



ORIGINAL ARTICLE

Literature review of trauma-informed care: Implications for mental health nurses working in acute inpatient settings in Australia

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ABSTRACT: Trauma-informed care (TIC) is increasingly recognized as an approach to improving consumers' experience of, and outcomes from, mental health services. Deriving consensus on the definition, successful approaches, and consumer experiences of TIC is yet to be attained. In the present study, we sought to clarify the challenges experienced by mental health nurses in embedding TIC into acute inpatient settings within Australia. A systematic search of electronic databases was undertaken to identify primary research conducted on the topic of TIC. A narrative review and synthesis of the 11 manuscripts retained from the search was performed. The main findings from the review indicate that there are very few studies focussing on TIC in the Australian context of acute mental health care. The review demonstrates that TIC can support a positive organizational culture and improve consumer experiences of care. The present review highlights that there is an urgency for mental health nurses to identify their role in delivering and evaluating TIC, inclusive of undertaking training and clinical supervision, and to engage in systemic efforts to change service cultures.

KEY WORDS: inpatient setting, literature review, mental health nursing, trauma-informed care.

INTRODUCTION

The aim of the present study was to clarify what is known about and what the challenges are facing mental health nurses (MHN) to imbed trauma-informed care (TIC) into acute inpatient settings within Australia. While TIC is an emerging phenomenon, there is agreement that TIC requires services to understand the mental health consumer and respond to their needs within the context of their personal trauma history (Wall *et al.* 2016). TIC is essentially a systems-focussed approach that recognizes the pervasiveness and impact

of trauma (Bateman *et al.* 2013; Kessler 2014; Reeves 2015). The TIC approach acknowledges that consumers have a high prevalence of historical trauma, and argues that service providers are in a powerful position to recognize and respond to their trauma (Bateman *et al.* 2013; Mueser *et al.* 1998).

The majority of consumers within inpatient settings will have been exposed to trauma at some point in their life, an exposure that will challenge their mental health (Kezelman & Stavropoulos 2012). Childhood trauma has been linked to schizophrenia, mood disorders, and the loss of both social function and physical well-being (Pacella *et al.* 2012; Trickett *et al.* 2011). Trauma has consequences across the lifespan for physical health, mental health, psychopathology, neurobiological changes and correlates as well as, social and occupational adversity (Jacobs *et al.* 2013; Patel *et al.* 2012).

Mental health services are increasingly knowledgeable that how they interact with inpatient consumers can potentially exacerbate these negative influences on

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well-being, or even traumatize those with no previous exposure to psychological trauma (Bateman *et al.* 2013). Retraumatization occurs secondary to a number of not uncommon coercive practices and experiences, including forced medication adherence, seclusion, restraint, verbal and physical aggression, and involuntary detention (Bateman *et al.* 2013; Ashmore *et al.* 2015).

Background

The successful integration of TIC into inpatient settings requires some consideration of the contexts in which Australian mental health services operate. These services retain a longstanding patchwork and fragmented structure that often fail the needs, yet alone the aspirations, of consumers through lacking individualized responsiveness (Australian Government, 2009; Mendoza *et al.* 2013). Growing a TIC culture will need to be undertaken with the still incomplete adoption of recovery approaches and incorporating the lived experience workforce into service teams, with both strategies still experiencing resistance and inconsistent take up (Davies & Gray 2015; Hurley *et al.* 2016). Recovery approaches within this context include mental health services placing consumers at the centre of the care, being personalized, and supported to make empowered choices (Department of Health, 2010).

With the specific context of TIC within inpatient settings, the National Mental Health Commission's (2014) recommendation to focus spending on community and preventative services has been identified as highly problematic for acute inpatient wards. High occupancy rates, combined with high levels of consumer acuity, have been identified as challenging the capacity of mental health services to offer basic safe care, yet alone the cultural change required for TIC (Allison *et al.* 2015).

The Mental Health Commission (2014) report also recommended the need for additional MHN workforce numbers and capability, acknowledging the ageing workforce and lack of postgraduate education within the discipline. While MHN have shown adaptability to the many systemic changes over the past 20 years, their roles are being increasingly narrowed towards safe containment of consumers, rather than offering therapy-based interventions within inpatient settings dominated by medicine-based psychiatry (Carlyle *et al.* 2012; Cleary *et al.* 2014; Browne *et al.* 2014).

It is into these contextual challenges that TIC needs to be adopted. These contexts raise genuine questions as to how this can be successfully achieved without a

paradigm shift away from psychiatry-driven values and interventions, towards an investment into the workforce capabilities and roles of the MHN. To address contemporary evidence for TIC, the aim of the present literature review was to identify and critically evaluate key themes of TIC as they relate to acute adult inpatient mental health. This review builds upon the earlier review by Muskett (2014), which explored literature up to 2011; this also included child and adolescent studies and a number of studies examining broad principles of mental health care delivery not specifically focussed upon TIC. Cleary and Hungerford (2015) and Reeves (2015) have also published recent TIC literature reviews, which were focussed on women with experiences of sexual assault or applied to a US context, respectively. The present literature review seeks to explore findings applicable to MHN practice within adult inpatient contexts. These contexts include high rates of acute and often complex involuntary admissions, and climates of moderate-to-high levels of hostility (Carr *et al.* 2008).

METHOD

A narrative review and synthesis of the literature was undertaken, as this approach is suited to the combination of findings from studies with diverse methodologies. A narrative review summarizes findings from primary studies to provide an integrated interpretation. By drawing together past empirical literature, this approach provides a comprehensive understanding of the phenomenon being examined (Mays *et al.* 2005; Kitson *et al.* 2013).

Literature search strategy

A literature search was conducted of the CINAHL, PsychINFO, PsycARTICLES, Psychology and Behavioral Sciences, Web of Science, and Cochrane Collaboration databases. In order to find studies that specifically focussed on TIC in acute adult mental health services, the key words searched included: 'trauma AND informed AND care' OR 'trauma AND informed AND practice' OR 'trauma AND informed AND service' AND 'acute AND mental AND health AND unit' OR 'psychiatric AND unit' OR 'psychiatry' OR 'acute AND mental AND health AND setting'. Limiters were set to identify English, peer-reviewed papers with available references of adult populations. No date range was applied; however, the studies identified had publications ranges from 2005 to 2015. The search, initially undertaken at the beginning of 2016, was then repeated at the

end of 2016 to capture more recent papers. A total of 304 full-text, English-only studies were identified.

Inclusion and exclusion process

The abstracts of all 419 articles were then reviewed for the key words in the literature search strategy. The inclusion criteria included studies that: (i) examined TIC in an acute adult mental health unit; (ii) were written in English; and (iii) met the stated overarching aim of the literature review. Studies meeting those criteria were retained. The reasons for exclusion of papers and the process of inclusion are displayed in Figure 1. A manual search of the reference list of retained papers was then undertaken to identify any additional articles that met the inclusion criteria. A total of 10 studies met the criteria (Ashcraft & Anthony 2008; Ashmore 2013; Barton *et al.* 2009; Borckardt *et al.* 2011; Chandler 2008; Clark *et al.* 2008; Elliot *et al.* 2005; Goetz & Taylor-Trujillo 2012; Isobel 2015; Lietz 2014). The date range for the studies spanned 2008–2015, and two Australian studies were included (Ashmore 2013; Isobel 2015). Only one Australian study was found that examined TIC from the consumers' perspective in an acute adult mental health unit (Isobel 2015).

Analysis and results

Themes were identified by synthesizing, reviewing, analysing, and comparing the literature against the

principles of TIC (Tables 1 and 2). A content analysis approach was adopted for this process. This content analysis included the reading of retained papers, with constant comparison being undertaken, as well as regular checking with the aims of the study. Emergent themes were identified and then shared with other investigators, with only those themes reaching consensus between the investigators being forwarded (Thomas & Harden 2008). Through this process, five themes were identified: (i) therapeutic relationship; (ii) recovery; (iii) choice and control; (iv) seclusion and restraint; and (v) the environment.

Therapeutic relationship

The TIC literature contains a powerful theme on the centrality of the therapeutic relationship to TIC (Ashcraft & Anthony 2008; Ashmore 2013; Barton *et al.* 2009; Borckardt *et al.* 2011; Isobel 2015; Lietz 2014). Integrating TIC services into an adult inpatient unit over a period of 12 months, Clark *et al.* (2008) conducted a quasi-experimental study ($n = 2729$) to evaluate the psychometric properties of a consumer perspective of care tool. They found that interpersonal processes were integral to consumers' perceptions of MHN care, with the therapeutic relationship the single most important predictor of consumers' satisfaction (Clark *et al.* 2008). While consumer satisfaction has been argued as lacking depth to accurately evaluate the quality of nursing interventions (Browne *et al.* 2014),

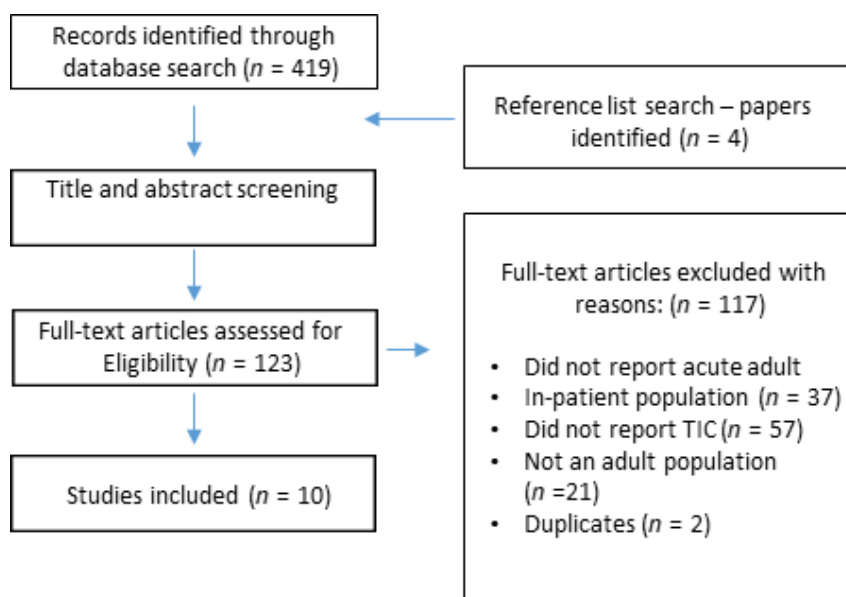


FIG. 1: Literature review search process.

TABLE 1: *Synthesis, review, analysis, and comparison of the literature against the principles of TIC in mental health settings*

Citation	Retrieved from:	Study design	Aim	Sample size	Setting	Intervention/method	Outcome	Key concepts	Limitation
Elliot <i>et al.</i> (2005)	Cross-referenced.	Mixed methods. Cross-site evaluations, 2 semistructured questionnaires.	To determine how the sites operationalized and defined TIC.	Across 9 mental health and drug and alcohol sites. Sample size not indicated.	Mental health, drug and alcohol, and domestic violence sites.	Workgroup developed definitions. Semistructured questionnaires. Definitions shared, and examples developed from sites.	Found 10 principles that underpin TIC.	Empowerment model. Recognize the Impact of violence and victimization on development and coping strategies; identify recovery from trauma as a primary goal; employ an empowerment model; strive to maximize a woman's choices and control over her recovery; relational collaboration; create an atmosphere that is respectful of survivors' need for safety, respect, and acceptance; emphasize women's strengths, highlighting adaptations over symptoms and resilience over pathology; minimize the possibilities of retraumatization; strive to be culturally competent and to understand each woman in the context of her life experiences and cultural background; solicit consumer input and involve consumers in designing and evaluating services.	Questionnaires based on 8 core service areas—poorly defined. Theoretical framework hard to determine.

(Continued)

TABLE 1: (Continued)

Citation	Retrieved from:	Study design	Aim	Sample size	Setting	Intervention/method	Outcome	Key concepts	Limitation
Ashmore (2013)	Cross-referenced.	Exploratory study. Qualitative research design using social constructionism theory.	To explore how TIC is implemented in two mental health units.	8 staff members in total.	2 mental health units: 1 in Australia and 1 in New Zealand.	Document analysis in policies to see TIC application. Semistructured interviews with staff.	Document analysis found 12 key themes: sexual assault as a risk factor for mental illness, safety from interpersonal violence, sexual assault service provision, universal screenings, responding to disclosures, retraumatization, inconsistent use of terminology, staff training, vicarious traumatization, cultural awareness, gender-specific services, choice, and control.	Trauma awareness, safety, choice, control, empowerment, and collaborative practice.	1 participant had TIC training; this could have influenced the findings. Staff who did not participate might have had no interest in TIC; therefore, differing findings – not truly representative. Mental health consumers were not involved in the study.
Chandler (2005)	Psych INFO database.	Qualitative, descriptive study.	Describe the experiences of staff transitioning from traditional inpatient care to a TIC approach.	n = 10 staff members.	20-bed mental health unit.	Personal narratives were taken. Interviews were taped and transcripts verbatim. Inductive content analysis.	Semistructured interviews found: trauma awareness, safety, choice, control, empowerment, and collaborative practice. Won state recognition for decreasing restraints. From 26 restraints in 2003 to 3 in 2008.	TIC meant emphasizing choice. Use of the Empowerment model, collaborative care, strengths based, culturally sensitivity, decreasing retraumatization and ensuring a trauma-informed approach.	Sample was nurse counsellors and 2 administrators. Consumers were not included in the study. Theoretical framework not provided.

(Continued)

TABLE 1: (Continued)

Citation	Retrieved from:	Study design	Aim	Sample size	Setting	Intervention/method	Outcome	Key concepts	Limitation
Borkardt <i>et al.</i> (2011)	Cochrane database.	Randomized control trial; multibase design.	Reduce seclusion and restraint.	$n = 446$ patients, $n = 340$ staff.	5 mental health inpatient units at 1 hospital.	3.5-year study in 3-month phases over 89,753 patient days. Patient QoC questionnaires. Staff QoC questionnaires.	Decreased seclusion and restraint by 82.3% ($P = 0.008$).	TIC training entailed a half-day standardized training on nature of trauma, effects, physiology, psychology, and behaviours that can exacerbate trauma-related behaviours. Rules and language: all staff had training on the effects of rules and language on patients' perceptions. This included the establishment of a team that reviewed and modified the rules of the unit to be less restrictive. All staff had a follow-up day training, in which rule changes were articulated and the effect of coercive language was discussed. Therapeutic environment: involved making inexpensive changes, painting walls, and decorative throw rugs, plants, and furniture. Patient involvement: all staff attended a half-day standardized training seminar that included a rationale for patient benefits.	Cofounding variable might have been a larger initiative, which was being implemented at the same time.

(Continued)

TABLE 1: (Continued)

Citation	Retrieved from:	Study design	Aim	Sample size	Setting	Intervention/method	Outcome	Key concepts	Limitation
Barton <i>et al.</i> (2009)	PubMed database.	Feasibility study.	Elimination of restraint.	No sample size provided.	Mental health inpatient unit.	18-month intervention of staff training. Education programme with trauma theory heavily embedded and a focus on changing unit culture. Project team established timeframe and action plan.	No restraints between 2007 and 2008 (decreased from 3, 4 and 9 between 2004 and 2006, respectively). Decrease in sedative-hypnotic use from 0.87 to 0.68 dosage rate/patient day.	Education intervention 1: focussed on the prevalence and effects of trauma, trauma theory, and statistics. Personal experiences of trauma of staff with support and opportunities to debrief with staff. Education intervention 2: neurobiology of trauma. Allowing staff to visualize trauma effects on brain. Education intervention 3: changing culture. Seeing patients as people, reframing language (not borderline), personalization of patients (known as mothers/fathers/brothers etc.). Therapeutic relationship at point of admission was a priority. Seclusion room changed to a 'comfort room'. Sensory modulation in place with the choice of music, soft and washable toys, journaling, stress balls, and smells.	Overall, poor methodological rigour. No sample sizes given or participant information. No evaluation of training pre and post, or how trauma training might have influenced change in culture.

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TABLE 1: (Continued)

Citation	Retrieved from:	Study design	Aim	Sample size	Setting	Intervention/method	Outcome	Key concepts	Limitation
Coetz and Taylor-Trujillo (2012)	PubMed database and Web of Science database.	Pilot project.	Reduce staff injuries by 20% and decrease workers' compensation costs.	No sample sizes provided.	80-bed mental health unit.	Multilayered implementation model of safety measures over 5 years. 9 elements of the model: TIC, aggression management, event review, leadership involvement, quality feedback, recovery orientation, patient assessment, education, and collaboration.	Decrease in staff injuries by 48% (52 in 2005, 103 in 2006, 50 in 2007, 58 in 2008, 13 in 2009, and 3 in 2010). Decrease in seclusion and restraint by 50% (accurate data not provided).	Patient-focused intervention model with TIC at the core. Recovery orientation using the WRAP. Collaboration: a peer specialist was employed, who functioned as a consumer advocate and liaison. Peer specialist would conduct WRAP groups. PFI model utilizing 'caring rounds' were independent of safety checks with the specific intent of assessing patient feelings of safety, control, medication response. Staff were orientated to TIC, safe boundaries, and patient-centred interventions.	Poor methodological rigour. Descriptive statistics only. Statistical analysis not provided. No clear data on compensation costs.

(Continued)

TABLE 1: (Continued)

Citation	Retrieved from:	Study design	Aim	Sample size	Setting	Intervention/method	Outcome	Key concepts	Limitation
Lietz (2014)	CINAHL database and ProQuest database.	Qualitative case study.	To understand the experience of recovery from mental illness through a TIC approach.	N = 1.	Mental health unit.	Recovery Assessment Scale eligibility criteria. Symptom checker (Symptom Checklist-90 revised) eligibility criteria. Data were audio-recorded, transcribed, and used NVivo 9. Reconstructed and triangulated. Meaning units from each participant's story against the medical file.	2 mental health professionals dismissed her trauma, leading to retraumatization.	Participant experienced a long and significant history of trauma and child maltreatment. Few mental health professionals enquired about this. Participant denied her trauma history for years. Risk of retraumatization when mental health professionals ask; however, if left unaddressed, this adds to emotional distress. Research on many therapies for trauma; however, little research on how clinicians can facilitate a dialogue with people who have experienced trauma. Damaging relationships: dismissing her trauma. TIC approach would have recognized the significance of her trauma. By discounting her trauma, the practitioner harmed the helping relationship and hindered her recovery. Positive relationships occurred when practitioners validated her trauma history, listened, and honoured her choice.	Poor orientation to theoretical framework of the study.

(Continued)

TABLE 1: (Continued)

Citation	Retrieved from:	Study design	Aim	Sample size	Setting	Intervention/method	Outcome	Key concepts	Limitation
Clark <i>et al.</i> (2008)	CINAHL database.	Quasi-experimental study.	Evaluating the psychometric properties of the consumer perceptions of care (CPC) tool and analysing consumers' perception of care.	$n = 2729$.	Mental health unit.	Using 3 psychometric tests at 3, 6, 9, 12 months: 1. Consumer perceptions of care. 2. Working alliance inventory-short form. 3. Client satisfaction questionnaire.	CPC has good internal consistency and ensures that consumers' feedback on implementation is put forth. It is a valid and reliable tool of clients' satisfaction.	Interpersonal processes as the most important aspect of care. Trauma history is associated with an increase in dissatisfaction with care.	Only generalizable to women. Number of participants were court ordered to participate. Increased likelihood of type 1 errors due to sample size.
Ashcraft and Anthony (2008)	ProQuest database.	58-month retrospective study of a programme evaluation.	Elimination of seclusion and restraint.	$n = 95$ staff members.	2 mental health units.	Implementation strategies included strong leadership, policy and procedure change, staff training on specific issues, debriefing, and feedback on progress.	Larger crisis centre took 10 months until a month registered 0 seclusions, and 31 months until a month recorded 0 restraints. The smaller crisis centre achieved these same goals in 2 months and 15 months, respectively.	CEO of the services met with staff and informed staff they would no longer be using seclusion and restraint. CEO participated in training with all staff. Training focussed on recovery and strengths-based conversations. Emphasis on immediate engagement with clients. Debriefing with consumers on what staff could have done to avoid seclusion and restraint. Quality manager sent regular reports to staff on the dangers of seclusion and restraint.	Descriptive statistics and no inferential statistics were used. No randomization of a control group or alternative intervention.

(Continued)

TABLE 1: (Continued)

Citation	Retrieved from:	Study design	Aim	Sample size	Setting	Intervention/method	Outcome	Key concepts	Limitation
Isobel (2015)	CINAHL database.	Mixed methods (qualitative and quantitative study).	To review nurse-initiated rules within a TIC perspective.	n = 17 nurses; n = 16 consumers.	1 mental health unit.	Open-ended questions—analysed thematically based on TIC. Simple descriptive analysis on responses.	33 rules were identified. Nurses expressed frustration with inconsistent rules, rules used by some nurses as a means of avoiding engagement and restrictive policies. Consumers viewed rules as frustrating, smoking, and leave restriction, and also viewed rules as maintaining safety on the unit.	Critically evaluating rules to align with person-centred care. Rules in mental health units are generally unexplored. Rules can lead to conflict, which affects the therapeutic relationship and environment. If rules are consistent and predictable, and clearly communicated, they support the therapeutic relationship. Clear rules demonstrate consistency in care.	Methods unclear. Ambiguous ethical considerations. Poor adherence to qualitative research methodology (i.e. sampling, data collection, and analysis unclear).

CEO, chief executive officer; CPC, consumer perceptions of care; QoC, quality of care; TIC, trauma-informed care; WRAP, wellness, recovery, action, plan.

in the context of TIC it can be positioned as at least indicating an absence of trauma evoking interactions with staff. Similarly, Barton *et al.* (2009) conducted an 18-month TIC feasibility study that aimed to eliminate restraint in an acute inpatient unit, and that contained findings pertinent to the therapeutic relationship. In that study, staff attended education sessions that challenged paternalistic views, and employed what the authors called a ‘TIC strategy’ of encouraging staff to view ‘patients as people’, and focussed on this personalisation of patients. The authors reported that the unit remained restraint free for a 2-year period following the programme, accompanied by a decrease in the use of sedative-hypnotic medications (Barton *et al.* 2009). Wider discussion and exploration of the mechanisms that initially shaped the staff’s dehumanizing behaviours was, however, absent.

In a TIC case study, Lietz (2014) found that, while therapeutic relationships were enhanced when practitioners validated consumers’ trauma experiences, practitioners can equally so cause harm by dismissing consumer trauma stories. This again seemingly highlights the importance of therapeutic relating to TIC specifically, and to effective MHN more widely. However, the factors that enable poor therapeutic relating and the consequent dismissal of consumers’ experiences that equates to a rejection of their very identity was left unexplored in that study. Further linking of the therapeutic relationship to TIC, a cross-site evaluation study examining how both mental health and drug and alcohol sites operationalized TIC was conducted by Elliot *et al.* (2005). A key overarching principle found was that TIC is based on relational collaborations, and that healing from trauma can only occur in the context of relationships that have positive human connections (Elliot *et al.* 2005). While forwarding that consumers should be central to how TIC is delivered, the authors offer few substantive ways for achieving this considerable cultural and systemic shift in service delivery. Chandler’s (2008) qualitative study of 10 acute mental health staff described the experiences of staff transitioning to a TIC approach, and emphasized that staff–consumer relationships are central to achieving that end. Following the implementation of a TIC training, restraints decreased from 26 to three over a 5-year period (Chandler 2008). Similarly, Borekardt *et al.* (2011) conducted a randomized, controlled trial (RCT) (n = 446 consumers and n = 340 mental health staff) on implementing TIC educational interventions with staff that focussed on therapeutic engagement. Their conclusions were that the 82% reduction in seclusion

TABLE 2: *Principles of TIC*

Citations	Principles of TIC
Six principles of TIC (Elliot <i>et al.</i> 2005; Harris & Fallot 2001, as cited in Substance Abuse and Mental Health Services Administration, 2014).	<ol style="list-style-type: none"> 1. Safety 2. Trustworthiness and transparency 3. Peer support 4. Collaboration and mutuality 5. Empowerment, voice and choice 6. Cultural and historical 7. Gendered issues
Mental Health Coordinating Council's 8 foundational principles of TIC (Campling, 2001; Bloom & Farragher, 2011; Bloom & Sreedhar, 2011; Harris & Fallot, 2009; Moses, Reed, Mazelis & Ambrosio, 2003, as cited in Bateman <i>et al.</i> 2013).	<ol style="list-style-type: none"> 1. Understanding trauma and its effect 2. Safety 3. Cultural competence 4. Consumer control, choice, and autonomy 5. Sharing power and governance 6. Integrating care 7. Healing happens in relationships 8. Recovery
Elliot <i>et al.</i> (2005)	<ol style="list-style-type: none"> 1. Recognize the impact of violence and victimization on development and coping strategies 2. Identify recovery from trauma as a primary goal 3. Employ an empowerment model 4. Strive to maximize a woman's choices and control over her recovery 5. Relational collaboration 6. Create an atmosphere that is respectful of survivors' need for safety, respect, and acceptance 7. Emphasize women's strengths, highlighting adaptations over symptoms and resilience over pathology 8. Minimize the possibilities of retraumatization 9. Strive to be culturally competent, and to understand each woman in the context of her life experiences and cultural background 10. Solicit consumer input and involve consumers in designing and evaluating services
Harris and Fallot (2001)	<ol style="list-style-type: none"> 1. Understanding trauma 2. Understanding the consumer survivor 3. Understanding services 4. Understanding the service relationship

TIC, trauma-informed care.

and restraint was attributable almost exclusively to the improved therapeutic relating.

While this group of studies reported favourable outcomes from TIC, Elliot *et al.* (2005), as well as Ashcraft and Anthony (2008), in their retrospective studies on staff behaviours, reported undercurrents of power differentials between staff and consumers in the therapeutic relationship. These staff behaviours were driven by hegemonic relating that was found to mimic the 'power-over' dynamics often seen in abusive relationships (Elliot *et al.* 2005).

Recovery

Found within this literature review was that recovery is integral to TIC (Barton *et al.* 2009; Borckardt *et al.*

2011; Chandler 2008; Elliot *et al.* 2005; Goetz & Taylor-Trujillo 2012; Lietz *et al.* 2014). It is an important premise of recovery that consumers have choice and control over their treatment plans, and that a hopeful and strengths-based approach is taken towards consumers by staff. Goetz and Taylor-Trujillo (2012) tested a nine-component model of nursing leadership aimed at improving safety within acute inpatient settings, with recovery alongside of TIC principles being central to those components. The reported outcomes of that programme included a reduction in staff injuries from 52 in 2005 to three in 2010. The joining of TIC with recovery was not explored from the perspective of theoretical modelling, despite both constructs sharing underpinning principles, while having different priorities.

Borckardt *et al.* (2011) conducted a TIC RCT in which mental health staff attended training, emphasizing the importance of involving consumers in treatment planning. The authors reported the training benefitted both services and consumers. Barton *et al.*'s (2009) TIC feasibility study supported the notion that hospitals should be used as tools in the recovery process, while Chandler's (2008) qualitative TIC study ($n = 10$ staff members) highlighted the importance of resilience in recovery for TIC to be undertaken. Elliot *et al.* (2005) highlighted that the traditional biomedical approach of mental care views trauma symptoms as pathological, rather than as adaptive, coping strategies, and that mental health staff working within that model often fail to validate resilience in consumers' recovery journeys.

Choice and control

Building on from recovery, in seven of the studies reviewed advocating for consumer choice, control and autonomy were highlighted as important TIC principles (Ashmore 2013; Barton *et al.* 2009; Chandler 2008; Elliot *et al.* 2005; Goetz & Taylor-Trujillo 2012; Isobel 2015; Lietz 2014). Ashmore's (2013) TIC study of mental health staff ($n = 8$) showed that controlled regimes and activities take power away from consumers, particularly if they are being treated involuntarily under the New South Wales Mental Health Act (2007). Tangible symbols of control include the sound of keys held by nurses and staff, the use of swipe access cards and uniforms (Cleary & Hungerford 2015).

Barton *et al.* (2009) reported that offering consumers the choice to regulate their emotions with sensory approaches, as opposed to restraint, shifted this power differential between MHN and consumers. In that study, the use of restraint as a form of controlling emotions was viewed as a treatment failure (Barton *et al.* 2009). Chandler's (2008) study gained recognition, as it moved away from the provision of reactive care with pro re nata medication, and sought to give consumers autonomy and build their capacity to organize and understand their behaviours as responses to trauma. Isobel (2015) conducted a mixed-methods TIC study of 17 nurses and 16 consumers in an acute inpatient unit that aimed to empower consumers by critically evaluating the rules of the unit. The findings highlighted that ward rules lead to conflict, and adversely affected therapeutic relationships. Nurses reported feeling frustrated with these rules, as they

were often inconsistently applied in accordance with restrictive policies that were beyond their control (Isobel 2015). It was found that examining the ward rules from a TIC perspective led to transparent care and enabled consumers to better understand the environment, as known and understood rules provide consistency and predictability (Isobel 2015).

Seclusion and restraint

Four of the TIC studies in the present literature review identified seclusion and restraint as a theme (Ashcraft & Anthony 2008; Barton *et al.* 2009; Borckardt *et al.* 2011; Goetz & Taylor-Trujillo 2012). Ashcraft and Anthony's (2008) retrospective study used TIC training and an organizational change manual to decrease seclusion and restraint. Their TIC study owed its success to the following five key strategies: strong leadership, policy and procedural change, staff training, debriefing, and feedback on progress (Ashcraft & Anthony 2008). Staff members were specifically educated on how to support consumers who were experiencing trauma (Ashcraft & Anthony 2008). Debriefing was also used following any seclusion and restraint episode to elucidate consumers' experiences, and consumers were given opportunities to discuss what could have been done to avoid the restraint or seclusion (Ashcraft & Anthony 2008). In that study, seclusion and restraint were eliminated across two sites over a 58-month period; however, it should be noted that the study used descriptive statistics, and no inferential statistics were used (Ashcraft & Anthony 2008).

Conversely, Borckardt *et al.*'s (2011) RCT failed to eliminate seclusion and restraint; however, it did decrease the use of seclusion and restraint by 82.3% ($P = 0.008$). That study used a trauma-informed engagement model that comprised of four components to decrease seclusion and restraint rates: TIC training, rules and language changes, consumer involvement in treatment plans, and changes to the physical environment (Borckardt *et al.* 2011). Borckardt *et al.* (2011) emphasized unit rules and language as imperative, with staff members modifying the rules so that they were less restrictive and more transparent for consumers'. Training on coercive language was also provided to mediate power differentials and decrease the likelihood of aggressive events arising that could lead to seclusion or restraint (Borckardt *et al.* 2011).

Barton *et al.*'s (2009) feasibility study focussed solely on restraint over an 18-month period, and ultimately, registered a restraint-free period for the 2007–2008

fiscal year. In their study, staff attended training sessions on childhood trauma, the neurobiology of trauma, and ways to facilitate cultural changes within the workplace (Barton *et al.* 2009). However, despite the positive results, the study lacked methodological rigour, and no evaluation was undertaken of the training and how it affected the culture change. Goetz and Taylor-Trujillo (2012) adopted a patient-focussed intervention model that used a core of TIC to decrease the use of seclusion and restraint. Specifically, a peer specialist was employed as an advocate and liaison for consumers in an acute inpatient unit (Goetz & Taylor-Trujillo 2012). Staff members were also required to attend training sessions to assist them to implement the TIC principles (Goetz & Taylor-Trujillo 2012). Training for initial assessments included trauma-related triggers, past trauma responses (anxiety and fear components), and strength-based questions (e.g. ‘What has helped you cope in the past?’) (Goetz & Taylor-Trujillo 2012). Clinicians and consumers used a collaborative TIC safety plan during the period of hospitalization (Goetz & Taylor-Trujillo 2012). The study had poor methodological rigour; however, staff injuries decreased from 52 in 2005 to three in 2010, and there was a 50% reduction in seclusion and restraint rates (Goetz & Taylor-Trujillo 2012).

Environment

Although only two TIC studies identified the environment as being important, it is included here as it is influential upon all other identified themes (Borckardt *et al.* 2011; Elliot *et al.* 2005). Borckardt *et al.* (2011) found that inexpensive changes could be made to inpatient environments to improve the perceived quality of care for consumers and to decrease rates of seclusion and restraint ($P = 0.006$). Indeed, their experimental study indicated that within the context of inpatient adult units, the physical environment was a significant variable. Changes to mental health unit environments included painting the walls, changing the furnishings, the addition of indoor plants, and the purchase of floor rugs (Borckardt *et al.* 2011). Elliot *et al.* (2005) argued that service providers need to ensure that mental health environments are safe and welcoming for trauma survivors.

DISCUSSION

The present literature review sought to clarify the challenges facing MHN to imbed TIC into acute inpatient

settings within Australia. The thematic findings presented here group these challenges predominantly around establishing effective therapeutic relationships with consumers, and enacting recovery principles within standard inpatient acute care. Reductions in seclusion and restraint in the reported studies pivoted around the delivery of TIC education to staff and culture changes that reflect those of recovery, such as greater consumer choice, empowering consumers, working in partnership with consumers, and building hope (Kitson *et al.* 2013; Stickley & Wright 2011). Indeed, the TIC principles outlined in Table 2 either overtly include recovery or reflect key components of it.

Equally so, core principles of person-centred care, such as respecting people’s values, putting people at the centre of care, ensuring consumer safety, and including consumer preferences and needs within care planning, are also evident within TIC (Cronin 2004). The symmetry between these care models appears to focus upon staff values and attitudes that are used to form respectful and collaborative relationships with consumers, as well as requiring significant changes to the systems and cultures of mental health services in Australia.

The themes from the present review suggest that while being distinct constructs, both TIC and recovery need to be adopted by MHN for either to be fully effective for consumers. Paternalistic-driven interventions stemming from the dominant biomedical model cultures in Australian mental health services (Lakeman 2013) are seemingly incompatible with TIC principles (Elliot *et al.* 2005).

Consequently, a key barrier to embedding TIC into inpatient units is that the adoption of recovery into these settings is incomplete. While MHN widely understand the features and principles of recovery, within the context of inpatient care, most see it as commencing at the point of discharge from the unit into a community setting (Cleary *et al.* 2013). Thus, nursing interventions and cultures are focussed on preparing the consumer for recovery through more biomedical model-style interventions, such as medications (Cleary *et al.* 2013). Embedding recovery, choice, and control has traditionally been identified as ‘too risky’ by clinicians within the context of acute mental health settings (Harris & Fallot 2001). A lack of alternative interventions or workforce capability to deliver alternative interventions, and an unsatisfactory understanding of the impact of trauma has meant that staff members have traditionally adhered strictly to protocols to

ensure their safety (Chandler 2008). However, mental health services do a disservice to themselves by failing to provide trauma survivors with the opportunity to maximize their choices and control their treatment goals (Elliot *et al.* 2005). Service policy that enables this passing of control and enhancement of consumer choice, and supports staff to do so, will of itself change the very culture of the services, with service culture and caring practices being mutually embedded (Lakeman 2013). As Chandler (2008) noted, passing control to consumers is part of the service's transitional journey under TIC.

The key differentiation between TIC and that of recovery or person-centred care is that TIC requires staff to look for and understand the connection between childhood trauma and adult psychopathology as a means of understanding consumer behaviours. (Elliot *et al.* 2005). The findings from this review indicate that TIC education and training can be an effective mechanism by which to embed TIC and promote recovery-based therapeutic relationships with consumers. TIC education offers an explanatory model for consumer behaviour that can manifest in the daily working life of acute inpatient MHN. Within the context of the aetiological uncertainties of diagnostic labelling and biomedical model explanations of consumer behaviours that generate debate within the MHN discipline (Lakeman & Cutcliffe 2016), TIC potentially offers a more widely-acceptable model as to why consumers exhibit the behaviours they do. The TIC studies reviewed in the present paper places an emphasis on seclusion and restraint (Ashcraft & Anthony 2008; Barton *et al.* 2009; Borekardt *et al.* 2011; Goetz & Taylor-Trujillo 2012) can be understood as MHN seizing a practical clinical application of TIC, arguably more easily than they can from recovery, and that also has significant pertinence to acute mental health settings.

A question emerging from the literature is whether the decreased seclusions and restraints are a part of TIC, or rather an outcome of different relationships stemming from the additional training and supervision offered to staff. The use of seclusion and restraint is highly disempowering; however, the studies discussed in the present paper show that TIC can be used to decrease rates of seclusion and restraint and staff injuries, and improve collaborations and therapeutic alliances. Consumers have commonly reported feeling disempowered in acute mental health settings in which they are held against their will, forced to take numerous psychotropic medications, cannot access their basic

liberties, and cannot see their loved ones (Elliot *et al.* 2005). Honouring consumers' choices through less-restrictive ward rules, and offering interventions to enhance consumer emotional regulation, rather than offering interventions around seclusion and restraint, has been shown to be achievable in other international contexts. This is an important TIC principle, as overriding consumers' autonomy and disempowering consumers is reminiscent of abuse dynamics common in trauma survivors (Harris & Falloot 2001).

TIC education and training offers the MHN a new model in which to understand and relate with consumers. Within the themes presented from the present review, the characteristics of the MHN consumer therapeutic relationship were pivotal to embedding TIC, and is thus both a barrier and opportunity to embed TIC within inpatient settings. The therapeutic relationship has long been a platform upon which the MHN profession has based its identity upon (Cleary 2003; Peplau 1989), and has been used as an intervention in and of itself, rather than being a platform from which to offer more complex psychological interventions (Browne *et al.* 2014). However, for MHN and consumer relationships to be non-coercive and respectful, the MHN must be able to emotionally labour and invest of themselves, often within emotionally-corrosive environments (Hurley 2009; Lakeman 2012). The therapeutic relationships that sustain TIC and recovery-related principles are challenged by MHN being among the highest occupational groups exposed to physical and non-physical forms of aggression and violence (Cutcliffe 2013; Edward *et al.* 2014; Ward 2013). An Australian descriptive survey conducted across two adult mental health inpatient units found that more than 80% of nurses were assaulted (McKinnon & Cross 2008). Further, a systematic review conducted by Edward *et al.* (2014) examining 84 studies of patient aggression towards nurses found that the longer-term effects of aggression included decreased confidence, absenteeism, negative effects on work place relationships, workplace avoidance, increased substance use (of alcohol and other substances), and exiting the profession (Edward *et al.* 2014).

There has been a paucity of research on the rates of compassion fatigue in mental health nursing; however, one study conducted by Franza *et al.* (2015) showed that compassion fatigue was evident in 28.57% of MHN and 36.36% of psychologists (total sample size $n = 47$). Compassion fatigue can severely damage therapeutic relationships and hinder or harm consumers' recovery (Mamer 2008). Indeed, the very workforce being

identified as central to delivering TIC is being exposed to trauma, and subsequently, experiences high levels of post-traumatic stress disorder (Ashmore 2013; Zerach & Shalev 2015). The risk of consumers being retraumatized is high if services fail to identify and respond to their own systemic traumas. None of the studies considered in the present literature review assessed the effect of compassion fatigue, burnout, secondary traumatic stress, or vicarious trauma on TIC practices. Given the centrality of the MHN therapeutic relationship to achieving TIC, service-based responses around funding clinical supervision and more frequent rotation of nurses out of acute inpatient environments appear warranted.

Achieving TIC within inpatient settings will require a systems-wide response to the high levels of occupancy and acuity and the impact this has on the MHN who are the only discipline within these settings across a 24-hour period (Allison *et al.* 2015). The positive influence on TIC education and training was evident in the literature; however, there is a puzzling absence of remedial-focussed debate on how the nursing profession reached the point of needing to be educated to treat consumers as people. The requirement for this suggests systemic wide flaws and an urgent debate on how the MHN workforce can be better supported to achieve TIC. Evident across the themes taken from TIC studies examined in the present paper is that the clinical workforce, predominantly MHN, received additional training, education, and investment as well, as organizational support, to change practice to achieve the positive consumer outcomes described. Such factors can be argued as needing wider adoption for MHN to be able to use the therapeutic relationship as the starting point of developing a culture of TIC and practice (Browne *et al.* 2014).

CONCLUSION

The literature suggests an emerging set of underpinning principles that describe TIC, rather than there being a single universal definition.

Trauma-informed care offers an explanatory model through which to understand and respond to consumer behaviour through collaborative and sensitive therapeutic relationships. Its major point of separation from the still-to-be-embedded constructs of recovery and person-centred care is that TIC education and training are seemingly more accessible for nurses to translate into their practice. Positive outcomes from TIC education and training were most apparent around seclusion and restraint (Ashcraft & Anthony 2008; Borekardt *et al.*

2011), which importantly was delivered in conjuncture with changes to leadership styles, mitigation of authoritarian-styled nurse–consumer relationships, and changes to policies. This suggests that while training and education are pivotal, TIC requires service-wide acceptance, key performance indicators being set particularly around non-coercive recovery-orientated and trauma-informed practices, and significant changes to inpatient culture that is inclusive of the physical environment and the impact of compassion fatigue. Breaking down defensive reasoning towards current coercive practice and systems would be needed to achieve these outcomes.

RELEVANCE FOR CLINICAL PRACTICE

The findings of the present review indicate that there are very few TIC studies applied to Australian inpatient mental health contexts, with findings highlighting that TIC offers the potential for more frequent, positive consumer experiences of care. MHN within the Australian context of biomedical model-dominated systems and cultures retain an emphasis on the therapeutic relationship, and are thus well placed to implement TIC. The present review highlights that there is an urgency for MHN to identify their role in delivering and evaluating TIC, inclusive of undertaking training and clinical supervision, and to engage in systemic efforts to change service cultures.

FUTURE RESEARCH

Robust and urgent research is needed to understand and respond to the potential mechanisms that influence dehumanizing behaviours towards consumers. Research is also indicated towards the sustainability of staff clinical practices over time following TIC training and education. Finally, further research is required to understand consumers' lived experiences of revictimization and vicarious traumatization in practice, and the protective modalities that support the resilience and growth of trauma survivors.

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