

Coordinating a trauma-informed response to COVID 19 - What, why and how?

These are, as we keep hearing, unprecedented times. We have not in recent history dealt with a healthcare crisis on such a global scale. None of us can say with any certainty how many people will be affected by the crisis or in what ways. However, we do know that frontline healthcare workers are going to be exposed to many traumatic experiences which confer a high risk of adverse mental health outcomes. We also know that certain forms of support are likely to be helpful, and we also know that, although well-intentioned, other forms could cause harm. At such times of uncertainty, it is vital to provide a coordinated, evidence-based and trauma-informed response to the COVID-19 crisis.

Whilst we cannot know with any certainty what will happen in the next few weeks and months, we can draw on existing research, access expert clinical opinion and learn from our colleagues around the world who have been living through this crisis a few weeks ahead of us.

We know that **healthcare staff face a direct threat to their own lives** (primary traumatic exposure) whilst treating severely ill patients, often without sufficient personal protective equipment (PPE). Witnessing the suffering, death and bereavement of others (secondary traumatic exposure) is an inevitable part of their work. Healthcare professionals may also be affected by their own losses during this time.

We know that **healthcare workers are at risk of developing mental health difficulties** including stress, burnout and PTSD. Estimates from previous epidemics suggest up to a third of staff will experience high levels of distress.

We know that high levels of severe clinical need and limited resources will mean that **healthcare workers will face moral dilemmas in their clinical work** and that this may evoke feelings of distress. Moral injury has been defined as the psychological distress caused by actions, or inactions, which violate an individual's moral code. Moral injury is not in itself a mental disorder but is a risk factor for a range of mental health problems including PTSD and increased suicidality. It is very likely that the nature of the decisions that healthcare professionals will have to make in the coming weeks and months confer a high risk of moral injury.

We also know that **people are resilient**. Despite the huge physical and psychological demands being placed on staff, most will cope and most will recover. Nonetheless, we need to support people's natural coping mechanisms, enhance team spirit and acknowledge that in the current crisis many people's usual coping mechanisms and outlets for stress may be limited. People who chose to work in these professions have usually developed resilience to the demands of their work over their careers. However, we know that people who are early on in their careers and are less experienced, including student nurses and junior doctors, may be at increased risk of stress, distress and PTSD, as are colleagues at the other extreme, who may become overwhelmed by a cumulation of stressful events.

We know that **positive social support is one of the most well-established protective factors in mitigating the risk of many mental health issues**. However, in the current crisis people's ability to access social support is significantly impacted by social distancing and quarantine measures. For many frontline healthcare professionals this is exacerbated by them self-isolating from their families whilst working. We also know that adequate time and opportunity to mentally process stressful and traumatic experiences after they have happened is important, and **adequate sleep is vital for the normal processing of memories**. However, we also know that many healthcare professionals' working patterns, with long shifts and only brief periods for rest significantly compromises this.

We know that **a phase-based response is likely to be most helpful**. In the early phase of this health crisis, the most helpful support will involve ensuring that staff are physically safe including having access to adequate personal protective equipment (PPE), rest, food and appropriate psychological support. As the crisis progresses, staff will benefit from continued careful assessment, active monitoring of their mental health and wellbeing, and ensuring they have access to psychological support from appropriately trained and supervised practitioners. As the crisis wanes, there will most likely be a need for more formal psychological intervention for some.

It is important for us to be aware of **what we don't know**. We need to rapidly develop guidance which draws on existing evidence and best practice recommendations. We need to canvass expert clinical opinion and we need to learn from the experiences of our global colleagues. Our guidance needs to be 'trauma-informed' in that we recognise that certain events are particularly stressful and may be psychologically traumatic. We need to adapt our guidance and interventions as the situation evolves.

We know that **good quality research will be needed** to evaluate psychological distress and coping in different groups and the effectiveness of any interventions in the longer term. We will need to coordinate our efforts to answer these questions and generate this knowledge.

The COVID trauma response working group

The COVID trauma response working group has been set up to collate, disseminate and produce immediately accessible, evidence-based and trauma-informed guidance on the psychological response to COVID 19. We are made up of specialist trauma researchers and clinicians from across UK universities and National Health Services. The working group is coordinated by staff in the Institute of Mental Health at University College London and the Traumatic Stress Clinic in Camden & Islington NHS Trust. All of our resources are freely available at www.trauma.group.org.

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