Cochrane review regarding work-related resilience interventions in the context of disease outbreak (Pollock et al., 2020). Successful implementation of programs, according to this review, depends upon flexible interventions that are culturally appropriate and adaptable to local needs. Also important are effective communication, cohesion through networks, a positive learning climate where team members feel valued and a part of the change process, and sufficient time and space for reflective thinking and evaluation. The goals of the project were to (a) describe how we adapted the SFA framework into a program for hospital workgroups during the COVID-19 pandemic and (b) summarize our preliminary mixed-methods evaluation of the SFA program and the lessons learned during the initial implementation phase.

Method

Participants

We evaluated the SFA model after initial implementation at four Veterans Health Administration (VHA) facilities and one Veterans Integrated Services Network (VISN) Clinical Resource Hub. Project sites were identified based on interest and with the intent of keeping the scope small for this initial pilot. Sites

included the VA Connecticut Healthcare System ($n = 33$), the Iowa City VA Health Care System ($n = 41$), the Minneapolis VA Health Care System ($n = 84$), the New Jersey VA Health Care System ($n = 38$), and the VISN 19 Clinical Resource Hub ($n = 50$). Sample sizes differed because recruitment was based on interest and our primary aim was to offer the intervention to all interested workgroups with the goal of alleviating pandemic-related work stress and preventing provider burnout.

Participants were recruited by workgroup rather than individually. Facilitators provided information about the program to local workgroups through a variety of methods, including reaching out directly to workgroup leads, presenting at staff meetings, grand rounds, educational lunchtime events, and wellness committee meetings, as well as highlighting the program in regional email newsletters. Participants included nurses who worked in the intensive care unit, dementia care, psychiatric nursing, hospice, homeless care; advanced practice registered nurses; nurse interns; nurse care managers; social workers who worked in mental health and homeless outreach; physicians who worked in primary care, patient aligned care teams, and the non-profit Home Base organization; and patient advocates. Program attendees were invited to complete an anonymous survey at the beginning ($N = 246$) and end ($n = 94$) of the program. Information was not collected on reasons for participant dropout. This study was designated as exempt from the institutional review boards at participating sites.

SFA Program

Based on the SFA model, we developed a brief, multi-session, interactive, didactic program to educate and engage HCW in the SFA model. Foundational components of the SFA model, including the "stress continuum" and the "7 Cs" were adapted into interactive, didactic content and divided for delivery across program sessions. The program typically included eight 20- to 30-min weekly sessions completed either through a teleconferencing platform due to COVID-19 physical distancing restrictions or in-person. Staff from the participating workgroups were invited to attend each SFA program session. The SFA program that we developed was necessarily flexible in its delivery to be responsive to the needs of different workgroups across facilities and at different times in the pandemic. The first session provided an overview of the SFA model, including the "stress continuum" model. The subsequent sessions each covered one of the SFA "7 Cs," which are considered the essential elements for managing stress reactivity in the SFA model.

A handout to facilitate group discussion was developed for each SFA session. Based on feedback from some of the first workgroups to participate in the program, in subsequent groups, sessions were modified to begin with a 5-min mindfulness meditation intended to help participants transition from work into the SFA session by focusing on physical sensations, breathing, aspects of the environment, and/or current thoughts and feelings. The handouts for each of the

"7 Cs" included (a) a brief summary of the element; (b) several questions to stimulate group discussion about how the workgroup was already engaged with that element (e.g., "What are some ways that you have been able to connect with others that have been helpful for you?"), this discussion also allowed the facilitator to reinforce peer support and self-care efforts already in place; (c) A short activity related to the element in question (e.g., Cover: sharing signs of being in the orange zone on the stress continuum, Confidence: sharing a recent success and challenge that was overcome); (d) Brief discussion of additional strategies participants could use to promote the element in question, both for self-care (e.g., "What are new ways your team could encourage Check self-care actions?") and for peer support (e.g., "What are new ways you and your team could encourage Check peer-support actions?"); and (e) Setting a SMART goal (Specific, Measurable, Action-oriented, Realistic, Timetable to complete) for a self-care or peer support action associated with the element in question, to identify barriers and solutions to accomplishing the goal over the coming week, and to rate their confidence in accomplishing the goal.

Measures

Online Survey

Participants completed a 21-item survey before and after the SFA program. Six items assessed participant demographics and one item assessed the proportion of direct care patients with a suspected or known diagnosis of COVID-19.

Three high-loading single items from the Acceptability of Intervention Measure, Intervention Appropriateness Measure, and Feasibility of Intervention Measure (Weiner et al., 2017) assessed implementation outcomes. These items referenced SFA ("Stress First Aid is appealing to me," "Stress First Aid is suitable for my organization," "Stress First Aid seems doable") and were rated on a 5-point Likert-type scale from "completely disagree" to "completely agree." Internal consistency in the current sample was $\alpha = .85$.

Two items obtained from Rodriguez et al., (2020) assessed the impact of the pandemic on stress and anxiety: "How much has the COVID-19 pandemic affected your stress or anxiety levels (in the workplace/at home)?" Internal consistency in the current sample was $\alpha = .77$.

A single item measure was used to assess burnout (Dolan et al., 2015; Schmoldt et al., 1994): "Overall, based on your definition of burnout, how would you rate your level of burnout?" with responses rated on a 5-point Likert-type scale from "I enjoy my work. I have no symptoms of burnout" to "I feel completely burned out and often wonder if I can go on. I am at the point where I may need some changes or may need to seek some sort of help."

Three items from the six-item Mental Component Subscale of the RAND 36-Item Short Form Survey (Ware & Sherbourne, 1992) assessed how much participants felt calm and peaceful (reverse scored), had a lot of energy (reverse scored), and felt downhearted and depressed. Instructions were modified to

inquire about the past 2 weeks and items were rated on a 5-point Likert-type scale from "all of the time" to "none of the time." Internal consistency in the current sample was α = .69.

Two items from a four-item Self-Valuation Scale (Trockel et al., 2019) measured the degree to which participants prioritize well-being and self-care in the context of their professional demands. Included items were "I put off taking care of my own health due to time pressure" and "Taking care of my needs seems incompatible with taking care of my patients' needs." Internal consistency in the current sample was α = .78.

Two single item measures developed by our study team assessed perceptions of being supported by peers: "Members of my team are interested in my wellbeing" and "The leaders on my team are interested in my personal welfare." Internal consistency in the current sample was α = .79. Two items assessed proficiency in supporting peers: "I know how to respond to signs of emotional of psychological distress in my colleagues" and "I do things to support the well-being of my fellow team members at work" rated on a 5-point Likert-type scale from "agree strongly" to "disagree strongly." Internal consistency in the current sample was α = .62.

Please see Supplemental Table 1 for complete details on the survey instrument.

Phone Interviews

A subset of participants (*n* = 11) completed a brief, 15-min phone interview assessing perceptions of program acceptability and feasibility (e.g., "To what extent were you and your workgroup able to integrate SFA into your regular routine?"), perceived program value (e.g., "which parts of the model stand out as being particularly useful to you?"), impact on health and well-being (e.g., "How did the program impact your sense of feeling supported by people in your workgroup?"), and potential enhancements ("How could the program be improved to make it more useful or helpful for you and your workgroup?").

Procedures

The program was delivered by a local facilitator who was a member of the project team and typically employed by the VHA site where they were delivering SFA. Facilitators set the tone for psychological safety to build trust among participants to learn and share in a safe and confidential manner. We used the term "facilitator" given the aforementioned mental health stigma and to reinforce that SFA is not psychotherapy. Facilitators were psychologists, nurses, social workers, and employee assistance program leads who completed a 4-hr training on SFA led by the co-developer of SFA, and project team member, Dr. Patricia Watson.

SFA sessions were scheduled with interested workgroups at an agreed upon time (typically carving out time from a regular staff meeting), frequency (typically once weekly), and with their preferred modality (teleconferencing platform or in person). Local facilitators (one to two per group) implemented the SFA

program as an unfunded collateral duty role. Posters of the stress continuum model and badge cards with the model and an overview of the "7 Cs" were developed and offered to workgroups with the goal of serving as visual reminders that might support sustainment.

Attendance at the SFA program sessions was voluntary and varied across sessions and sites. At the first and last SFA program sessions, facilitators invited participants to complete the 21-item online survey anonymously. At the last session, facilitators invited participants to volunteer to complete a brief phone interview, with the goal of interviewing two to three participants per workgroup. Interested participants shared their contact information with the first author (C.P.M.), who conducted all phone interviews and took detailed notes to record participant responses. The interviews were not audio recorded.

Program implementation began on October 30, 2020 and the program evaluation component (i.e., survey and interview procedures) was completed on April 20, 2021. The Institutional Review Boards at all participating Veteran Affairs hospitals deemed this project to be exempt from review.

Data Analysis

Descriptive analyses were used to characterize the sample and represent frequencies from the survey. Because the survey data were anonymous and could not be matched within participants, we used Mann–Whitney *U* tests to compare the groups before and after the SFA program on the survey outcomes. Qualitative data, which were comprised of detailed notes, including verbatim and paraphrased responses from participants to the interview questions, were reviewed by C.P.M. and C.A.D to inductively identify themes; repeated themes were coded and grouped together and the number of participants reporting each theme was noted. Illustrative quotes were identified for each theme.

Results

Participant characteristics are shown in Table 1. Participants were predominately White, cisgender women. For implementation outcomes, most participants reported that they "Agree" or "Completely Agree" that the SFA program is appealing to them (86.6%), suitable for VA (93.5%), and doable (90.5%). In terms of reported stress and anxiety, most participants reported that the pandemic impacted their stress and anxiety at least "Somewhat" or more before (76.6%) and after (79.6%) SFA. About one-third of participants reported negative mood symptoms "At least some of the time" or more before (31.5%) and after (35.5%) SFA. On self-valuation, most participants reported "At least sometimes" or more having difficulty prioritizing their own health needs before (65.6%) and after (68.1%) SFA. In terms of burnout, most participants reported that they are at least "definitely experiencing burnout" or more before (61.9%) and after (53.2%) SFA.

Table 1. Participant Demographics

Variable	Participants	Pre-SFA n = 246[a] n (%)	Post-SFA n = 94[a] n (%)
Age	18–25	4 (1.6%)	6 (6.4%)
	26–35	53 (21.6%)	19 (20.2%)
	36–45	58 (34.6%)	29 (30.9%)
	46–55	62 (25.2%)	24 (25.5%)
	56–65	35 (14.2%)	13 (13.8%)
	66+	6 (2.4%)	1 (1.1%)
Gender	Cisgender men	50 (20.3%)	17 (18.1%)
	Cisgender women	194 (78.9%)	76 (80.9%)
	Non-binary	1 (0.4%)	0 (0.0%)
Race[b]	White	201 (81.7%)	68 (72.3%)
	Black or African American	21 (8.5%)	13 (13.8%)
	Asian	16 (6.5%)	9 (9.6%)
	American Indian or Alaska Native	5 (2.0%)	0 (0.0%)
	Another racial identity	4 (1.6%)	3 (3.2%)
Ethnicity	Hispanic or Latinx	17 (6.9%)	6 (6.4%)
Living situation[c]	Single	45 (18.3%)	18 (19.1%)
	Roommate	9 (3.7%)	7 (7.4%)
	Partner/Spouse	175 (71.1%)	60 (63.8%)
	Adult children	20 (8.1%)	10 (10.6%)
	School age children	82 (33.3%)	30 (31.9%)
	Aging parents	8 (3.3%)	4 (4.3%)
	Dependent other	12 (4.9%)	3 (3.2%)
COVID-19 patients	1%–5%	100 (40.7%)	36 (38.3%)
	6%–10%	71 (28.9%)	28 (29.8%)
	None	50 (20.3%)	20 (21.3%)
	15%+[b]	22 (8.9%)	7 (7.4%)

SFA = Stress First Aid.
[a] Respondents were not required to answer all questions, so numbers within categories do not always sum to the total number of participants.
[b] Respondents could select more than one response option. [c] Majority of written responses indicated greater than 50% of their patients were COVID-19 positive.

Table 2. Comparison of the Program Outcomes Before and After the SFA Program

Variables	Pre-SFA *n* = 246 (%)	Post-SFA *n*= 94 (%)	Pre–Post Difference (Mann–Whitney *U*)
Stress and Anxiety			
Pandemic impacted my stress and anxiety at least somewhat or more	76.6	79.6	9,739.50*
Mood			
Negative mood at least some of the time or more	31.5	35.5	11,103.50
Self-valuation			
Difficulty prioritizing my own health at least sometimes or more	65.6	68.1	10,955.00
Burnout	61.9	53.2	11,420.50
SFA			
Agree somewhat or agree strongly that: Colleagues are interested in my well-being	73.1	89.4	10,375.50
I know how to support my colleagues	64.5	61.3	9,123.00**

Note. NS = not significant *p* > .05. SFA = Stress First Aid.
**p* < .05. ***p* < .01.

On the program specific outcomes, most participants reported that they "Agree somewhat" or "Agree strongly" that their colleagues are interested in their well-being (i.e., perceived social support) before (64.5%) and after (61.3%) SFA. Finally, most participants also reported that they "Agree somewhat" or "Agree strongly" that they are proficient in providing support to their colleagues before (73.1%) and after (89.4%) SFA.

The impact of the pandemic on stress and anxiety was higher among those who completed the post-SFA survey than those who completed the pre-SFA survey, $U(244) = 9739.50$, $p = .039$. Proficiency in supporting peers was also higher in the post-SFA group than the pre-SFA group, $U(245) = 9123.00$, $p = .002$. Burnout, mood, valuation, and perceptions of peer support were not different at the two time points ($\geq.197$) (Table 2)

Qualitative Interview Data

Qualitative themes and illustrative quotes are depicted in Table 3. These data indicate that SFA helped participants be more aware of signs of stress, develop a shared language for discussing stress, and helped normalize the experience of stress. Participants hoped SFA would meet a need for stress management tools and receiving the program made them feel valued as employees. The program helped participants feel empowered to manage their well-being and an increased connection with their fellow workgroup staff. The program was also perceived as insufficient to adequately shift the work culture long-term or address organizational sources of stress.

Discussion

This project demonstrates the feasibility of implementing a SFA program for VA staff. The program was acceptable to participants, as evidenced by the qualitative feedback and the implementation data. All interviewed participants reported that there was a high need for this type of program and that they would recommend the program to other VA workgroups. In fact, some participants indicated that SFA would have been more impactful if it had been in place prior to the start of the pandemic and that it was unfortunate that it took a global pandemic for them to receive this type of support. HCW have always faced significant workplace stressors, but the ongoing pandemic has exacerbated acute and chronic stressors and exposed cracks in under-supported systems.

Both the quantitative and qualitative findings from this evaluation suggest that the SFA program helped staff feel better prepared to identify and respond to their coworker's distress. This finding is important, given that peer support has been found to impact adjustment to stressors (e.g., De Brier et al., 2020; Griffith, 2012; Maguen et al., 2006) and may be protective against the development of psychopathology (Dickstein et al., 2010). An important component of this program was the group format, which allowed for sharing of ideas and modeling of peer support. Participants felt more aware of the impact of stress and how to manage it, and that the program normalized experiencing stress. Participants felt that SFA gave their team a shared language to talk to each other about stress and

Table 3. Description of Qualitative Themes and Illustrative Quotes

Description of qualitative themes	Illustrative quotes
SFA provided a *Shared Language* to talk about stress within their workgroups. Referencing the stress continuum model in particular, participants valued having an easy way to communicate with their peers about stress.	"Shared verbiage within the team is really beneficial so we can communicate with a similar understanding."
The program helped *Normalize* the experience of stress and the difficulties managing stress in the context of occupational demands and the uncertainties and challenges of the pandemic. Participants reported that hearing peers and leadership (team leaders often participated in the group) disclose stressors similar to their own promoted a sense of commonality and an opportunity to share ideas for managing stress and supporting one another.	"We've since had some really challenging situations come up and I think it's helped us come together and support each other and gave us permission to say we aren't doing."
Participants were excited to receive the SFA intervention because they anticipated that it would *Meet a Need*. They reported wanting additional tools to manage their current stress and believed that SFA could provide those tools.	"I was super excited for it because I was really stressed out to the point of dragging myself to work so it would be good to vent and learn new skills."
Participants felt that receiving the program made them feel *Valued* as employees.	"It was powerful to know that my supervisor thought this was important enough to approve and spend time on."
Through discussion of self-care and peer-support ideas, participants felt *Empowered* to manage their well-being and support their peers.	"I take care of everyone 24/7, so it was nice to have tangible actionable things I could do to take care of myself."
Participants experienced *Increased Connection* with their colleagues. Specifically, they noted a shift in the workgroup culture where checking in with each other became part of their routine.	"I am now more apt to reach out to colleagues who were in the training."
The program made participants more *Aware* of their stress and the signs of stress in themselves and their peers.	"It helped me be more aware because I didn't think much about stress and then I'd get really stressed so this helps me better understand."
The program was *Insufficient*. Participants discussed wanting more in depth SFA training and having SFA imbedded into their work culture rather than a time-limited program that lacked meaningful scaffolding to promote sustainment. Participants also reported wanting to have learned SFA earlier in the pandemic or as part of their employment onboarding	"Twenty minutes was really rushed to try to learn things and practice them. . . at least we got something though." "I was really frustrated that we got this at the end of a horrible time. It would have been incredibly beneficial to have gotten this earlier. It was too late. Many people already left the ward."

SFA = Stress First Aid.

permission to check in on each other regularly. This suggests that the SFA program was successful in helping to shift workplace norms about discussion and stress management. It also appeared to be successful in meeting an immediate need for emotional support among HCW faced with significant stressors at work and at home during a pandemic.

Quantitative data showed no changes on burnout, mood, self-valuation, or perceptions of support, but did show an increase in the perceived impact of the pandemic on stress and anxiety. It may be that this relatively light-touch intervention was insufficient to impact these outcomes, however, the lack of a control group and presence of a large historical effect (ongoing pandemic) makes it difficult to draw conclusions. It may be unlikely that a brief program targeting employees can impact organizational problems such as burnout in the absence of more systemic change. Indeed, a recent study of mental health providers revealed three major themes that might reduce burnout: (a) shifting work culture to prioritize person-centered

care as opposed to productivity and metrics, (b) management practices to overcome bureaucracy, and (c) opportunities for growth and self-care (Rollins et al., 2021). In addition, a synthesis of systematic reviews suggested that a genuine interest in staff well-being, accessibility of support, autonomy over time and content of work, regulated working hours, adequate staffing, and meaningful recognition may improve resilience in healthcare organizations (Kunzler et al., 2020). To a degree, the SFA program helped participants feel valued as employees and provided an opportunity for self-care. However, as noted, many participants also felt that it was insufficient and plans to sustain positive effects of the program differed across groups (e.g., training an in-house SFA champion, planning self-guided SFA booster sessions).

There were several important lessons learned during the adaptation and implementation of this program. One was the importance of protected time for HCW to participate in SFA whenever possible. This was a practical concern, as staff were sometimes called away for patient care during the brief sessions. The day and time of the session was also an important factor to consider when delivering SFA (e.g., not scheduling during lunch breaks or immediately prior to the end of the work week). There was also a psychological impact on participants who reported that the fact that their leadership provided protected time for SFA made them feel valued as employees. Another lesson learned was the importance of making program participation voluntary both in terms of attending the sessions as well as participating (e.g., turning on their camera, sharing via chat or speaker) to promote psychological safety. A final lesson learned was the value of implementing a brief supervisor needs assessment to understand the group's dynamics and any major stressors impacting the team prior to initiating SFA. Facilitators hypothesize that performing a supervisor needs assessment, reaffirming psychological safety and the group's collective strengths throughout, and using a more flexible model of SFA helped to increase in group engagement.

This was not a systematic evaluation. Rather, our primary goal was to support HCW and secondarily to collect data that may inform future efforts to support staff in the context on chronic stressors. The SFA program described here was adapted from the SFA model and implemented while it was being refined iteratively across a range of VA workgroups. There was variation in the workgroup size and composition, modality and structure of program delivery, the number and role of the facilitators, and many other variables. In addition, the pandemic context (restrictions, COVID-19 case count, hospital capacity, etc.) differed across VA facilities, which were geographically dispersed, and across time, as the pandemic waxed and waned. Not all program participants completed the surveys, and fewer completed the post-SFA survey than the pre-SFA survey. Because the surveys were anonymous, we were unable to link the surveys over time. In addition, data on participant attendance at SFA sessions was not systematically collected. The number of surveys completed underestimates session attendance, but we are unable to quantify this discrepancy.

The SFA program was well-received by participants. Proficiency in providing peer support improved over the course of the program, and the program gave workgroups a shared language to discuss stress reactions and helped shift team norms around stress disclosure. It also helped them to feel more aware of their stress reactions and empowered to care for themselves and support their peers. Other measured outcomes, including burnout, did not change, and the impact of the pandemic on stress and anxiety worsened, highlighting the challenges of addressing stress reactions while an unprecedented global pandemic is still unfolding. Despite the overall positive reception, many perceived the program as "too little too late."

Implications for Practice

Delivering a brief group SFA program targeting self-care and peer support appears to be feasible and acceptable to hospital staff. The program was valued for its ability to (a) create a shared language to discuss stress reactions, (b) shift team norms around stress awareness and disclosure, and (c) empower staff to care for themselves and support their peers. SFA's ability to help staff feel better prepared to support each other is important because social support is a strong protective factor in adjustment to stressors (e.g., De Brier et al., 2020; Griffith, 2012) and may protect against the development of psychopathology (Dickstein et al., 2010). Stress and burnout are multi-faceted institutional problems, and the impact of programs like SFA is likely to be modest when implemented in the middle of an ongoing pandemic, and in the absence of structural changes. It is recommended that programs like SFA that seek to change the culture regarding awareness, disclosure, and support for stress reactions be introduced early in medical careers and/or as part of staff onboarding, incorporated in an ongoing way into the culture of healthcare, and championed by leadership across the course of healthcare workers' careers, with extra support brought forward during public health crises like pandemics.

Authors' Note

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Supplemental Material

Supplemental material for this article is available online.

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