ORIGINAL ARTICLE

# Trauma-informed mental health practice during COVID-19: Reflections from a Community of Practice initiative

**Davi Manzini Macedo,**[1] (iD) **Julie-Anne Reilly,**[2] **Sophie Pettit,**[2] **Carmen Negoita,**[2]
**Laura Ruth,**[2] **Elizabeth Cox,**[2] **Rima Staugas**[2] (iD) **and Nicholas Procter**[1]

[1]*University of South Australia's Mental Health and Suicide Prevention Research and Education Group, and* [2]*Royal Adelaide Hospital Mental Health Short Stay Unit, South Australia, Adelaide, Australia*

**ABSTRACT:** *This article discusses insights arising from a Community of Practice (CoP) initiative within a mental health short stay inpatient unit adjacent to a major Emergency Department to explore how COVID-19 has influenced engagement and support of people in mental distress. The present initiative was designed as a collaboration between the University of South Australia and SA Health. Community of Practice (CoP) is combined with a narrative review of current evidence to explain specific nursing care responses within an operating environment of pandemic-induced fear and uncertainty. Meetings discussed the challenges associated with delivering mental health care for people experiencing mental health distress in the COVID-19 context. Applying trauma-informed principles to mental health care delivery was identified to be of relevance in the context of an ongoing pandemic. Humanizing nursing care and increasing people's sense of predictability and safety contributed to therapeutic engagement and support during COVID-19. Factors discussed to mitigate the effects of safety measures include, for example, nuanced verbal and non-verbal engagement of health workers with people in mental distress when wearing personal protective equipment (PPE). We highlight the need to 'humanise' nursing and openly communicating that both practitioners and people in distress are navigating special circumstances. The CoP participants additionally acknowledged that the experience of moral distress among frontline health workers needs to be addressed in future policy responses to COVID-19. Person-centred and trauma-informed responses at the point of care might help to mitigate the pandemic short- and long-term effects for both service users and frontline health workers.*

**Correspondence:** Davi Manzini Macedo, Mental Health and Suicide Prevention Research and Education Group, UniSA Clinical and Health Sciences University of South Australia, GPO Box 2471, Adelaide SA 5001, Australia.
Email: davi.macedo@unisa.edu.au
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Davi Manzini Macedo, PhD.
Julie-Anne Reilly, BNurs.
Sophie Pettit, BNurs.
Carmen Negoita, BNurs.
Laura Ruth, BSW.
Elizabeth Cox, BSW.
Rima Staugas, M.D.
Nicholas Procter, PhD.

## AIMS

The aim of this Discursive paper was to explore the experience of the authors as mental health professionals supporting people presenting to a hospital Emergency Department during the initial stages of the COVID-19 pandemic. A Community of Practice (CoP) methodology was used to synthesize the author's clinical experience at the point of care for people in acute mental health and suicidal distress. A person-centred and trauma-informed lens was used to analyse the perceived challenges and practical actions adopted to support people experiencing mental health crisis. The authors propose strategies that have the potential to assist people in mental health distress in the context of pandemics. Driven by the context of COVID-19, people experiencing acute mental health crisis are supported by practitioners who themselves adapt to current circumstances.

## BACKGROUND

### The effects of COVID-19 on population mental health

The spread of the coronavirus SARS-CoV-2 causing Coronavirus (COVID-19) has affected the lives of millions of people worldwide. In January 2020, the World Health Organization (WHO) declared the COVID-19 outbreak to be a public health emergency of international concern, WHO's highest level of alarm. By March 2020, WHO had assigned to COVID-19 the status of pandemic, mobilizing resources and taking action to contain its spread. The effects of the pandemic on the mental health and wellbeing of the population have been documented. Examples of the impairment on mental health are the observed increases in generalized anxiety, depression, loneliness, psychological distress, and poor sleep quality (Huang & Zhao 2020; O'Connor *et al*. 2020; Xiong *et al*. 2020). Specific risk factors for mental health distress exacerbated by COVID-19 include: fear and anxiety about infection and the aftermath consequences of the pandemic; prolonged experience of stress and uncertainty due to intermittent lockdown measures; financial stress due to reduced working hours or unemployment; loneliness; anger; confusion; social isolation, and limited access to healthcare services and mental health support (Brooks *et al*. 2020).

### Trauma-informed practice and mental health care during COVID-19

Trauma-informed practice involves awareness of the incidence of trauma in the population, its effects on mental health, and acknowledging the need to avoid re-traumatization during care delivery (Javakhishvili *et al*. 2020). Trauma-informed practice is built upon the understanding that mental health distress can be trauma-driven and challenging behaviours may be expressions of coping strategies developed to manage the impact of traumatic experiences (Procter *et al*. 2017). Health workers and people's relationship can be considered one of the main factors influencing either trauma recovery or re-traumatization (Miller & Najavits 2012). Based on the perception of people receiving care, recommendations for trauma-informed practice include active initiatives to build trust and increase safety, trustworthiness, and transparency, investing on consistency and continuation of care, and promotion of empowerment, flexibility, and choice (Isobel *et al*. 2021; Procter *et al*. 2017).

The COVID-19 pandemic can be perceived itself as traumatic due to not only the threat of contracting a potentially lethal viral disease but the associated deterioration of livelihood, restriction of social contacts, and initial uncertainty around the efficacy of infection control measures (Javakhishvili *et al*. 2020). Moreover, it increases exposure to traumatic events such as maltreatment and family violence, lack of predictability and control, and loss of income, which can be further aggravated by poor access to social networks and professional support (Collin-Vézina *et al*. 2020). On such basis, the European Society for Traumatic Stress Studies has recommended the observation of trauma-informed principles in responding to the immediate and aftermath periods of the pandemic. The society states that trauma-informed policies, strategies, and practices can contribute to mitigate the effects of COVID-19 on population mental health and support

the recovery of affected individuals, families, communities, and societies (Javakhishvili *et al.* 2020). A significant challenge in implementing trauma-informed care (TIC), however, is the lack of clarity on how to translate these principles into practice (Isobel 2016).

Observation of principles of trauma-informed practice has been found useful in the author's experience of supporting people affected by COVID-19. The limited interpersonal contact imposed by the pandemic safety requirements can limit perception of a warm and empathic care response, compromising de-escalation of mental health distress. Besides worsening previous mental health conditions, stressors combined with lack of social, professional, and financial support were experienced as unendurable and unsustainable by people presenting to hospital in mental health crisis. Due to disruptions in the care delivery routine prompted by COVID-19, strategies to provide for the needs of people in mental health distress needed to be revisited. Based on the potential of trauma-informed practice in supporting the recovery of people experiencing mental health distress in the context of pandemics (Javakhishvili *et al.* 2020), the authors reflect on their own experience of care delivery to discuss perceived challenges and propose potential recommendations on how these principles can be translated into practice during the context of pandemics.

## DESIGN

This discussion paper draws from clinicians' insight on responding to acute mental health distress during the onset of COVID-19 raised during a Community of Practice (CoP) initiative. CoP involves the coming together of people who don't necessarily work alongside each other every day, however might find value and meaning in sharing their professional experience and being supportive. When promoted in the healthcare sector, CoP holds a great potential for facilitating clinician-led practice changes (Ranmuthugala *et al.* 2011). CoP consists of creating a safe space for dialogue where people who share a concern or set of problems can increase their expertise or problem-solving by interacting on an ongoing basis (Wenger 1998). A CoP may be organized by professionals interested in quality improvement or can similarly be suggested by an external organization, such as University Department (Jiwa *et al.* 2011).

The present initiative aimed at exploring perceived challenges and helpful strategies identified by health workers in supporting people in mental health distress

presenting to a hospital Emergency Department during the COVID-19 pandemic. Due to the potential traumatic impact of COVID-19 and recommendations from bodies of reference on trauma-informed practice (Javakhishvili *et al.* 2020), a trauma-informed lens was adopted to reflect on the practical actions and strategies to de-escalate mental health distress and prevent trauma-based responses identified. The participants of this series of CoP meetings are the authors in this paper. More specifically, this initiative was designed as a collaboration led by Author 2 and Author 8 between the University of South Australia and SA Health. The key features of this CoP are that it is nurse led, has a voluntary membership, and is interdisciplinary. As to facilitate the translation of TIC principles into practice, the lived experience of nurses in responding to mental health distress during COVID-19 is used to facilitate the identification of practical actions to support recovery and prevent that the effects of trauma go unnoticed.

## METHODS

The CoP meetings occurred within a mental health short stay inpatient unit adjacent to a major Emergency Department to explore how COVID-19 has influenced engagement and support of people in mental distress. Meetings discussed the changes in practice and challenges associated with delivering mental health care for people experiencing mental health crisis in the COVID-19 context. A total of six meetings were held between January and July 2021 involving all authors. The meetings were centred at discussing perceived challenges and adaptations to delivering mental health care during COVID-19. After identifying a common problem or compelling topic, members engaged in detailed discussions over the next meetings. As a Discursive paper, this study presents the insights and perspectives of the authors. To potentialize the validity of the findings, the content of the CoP discussions was summarized and categorized using thematic analyses principles (Braun & Clark 2006) to identify patterns in the experience of clinicians.

The practical recommendations discussed – more specifically – were subsequently categorized based on trauma-informed practice principles. A deductive approach was used to categorize the recommendations based on principles the authors considered relevant to trauma-informed mental health care in the context of a pandemic. A first draft with recommendations was circulated by Authors 1 and 8 for feedback; further

discussion rounds were run to help unfold participants' perception on key areas for intervention, methods to approach issues, and designing final practical recommendations to achieve desired outcomes. Therefore, the authors' (Authors 2–7) experiences as health professionals' are synthesized to offer a first-hand input into responding to mental health distress at a hospital mental health short stay unit during the onset of the COVID-19 pandemic. The authors prioritized presenting the recommendations on a Table format for a better understanding of how the principles are applied. Literature findings were integrated with the conclusions presented aiming at drawing a parallel with the direct experience of clinicians responding to acute mental health distress during the onset of COVID-19.

This piece is proposed as a reflection on the authors' own experience in responding to mental health distress in the context of pandemic. We acknowledge its limitation as it might not represent the general experience of mental health workers responding to mental health distress or that of all people presenting to hospital Emergency Departments during the COVID-19 pandemic. The lack of clarity on how to translate principle of trauma-informed practice into practice has been noticed in the literature (Champine et al. 2019; Isobel 2016). The discussion herein presented aims at synthesizing practical recommendations based on principles of trauma-informed care (TIC) that have the potential to humanize care delivery, prevent the long-lasting impact of trauma, and improve the experience of those receiving care.

As a partnership between The University of South Australia and SA Health, the CoP initiative was regulated by the signing of a Standard Goods and Services Agreement. The original initiative aimed at offering mental health workers a space to share experiences and build communal understanding and to identify potential solutions for challenges experienced in the work context. The results of these discussions are presented herein as a product of the authors' experience. No ethical approval was deemed necessary for the execution of this project. Participants were informed of the voluntary nature of the CoP and their right to withdraw at any time.

## CONCLUSIONS

The content of the discussions held in the Community of Practice (CoP) meetings was classified into two main categories: 1) Challenges in mental health care delivery in the COVID-19 context and 2) applying principles of

trauma-informed practice during the COVID-19 pandemic. The challenges identified by the authors as mental health professionals are explored and strategies identified to mitigate its impact for both professionals and people receiving care follow. Each section is presented alongside literature on the development of mental health care in the context of COVID-19 so as to contribute to the validity of the findings herein presented. The clinical relevance of the discussions and limitations of the design implemented are explored subsequently.

## Challenges in mental health care delivery in the COVID-19 context

### Maintaining a therapeutic relationship – 'Organic' versus 'mechanic' approaches

Due to COVID-19 containment measures, it was identified the need to adapt care delivery to what was considered to be a 'fragmented' form of care. Since mental health care delivery is centred around building up relationships, every day-to-day interaction is potentially therapeutic. Nevertheless, a significant change in practice was the need to deliver care in a procedural and manufactured way. For example, health workers had to instruct people to hold their distress whilst complying with social distancing and other COVID safety measures. That immediacy inherent to professional practice was gone.

Empathy towards individuals at the point of care is routinely expressed through non-verbal language, proximity, and immediate response. In the author's experience, the limitations imposed by COVID-19 safety procedures limited the communication of empathy and understanding and imposed new challenges for the development of trust between health workers and patients. Adapting to these new circumstances was challenging at first and health workers reported not feeling sure whether care delivery quality was up to previous standards. It increased worker's anxiety and decreased the work environment morale, as workers did not want to 'leave everyone on their own'. At this point, the authors experienced a sense of limited control over care delivery procedures and outcomes. The need to adequate care delivery was noticed as trauma-driven responses (e.g. increased sense of alarm, anxiety, worry, rumination) were observed to increase in the ward. Additionally, it was challenging being prevented from including significant others in the care delivery process. Health workers feeling overwhelmed for not being able to include carers in recovery and often

seeing service users decease in the absence of their loved ones has been documented (Daubman *et al*. 2020). Adapting care to the context of COVID-19 was distressing in many ways, contributing to potential experience of moral distress (Godshall 2021), as further explored below.

Moral distress experienced by health workers – Serving the community versus individual and family safety

The uncertainty in the COVID-19 infection pathways and its consequences also affected health workers' sense of safety. Health workers in the CoP noticed feeling ambivalent about commitment to serve the community and the safety of their families. Workers reported struggling with thoughts such as 'Wait a moment my family matters as well'. This was experienced with ambivalence as mental health care is around providing compassionate and person-centred care. It was very anxiety-provoking for workers to know that their work was necessary, and people needed them, but they were also very concerned about their own safety. As the pandemic unfolded, workers reported having noticed colleagues who lost loved ones as a result of the virus trying to manage their distress. This further brought up the realization that the risk was real and near. This perception of risk was likewise amplified by lack of personal protective equipment (PPE) at the early stages of the pandemic and uncertainty around its efficacy in preventing infections. Health workers were experiencing limited sense of control over care delivery procedures and outcomes, increasing their vulnerability to trauma-driven responses.

The effects of COVID-19 perceived threat on the mental health of health workers have been documented. More specifically, higher perceived threat would be associated with higher levels of somatic symptoms, socially dysfunctional behaviour, anxiety, insomnia, and depression in nurses actively employed during the pandemic (Gazquez Linares *et al*. 2021). The term moral distress can be defined as the psychological impact resultant from making or witnessing decisions that are contrary to one's core moral values (Jameton 1984; Morley *et al*. 2019). If moral distress is sustained it can lead to burnout or psychological trauma. Similar to the experiences we described, COVID-19 has been reported to have amplified moral distress in healthcare delivery. Sources of moral distress in this context can be triaging scarce resources (e.g. ventilatory support), making ethical decisions without appropriate support, and not providing access to important social and emotional support due to infection control measures (Sheather & Fidler 2021). Additionally, health professionals' personal safety is implicated, due to risks of contamination of themselves and their extended social network (Ashley *et al*. 2021).

## Applying principles of trauma-informed practice during the COVID-19 pandemic

Humanizing care – Offering a sense of safety, predictability, empathy, and choice

In the CoP discussions, it was emphasized the need to humanize care to circumvent the limitations and challenges imposed by the COVID safety protocols. Overall, it was highlighted the need to invest in non-verbal communication to transmit a sense of connection and empathy during care delivery. Workers identified that the overall uncertainty related to the duration of the pandemic, poor understanding around efficacy of safety measures, and changes in care delivery routines could be experiencing as triggering or retraumatizing for consumers. Participants thus attempted to foster the therapeutic relationship by trying to highlight the 'glimpse of the human person' delivering care. The importance of maintaining eye contact was identified to be one of our primary strategies. This needed to be maintained especially in the presence of PPE.

In order to further humanize contact and de-escalate stress, workers would present without PPE through a glass window first, introducing themselves as those responsible for delivering care. At this moment, providing a sense of structure and predictability would be helpful (e.g. 'My name is [X] and I am the mental health nurse who will be taking care of you today. This is how I look. In a minute, I will return and will look different with a mask and PPE'). Affirmations such as 'I am actually smiling behind this mask; I know you cannot see it too much' were also identified as a way of humanizing care. It was about emphasizing the human experience both workers and consumers shared in an empathetic way. Transmitting a sense of structure and predictability by making clear what would be happening at each point of care was another helpful strategy to increase connection between service user and health worker.

Beyond, it would be helpful in transmitting a sense of hope that, despite the challenges offered by COVID-19, all parts were in this together and could work collaboratively towards recovery ('We are in this together, we are feeling it too'). Considering how trauma might trigger fear-processing areas of the brain,

further humanizing of care at this point would involve validating emotions by acknowledging that anxiety and fear are expected emotions due to the 'strangeness' of circumstances. Workers also found it important to clarify that the pandemic has necessitated services and service providers to adopt new procedures not typically seen in mental health settings, such as the physical distancing requirements and use of PPE.

Another trauma-informed principle the CoP participants tried to advocate for was flexibility and choice. In the authors' experience, forced choices or absence of choice can increase people's perception of lack of control, increasing sense of unsafety. As much as social distancing measures imposed limitations, workers reported attempting to give people choices over whichever options were available to support their recovery. As people were admitted for longer periods of time, intervention was less focused on Safety Planning (used to support people experiencing acute suicidal distress) and more on distress tolerance techniques to be used in site and potentially after discharge. There was a need to focus on helping them to develop self-management skills to decrease stress, always emphasizing the person's right to make choices over their recovery journey.

Managing follow-up after discharge was another challenge. Care delivery in the community during COVID-19 had to be adapted to social distancing measures. For some service users, engaging with tele-health consultations was evaluated to be problematic and caused people to disengage from treatment. Limitations to access tele-health services might include lack of physical space for sessions, fear of stigma from others in the household, or associated risk for those experiencing interpersonal violence (Zemlak *et al.* 2021). In this manner, workers had to actively pursue links to make sure people were supported in the community, despite treatment options being limited. Being reflective that community services were not always able to follow people and provide support, it was important to be transparent about the limited options available. However, transmitting that consideration was given to consumers' right for choice when discussing options was therapeutic per se. Detailed trauma-informed practical actions for providing mental health care in the COVID-19 context are summarized in Table 1.

Coping strategies developed by health workers
Trauma-informed principles need also to be observed for the safety and wellbeing of health workers. To buffer the effects of COVID-19-related stressors, team members found it helpful to debrief with each other regularly. Having a safe space to discuss struggles with uncertainty and internal conflicts was fundamental. The principles of empathy and validation also apply to managing workers' own mental health and wellbeing. Understanding one's limitations and acknowledging these during challenging times was helpful. Moreover, peer support provided by one health worker to another was essential in learning how to navigate these unprecedented circumstances. Communication technology evidently was an important tool for building up such support network as containment measures were in place. Organizing technology-assisted activities in the unit to bond workers and the people receiving care was helpful. Building stronger teams and allowing for debriefs which lessen tensions was another helpful by-product of the necessity for limiting staff interaction and exposures. This continued beyond the COVID crises. Finally, the benefits of building up collective coping skills have been noted in the literature. Participants of a qualitative study on the impact of COVID-19 on health worker's mental health suggested a similar collective activity: the creation of a box of resources to help with de-escalation. Workers would call the 'code lavender' when feeling overwhelmed so they would access resources and receive support (Ashley *et al.* 2021).

## RELEVANCE TO CLINICAL PRACTICE

Based on the authors' experience, applying trauma-informed principles to mental health care delivery during COVID-19 offered practical tools to assist both workers and people in distress with individual coping. The effects of moral distress and efficacy of the proposed coping mechanisms need to be acknowledged and expanded so frontline health workers can be better prepared to face future circumstances similar to the COVID-19 pandemic (Godshall 2021). As those who are at the forefront of responding to mental health distress – which might include suicide-related distress – in a scenario of risk, assuring that health workers' mental health and wellbeing is not overlooked is of public health interest.

Application of trauma-informed principles to the COVID-19 context was considered to assist in building strong therapeutic relationships and help people to de-escalate when in distress. In the workers' experience, offering a sense of control and perception of safety was the most immediate principle to be observed and applied. Through presenting themselves without PPE

**TABLE 1** *Trauma-informed practical actions for providing mental health care in the COVID-19 context*

| Offer a sense of predictability and structure | • Due to the unpredictability associated to a new disease or variant, people are likely to need and value a sense of structure and predictability. Consider that people need to know what is happening and when |
|---|---|
| | • Try to offer a sense of structure to daily care routines and explain each step taken. Normalize routine activities such as probing for infection and delivering medication |
| Instil sense of safety | • Acknowledge that perceived threat (e.g. high risk of infection) can contribute to mental distress |
| | • Communicate to people that all safety procedures are in place to make sure risk is minimal |
| | • Consider the person's need to feel safe and in control throughout care delivery |
| | • Use that as a general principle, particularly when engaging involves physical proximity (e.g. probing for infections, taking temperature), which needs to be reduced to minimal during pandemics. Communicate what you are doing next before proceeding |
| | • Give people time and space to prepare and process |
| Validate emotional experience | • Validate the person's fear, anxiety, and distress associated with mental health in the COVID-19 context |
| | • As you normalize the experience, you can help find ways to process challenging emotions |
| | • Normalize the intermittent nature of emotions. Communicate these feelings might come and go and you are available to support them in their distress |
| Provide time for processing information and emotions | • Experiencing something unknown and uncertain (e.g. a highly transmissible and mutant virus) triggers key areas of the brain associated with fear-processing and survival mechanisms. These areas might be particularly activated for people with previous experiences of trauma |
| | • As the brain is preoccupied with processing overwhelming internal and external stimuli, people might struggle to understand and store information (e.g. reminders of physical distancing requirements) |
| | • Give people time for processing what you say, speak calmly, repeat information, or craft it in a different way |
| | • The same is valid for processing emotions. Offer reassurance and comfort as needed as difficult emotions take time to process |
| Offer flexibility and choice whenever possible | • People's needs for processing potentially traumatic experiences will differ. Try to offer options for coping strategies and recovery |
| | • The question 'What can I do to help you feel safe?' might prompt the person to consider what responses are available and help them feel their choice is important |
| | • Adapt the strategies to what is feasible and acknowledge the person's efforts in case requests cannot be accommodated |
| Acknowledge the unprecedented circumstances we are (still) travelling | • Contextualizing mental health distress and explaining we are still navigating stressful times can help to promote de-escalation and motivating people in accessing the right support |
| | • People with previous vulnerabilities might respond with particular distress to the pandemic scenario. They might need time to adapt to unprecedented circumstances |
| | • Acknowledge such feelings in yourself and colleagues too. Health workers had to adapt rapidly to stay functional but are equally vulnerable to the ongoing pandemic effects |
| Validate your own concerns and experience of moral distress | • Health workers might feel divided between serving the community and concerns for their own safety and that of their loved ones |
| | • Acknowledge that these feelings are normal. Acknowledge it in your colleagues to help them to feel understood and cared for |
| | • Create safe spaces for briefing about moral distress and conflict experienced when delivering care in the context of a pandemic |
| | • As a group, identify strategies to be used collectively for monitoring each other's wellbeing and assistance in coping |

when safe, to slowing down and explaining the routine of care, workers were able to assist people modulate their fear and anxiety response. Concomitantly, it was found helpful to validate consumers' worries and distress, acknowledging and normalizing responses, and building a sense of shared experience. Adapting to such unprecedented times required flexibility and need to adapt to stress rapidly. This set of suggestions can be used by both experienced and untrained clinicians learning how to navigate the challenges imposed at the onset of a pandemic.

It is important to highlight however that the suggestions herein presented are limited to the perceived experience of CoP participants. The authors consider

that the experience of 'workers on the ground' is a valuable resource for identifying practical responses in rapidly changing circumstances. The author's perception however might have been influenced by their own expectations and need for reassurance about the quality of care delivered. Therefore, further studies assessing the efficacy of the practical actions herein recommended are necessary. These recommendations, in addition, do not represent the perception of the people receiving care. Exploring mental health services users' experience of receiving care during COVID-19 could further contribute to the development of effective care delivery actions based on principles of trauma-informed practice. Research on mental health service users' perspectives is fundamental for effective implementation of a trauma-informed approach to mental health care delivery in a pandemic.

At the time of publication, the COVID-19 pandemic has not yet been fully controlled. Vaccination programmes are still progressing throughout the globe and the long-term efficacy of the vaccines available is yet unknown. Lockdown and other social distance measures are still being implemented as new outbreaks of the disease emerge and variation of the virus (e.g. Omicron SARS-CoV-2 variant) are identified (Karim & Karim 2021). Furthermore, it is speculated that future pandemics are likely to occur in the coming years, which might require health workers to adapt to similar adverse circumstances in the near future (Thoradeniya & Jayasinghe 2021). This scenario makes the findings here discussed of relevance as the traumatic impact of ongoing pandemic with uncertain trajectory – or new ones which might emerge in the upcoming years – is real. Observing trauma-informed principles from the very beginning of the care delivery process might help to buffer the immediate and long-term effects of mental health distress in the context of pandemics.

## FUNDING

## DATA AVAILABILITY STATEMENT

Data sharing not applicable to this article as no datasets were generated or analysed during the current study.

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