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FEATURE ARTICLE

# Trauma-informed care in inpatient mental health settings: A review of the literature

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**ABSTRACT:** *Trauma-informed care is an emerging value that is seen as fundamental to effective and contemporary mental health nursing practice. Trauma-informed care, like recovery, leaves mental health nurses struggling to translate these values into day-to-day nursing practice. Many are confused about what individual actions they can take to support these values. To date, the most clearly articulated policy to emerge from the trauma-informed care movement in Australia has been the agreement to reduce, and wherever possible, eliminate the use of seclusion and restraint. Confronted with the constant churn of admissions and readmissions of clients with challenging behaviours, and seemingly intractable mental illness, the elimination of seclusion and restraint is seen to be utopian by many mental health nurses in inpatient settings. Is trauma-informed care solely about eliminating seclusion and restraint, or are there other tangible practices nurses could utilize to effect better health outcomes for mental health clients, especially those with significant abuse histories? This article summarizes the findings from the literature from 2000–2011 in identifying those practices and clinical activities that have been implemented to effect trauma-informed care in inpatient mental health settings.*

**KEY WORDS:** *inpatient mental health, psychiatric care, seclusion and restraint, therapeutic intervention, trauma-informed care.*

## INTRODUCTION

The irrefutable linkage and prevalence of childhood exposure to trauma and long-term adverse mental health outcomes provides a compelling evidence base for inpatient mental health nurses to become trauma informed. Advances in neuroscience have identified that the structure and function of a developing brain is altered following exposure to significant childhood trauma (Bremner 2002; Heim & Nemeroff 2002). The experiences a child has in infancy and childhood determines how well the parts of the brain integrate and function together (Fan *et al*. 2011; Nelson 2011). Exposure to positive experiences during this time promotes the development of extensive connections between the different areas of the brain. Conversely, exposure to significant negative experiences suppresses neural pathway development and integration, especially between different parts of the brain, such as the cerebral cortex and limbic system (Curtis & Nelson 2003). Well-connected neural pathways, necessary for the development of healthy, adaptive responses to experiences and emotions, are diminished in children exposed to adverse environments compared to those exposed to more positive environments. The resulting impairment in mood and behaviour regulation leads to subsequent maturational difficulties, such as an inability to establish effective interpersonal relationships, regulate emotions, and learn from own and others' experiences (Schore 2003). Also becoming more evident is the phenomenon of neuroplasticity and the ability of the brain to compensate for deficits, such as those arising from childhood abuse, and reverse neural pathway discrepancies between the limbic system and cortex, given sustained

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exposure to positive experiences at any age (Citri & Malenka 2008).

The prevalence of trauma-related illnesses has also become more widely appreciated. Findings from the seminal Adverse Childhood Experience (ACE) study in the USA established an irrefutable link between the childhood exposure to harsh experiences, such as physical and sexual abuse, and neglect, and exposure to domestic violence and adverse health outcomes in adulthood. The ACE survey found that of all adults receiving any form of health care who responded to the survey over a 10-year period, 11% had experienced emotional abuse, 30% physical abuse, 20% sexual abuse, 23% had been exposed to direct physical abuse within a home situation where one or both parents were drinking to excess, and 12% witnessed maternal assault (Felitti *et al*. 1998). The significance of childhood abuse reported in the ACE study appears to be comparable to Australia, with an estimated 177 000 children in 2007 exposed to significant levels of abuse, generating estimated costs of $A10.7 billion per annum (Taylor *et al*. 2008). The ACE study also identified a graded positive relationship between childhood trauma and physical health problems, such as cardiovascular disease, diabetes, obesity, fractures, unplanned pregnancies, and sexually-transmitted diseases.

The ACE study, along with a number of other studies, reinforces the link between childhood trauma and long-term negative health outcomes (Felitti 2004; Hennessey *et al*. 2004; Morrison *et al*. 2003; Scaer 2005; Stein & Kendall 2006; Talbot *et al*. 2011; Wheeler *et al*. 2005). These studies show that up to 90% of people seeking treatment for serious and enduring personality disorders, substance abuse, and mental illnesses, such as eating disorders, anxiety, and depressive disorders, and those in contact with criminal justice systems, were exposed to significant emotional, physical, and or sexual abuse in childhood. While the most profound effects of trauma usually follow childhood exposure, adults exposed to such events, including beng a victim of serious crimes, or sustained domestic violence, or active hostilities during war, can also develop mental illnesses, such as post-traumatic stress (Volpicelli *et al*. 1999). Scaer (2005) found that 92% of adults experiencing a major traumatic event will not go on to develop post-traumatic stress disorder as a consequence.

Not all children exposed to childhood trauma experience negative health consequences. Boyce and Harris (2011) cited studies from the Isle of Wight and Australia that showed 45% and 64% of adult respondents, respectively, who were exposed to childhood trauma did not seek treatment for, or subjectively experience, mental illness as an adult. These authors found that exposure to childhood trauma, especially if an isolated adverse event, is able to be counteracted by the presence of other resilience-enhancing factors in the child's immediate environment. The resilience-enhancing factors identified included low levels of family discord, actively engaged and nurturing parents and extended families, maintenance of a continuous relationship with mother, and the absence of mental illness and/or substance abuse among direct family members residing in the home.

As attention to the pervasive impact of trauma has spread, people for whom trauma-specific services were originally established are no longer considered a small, discrete subset of the population. They are now known to represent the greatest proportion of people accessing public mental health, forensic health, and drug and alcohol services (Felitti 2004; Hennessey *et al*. 2004; Morrison *et al*. 2003; Scaer 2005; Stein & Kendall 2006; Talbot *et al*. 2011; Wheeler *et al*. 2005). To better meet the needs of persons accessing these services, trauma-informed care has therefore emerged as a key paradigm. Hodas (2006) stated that trauma-informed organizations, programmes, and services are those that are cognisant that their services can retraumatize admitted clients with significant trauma histories through the indiscriminate application of coercive practices, such as physical restraint. Admission to mental health services can be equally traumatic for clients without pre-existing trauma histories experiencing the onset of disabling symptoms, loss of autonomy, and dislocation from normal supports and family.

Much of the existing trauma-informed care information is grey literature located on the websites of organizations within the USA, such as the Substance Abuse and Mental Health Services Administration, Trauma-Informed Care Resources, the National Association of State Mental Health Program Directors (NASMHPD), and the ACE study. There is a great degree of consistency across all of these organizations about the key principles of trauma-informed care. They are as follows: (i) clients need to feel connected, valued, informed, and hopeful of recovery; (ii) the connection between childhood trauma and adult psychopathology is known and understood by all staff; and (iii) staff work in mindful and empowering ways with individuals, family and friends, and other social services agencies to promote and protect the autonomy of that individual.

The aim of this literature review was to identify and critically review the literature for observable and practical nursing examples of trauma-informed care that can be readily adopted in acute mental health inpatient settings.

## METHOD

A literature search of the Psychology and Behavioural Sciences, Nursing and Allied Health Comprehensive and Biomedical Collections electronic databases was performed, linking the primary subject terms of 'trauma-informed' plus 'adult' or 'youth inpatient mental health/psychiatric care'. Specific search parameters were also applied to identify articles published from January 2000 to June 2011, in peer reviewed journals, with full-text availability in English. A total of 116 articles were identified from the databases during the initial search. All abstracts were then screened to identify those journal articles that reported findings from qualitative or quantitative studies relating to trauma informed approaches to patient care, or reviewed care specifically undertaken in inpatient adult or youth mental health or forensic mental health setting.

A total of 13 papers were found that met the search parameters described above and specifically identified practices that could be utilized by mental health nurses in youth and adult inpatient settings to promote trauma-informed care.

## RESULTS

During the course of this literature review, a large number of trauma-related references were found, many identifying the impacts of trauma on children, youth, and adult populations, and also reported the efficacy of a range of therapeutic interventions for survivors of childhood trauma. The majority of these studies reported strategies and findings in community care settings and residential or custodial settings. There were far fewer empirical research studies and papers published reporting trauma-informed care specific to inpatient mental health settings. The articles identified in this review were analysed, and the key themes and findings are summarized in Table 1.

Within the available literature, the preoccupation with seclusion and restraint practices, as a key outcome of trauma-informed care, was evident, with multiple articles specifically focusing on the reducing rates of restraint and seclusion (Ashcraft & Anthony 2008; Azeem *et al*. 2011; Barton *et al*. 2009; Borckardt *et al*. 2011). The NASMHPD identified six pivotal ingredients in eliminating seclusion and restraint. Testing the effectiveness of these six ingredients in whole or part formed the basis of multiple studies in the USA. The NASMHPD strategies were proven to have a positive correlation to the reduction of seclusion and restraint by Ashcraft and Anthony (2008), Azeem *et al*. (2011), Barton *et al*. (2009) and Borckardt *et al*. (2011). Hummer *et al*. (2010) focused on the degree of compliance staff displayed with respect to the NASMHPD interventions, but did not link this back to specific client outcomes, such as seclusion and restraint rates.

The six NASMHPD principles found to be critical ingredients in successful implementation of trauma-informed care in the USA were: (i) active leadership support, role modelling, and engagement in trauma-informed principles; (ii) data collection (e.g. seclusion and restraint incidents); (iii) rigorous debriefing and prevention-focused analysis of events that do occur; (iv) trauma-informed education and skill development of staff; (v) use of a range of assessments (e.g. trauma, risk, and strengths identification) and tools to teach self-management of illness and emotional regulation; and (vi) involvement and inclusion of consumers at all levels of care.

The use of multiple strategies was found to be more effective in the implementation of trauma-informed care across a range of mental health settings, including inpatient units.

Leadership practices associated with successful trauma-informed care implementation included the allocation of responsibility for driving the agenda to a clearly-identified executive or senior leader within the organization who was committed to this goal. It also involved establishing executive support across services to prioritize trauma-informed care activities, and the nominated leaders had access to project planning, monitoring, communication, and evaluation resources. Clinical leaders and clinical managers, who were highly visible and committed to this agenda, and were actively included in planning for progressive and systematic changes in practice in their areas, were also associated with higher degrees of service success in adopting trauma-informed care practices in line with the NASMHPD framework (Ashcraft & Anthony 2008; Azeem *et al*. 2011; Borckardt *et al*. 2011).

The inclusion of nurses in the collection and use of data (including adverse incident reporting) to inform and change practices was reported as an important activity in enhancing the adoption of, and contributed to the evidence base for, trauma-informed care (Ashcraft & Anthony 2008; Azeem *et al*. 2011; Barton *et al*. 2009; Borckardt *et al*. 2011; Hummer *et al*. 2010). This mainly involved nurses participating in the collection and review of incidents relating to coercive practices, such as involuntary admission, seclusion, and restraint. Other data and documentation strategies found to be effective included those related to establishing an accurate picture of trauma-informed care requirements for clients, such as

**TABLE 1:** *Article review summary: Trauma-informed care practices in inpatient psychiatric settings*

| Author/year | Purpose of article | Setting description | Study design/instruments | Findings | Implications |
|---|---|---|---|---|---|
| Ashcraft and Anthony (2008). | To evaluate the effectiveness of specific initiatives designed to eliminate seclusion and restraint. | Two separate psychiatric crisis centres based in Arizona (USA) admitting over 14 500 patients annually, including 4600 involuntarily. Average LOS from 24 hours to 5 days. One centre higher volume and larger than other. | 58-month retrospective and comparative analysis of patient seclusion and restraint, staff time lost from injury, and chemical restraint data post-implementation of the NASMHPD. | Reductions in seclusion and restraint evident in both centres. Smaller centre results significantly greater in reduction, with achievement of multiple months of nil occurrences evident. Smaller centre also achieved significant reduction in staff injuries related to patient seclusion and restraint, while the larger one remained static. No increase in chemical restraint usage following initiative implementation observed. | Range of factors seen as contributing to likely success of initiative including:<br>• smaller size of centre<br>• visible leadership<br>• regular feedback to staff<br>• debriefing, including capture of consumer perspective to identify practice improvements<br>• specific staff training for alternative strategies to replace more coercive practices. |
| Azeem *et al.* (2011). | To determine the effectiveness of six core strategies based on trauma-informed care in reducing the use of seclusion and restraint. | 26-bed adolescent unit attached to a state psychiatric hospital in Minnesota, USA. Prior to study, hospital staff receive training in six core strategies based on trauma-informed care. | Comparative study using retrospective medical file audit for all incidents of seclusion and restraint for 458 youths admitted during the 12-month pre-and post-implementation of the six core skills training programme for staff. | Study identified a downwards trend in seclusion and restraint incidents among those youths hospitalized after implementation of training programme. | Six core strategies for the staff training included using primary prevention principles, including awareness of the patient's trauma history, utilizing safety plans and comfort rooms, diversional activities, and de-escalation techniques. The investment in staff training yielded positive results relatively quickly, which was sustained over a long period of time. |
| Barton *et al.* (2009). | To achieve a restraint-free work setting through the emphasis of person-centred care. | Adult behavioural health unit in a private, non-profit community hospital in Pennsylvania, USA. | Retrospective audit of client-related data on both rates of restraint and administration of sedative–hypnotic medications across 3-year periods audited pre-and post-training. | Unit incidence of restraint reduced from 19 in 2001/2002 (pretraining) to nine in 2004/2005, and to zero for 2007/2008 audits (post-training). The use of sedative hypnotic medications also showed a decline across same three audit periods for all clients. | Application of trauma-informed care principles by frontline staff made a restraint-free environment possible, and also appeared to reduce the need for sedative–hypnotic medications to control behaviour. |
| Borckardt *et al.* (2011). | To determine the effectiveness of a range of trauma-informed practices on the rate of seclusion and restraint. | Five inpatient units of a state-funded psychiatric hospital in South Carolina, USA. | Randomized, controlled study, with each of five inpatient units randomly assigned to implement an intervention component at different stages. PROC Mixed (version 9.2 in SAS) was used to determine impact of intervention on seclusion and restraint rates over a 3.5-year period. | Trauma-informed care interventions applied during study included staff training, policy and language change, environmental changes, and client involvement in treatment planning. At completion of study, seclusion and restraints had reduced by 82.3% ($P = 0.008$). Unlike other interventions, changes to the physical environment were associated with reductions in seclusion and restraint rates, independent of when introduced. | Changes to physical environment were rated by staff as the most significant intervention implemented. Immediate benefits attributed to the substitution of cold, stark surroundings to a more inviting, calm setting positively affected staff and client morale. Intervention of most significance to clients themselves was collaborative decision-making in relation to treatment. However, implementation of all four other NASMHPD initiatives had positive impacts on sustaining reduced rates of seclusion and restraint as well. |
| Borge and Fagermoen (2008). | To explore and describe patients with significant trauma histories and their perceptions of what were essential features of care in their recovery process. | Study took place within a 117-bed, six-ward adult psychiatric hospital in Norway. | Exploratory, descriptive study using hermeneutic–phenomenological design to analyse interviews with 15 individual clients post-discharge. | Client experiences of collaboration and self-worth were found to be critical for recovery. Positive perceptions and outcomes of care most evident when staff were perceived as professional and involved. | In the absence of perceived effective staff–client relationships, negative experiences of being a 'patient' were reinforced (i.e. being passive and inferior) for some. This study, while small scale, identified the importance of staff being fully engaged, optimistic, and responsive with clients who require hospitalization. |

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| Champagne and Stromberg (2004). | To determine the role and efficacy of trauma-informed sensory interventions in an acute care setting. | 24-bed acute inpatient unit within a general hospital (USA). | Article describes results of a small-scale quality improvement initiative undertaken by nurses and an occupational therapist employed on the unit. | Client perceptions of levels of distress were measured routinely before and after a sensory room session, with 89% patients reporting a significant decrease, 10% reporting no change, and 1% reporting an increase in the level of distress following the session. | Sensory interventions, such as the establishment of specific rooms with soothing decor (e.g. lava lamps, comfortable seating options, weighted throw rugs, and scented candles and oils), are an effective means of decreasing distress and assisting with emotional regulation for the majority of patients likely to be admitted to an acute unit. |
| Clark *et al.* (2008). | To develop a reliable, sensitive, and valid CPC tool. | Multiple site study across mental health and substance abuse service settings (inpatient and community) across the Eastern seaboard states of the USA. | Large-scale research study using quasi-experimental design to develop and test a tool to capture patient satisfaction (CPC) levels across settings identified as trauma informed under the WCDVS and more traditional service settings. | Efficacy of CPC tool tested across multiple sites and shown to have a high degree of reliability, sensitivity, and validity in capturing accurate and useful feedback from consumers regarding satisfaction (or otherwise) with care received. Those services identified as trauma informed were consistently rated higher than standard, traditional services. | Consumer perceptions and experiences of care are fundamental in measuring the quality and efficacy of services. CPC tool is one of a few tools that collects specific feedback in relation to the efficacy of trauma-informed practices, and as a copy of the 26-point questionnaire is included in the article, could be useful in measuring the penetration of trauma-informed principles into inpatient settings in Australia. |
| Cleary (2003). | To examine the behaviours that underpin contemporary nursing practice in acute inpatient mental health facilities. | 22-bed admission unit in a major public psychiatric hospital in New South Wales, Australia. | Interpretive, ethnographic study where researcher witnessed and analysed nursing practice as a participant observer on the ward for a 5-month period. | Key findings identified that most nurses perceive person-centred care, including building trust and rapport, as paramount to effective care. Those practices observed as most effective were those consistent with trauma-informed care, such as listening, responding, and working in partnership with client and families, and promoting self-worth and hope. | Findings indicated that the nurse–client relationship is still believed to be the foundation to mental health nursing practice, with the importance of rapport and trust resonating throughout all activities. Overwhelming tension experienced by many mental health nurses arose from the clash of values between what they saw as 'quality care' and the perceived inability to deliver this within an involuntary, enforcement treatment framework. |
| Elliott *et al.* (2005). | To identify actual staff practices that exemplified trauma-informed care. | Research conducted across nine comprehensive mental health and substance abuse services for women with co-existing conditions (USA). | Research consisted of site-level and cross-site level evaluations using Delphi process to theme information gathered through extensive surveys and two semistructured questionnaires completed with administrators and staff. | Exemplars of practices found as valuable in inpatient settings included creating respectful, safe, and welcoming service settings; specific staff training in interventions to assist patients establish supportive connections with others; effectively manage strong emotions and enhance personal safety; and staff clinical supervision. | Study identified that as trauma survivors represented the majority of clients in inpatient settings, and providers were often unaware of the extent of exposure, best practice was to apply 'universal precautions'; that is, staff to routinely use care approaches that were growth promoting and recovery focused, and least likely to retraumatize patients. |
| Gatz *et al.* (2007). | To identify and evaluate services for women with co-existing mental illness/ substance abuse and history of trauma. | Research funded under WCDVS national evaluation programme, and involved same nine services as above (Elliot *et al.*) | Quasi-experimental research design in which a trauma-informed, integrated intervention for the target group was compared to usual treatment in a mental health or alcohol and drug facility. | Positive patient outcomes from trauma-informed care compared to usual treatment included higher participation rates and compliance, with ongoing care at 3-, 6-, and 12-month intervals; decrease in trauma-related symptoms; increase in effective coping skills; decline in engagement in sexually-risky behaviours; and decrease in alcohol and substance use. | Effective trauma-informed inpatient care can also have positive outcomes for patients requiring community-based follow up, due to higher rates of ongoing participation and service engagement, and effect healthier, longer-term lifestyle adaptations. |

**TABLE 1:** *Continued*

| Author/year | Purpose of article | Setting description | Study design/instruments | Findings | Implications |
|---|---|---|---|---|---|
| Harris and Fallot (2001). | To identify and describe specific hospital-based, trauma-informed practices. | Article not site or service specific, other than discussing care in a hospital setting (USA). | Article describes ideal trauma-informed inpatient unit based on available evidence and author opinion, and some evidence. | Identifies need to ensure client has as much choice and control as possible, ensuring physical and emotional safety of staff and clients, the availability of same gender staff, separation of male and female consumers, availability of safe and comfortable time-out spaces and staff training in trauma theory. | Article also identified practices that are most likely to retraumatize patients (e.g. restraint and seclusion, being searched, having reports of abuse dismissed, loss of control, and decision-making). Article limitations included a lack of substantial evidence and research for many of the authors' suggestions. A number of these ideal practices have been proven effective in subsequent studies. |
| Hummer *et al.* (2010). | To examine the compliance of staff practices in youth inpatient settings with the principles of trauma-informed care. | Three inpatient adolescent psychiatric units in Florida, USA. | Study involved in-depth service evaluation by a dedicated assessment team by adapting the trauma-informed Program Self-Assessment Scale developed by Fallot and Harris (2006) for adult services. | Findings based on 75 interviews, 12 assessment team observational site visits, 33 file reviews, and reviews of the policy and procedure manuals at all three inpatient sites. Sites were rated according to degree of assessed trauma-informed care compliance, with varying degrees of achievement. | The highest areas of compliance were for the systematic review of seclusions and restraints; documented evidence of de-escalation, collaboration, and caregiver involvement; trauma screening and assessment; and formal service policies regarding de-escalation, seclusion, restraint, client rights and grievance procedures. As staff training and development, especially for new staff, was identified as an area that had received lesser focus, a set of field-based standards 'Creating Trauma-Informed Care Environments' was developed for ongoing use. |
| Walsh and Boyle (2009). | To explore clients' perceptions of care as helpful recovery. | Eight psychiatric hospitals where acute care was delivered across Northern Ireland. | Exploratory study using 10 focus groups to collect data from a total of 55 clients, which was then subjected to systematic content analysis. | Several key features of care emerged from content analysis as important to clients' perceptions of care and recovery, including being taught self-help strategies; having a relationship with staff who treated them with trust, empathy, and respect; sense of 'asylum' from the pressures of outside world; active communication; and information sharing and participation in care decisions. | Despite clear articulation from clients about what staff actions were therapeutic and helpful, clients generally perceived services as failing to consistently deliver trauma-informed care. The study found that the clients expected a higher standard of care than what was being provided. As part of the recommendations, a list of pertinent and practical nursing practice standards was articulated to improve nursing practices to better meet clients' expectations. |

CPC, Consumer perceptions of care; LOS, length of stays; NASMHPD, National Association of State Mental Health Program Directors; WCDVS, Women, Co-Existing Disorders and Violence Study.

the automatic screening of client trauma histories at point of admission whenever possible. Fallot and Harris (2006) found routine service satisfaction surveys, complaints feedback to staff, and the use of trauma-informed service evaluation tools, such as the Consumer Perceptions of Care (CPC) questionnaire and 'Trauma-Informed Services: A Self-Assessment Tool', developed by Clark *et al*. (2008), contributed to positive trauma-informed care service evaluations from staff and clients alike.

The development of a culture and belief in the value of trauma-informed care was found to only be possible when staff were confident and competent in the knowledge of the prevalence and impact of trauma on clients, and the understanding of their responsibilities in mitigating retraumatization (Elliott *et al*. 2005; Gatz *et al*. 2007; National Centre for Trauma-Informed Care 2011). Hummer *et al*. (2010) found this awareness needed to start at the point of orientation to the service for all new staff. The most effective staff orientation and ongoing staff development programmes included active learning opportunities of topics, such as substance abuse and trauma, therapeutic safety and boundaries, establishing, maintaining and terminating therapeutic relationships, de-escalation, strengths-focused care planning, and consumer participation and empowerment (Ashcraft & Anthony 2008; Azeem *et al*. 2011; Borckardt *et al*. 2011; Elliott *et al*. 2005; Gatz *et al*. 2007). There are a number of valuable resources, such as training modules, slide shows, and factual information, about all of these topics within the grey literature, and many are available on the websites cited among the references in this paper.

Many studies identified attention to the physical environment as a significant, positive (and relatively inexpensive) trauma-informed care strategy. The refurbishment of units to provide an welcoming physical environment included using comfortable home-like furniture; warm and inviting colour schemes; art and craft hangings; soothing soft furnishings, such as snuggle rugs and pillows; calming auditory stimulation, such as soft music; and the use of pleasant olfactory sensations, such as scented oil burners (Champagne & Stromberg 2004; Harris & Fallot 2001). Harris and Fallot (2001) and Champagne and Stromberg (2004) also identified the importance of adequate space and time-out options to enhance patient comfort and self-esteem, and to defuse distress.

Those units where security was an overriding concern were characterized by a stark, austere, and uninviting atmosphere, and were strongly perceived as unwelcoming and unsupportive of client needs (Walsh & Boyle 2009). The purposeful transformation of stark, impersonal wards to a more homely and welcoming environment was perceived by staff involved in service evaluations following the implementation of the NASMHPD principles of trauma-informed as equally important to all other measures they had taken (Azeem *et al*. 2011).

Borge and Fagermoen (2008), Clark *et al*. (2008) and Walsh and Boyle (2009) identified features of effective care from the client's perspective. These studies highlighted the nature of the nurse–patient relationship as critical to client perceptions of the quality and effectiveness of care. Identified features of suboptimal care, from the client's perception, included staff appearing disinterested or disrespectful, preoccupied by non-interactive tasks, and not empowering clients to be masters of their own destinies. These features were reported as contributing to the revictimization of clients by reinforcing previous pervasive patterns and thoughts of passivity and inferiority.

Borge and Fagermoen (2008) and Cleary (2003) found the focus of care in acute, mainstreamed, adult inpatient mental health units researched to be risk management, illness assessment, and medical stabilization. This focus was found to accompany a corresponding de-emphasis on therapeutic relationships and 'talking' therapies with clients. Staff, especially those working in acute units gazetted to accept admissions of involuntary clients under mental health legislation appeared largely preoccupied with medication and coercive activities, such as enforcing ward rules, treatment orders, undertaking close observations, and using physical interventions to respond to overt patient aggression and self-harm. This service culture was perceived by service users (i.e. clients and their families) as controlling and unhelpful, as opposed to units emphasizing psychological support, and growth, where service users perceived staff as more caring and supportive when they focused on therapeutic relationships and interventions to build self-determination and autonomy (Elliott *et al*. 2005; Gatz *et al*. 2007).

All of the articles reviewed, regardless of country, stressed the critical importance of emotionally-supportive care by nurses for clients with significant trauma histories, and the active inclusion and participation of these clients and their families in all care provision decisions.

## CONCLUSION

Trauma symptoms arising from past violence, and the absence of perceived safe and supportive inpatient environments, creates obstacles to effective treatment and care for consumers of mental health services (Borge & Fagermoen 2008; Clark *et al*. 2008; Elliott *et al*. 2005; Gatz *et al*. 2007; Walsh & Boyle 2009). As trauma

survivors represent the majority of clients in inpatient settings, and providers have no way of knowing who are actual trauma survivors, Elliott *et al*. (2005) suggest best practice is to apply 'universal trauma precautions' to all; that is, nurses routinely using practices that are growth promoting and recovery focused and less likely to retraumatize those already exposed to significant interpersonal trauma. Many practices and procedures, such as ward rounds, ward rules, search procedures, locked doors, mixed-sex patient populations, and the use of seclusion and restraint are retraumatizing, as they are experienced by consumers as emotionally unsafe and disempowering practices (Borge & Fagermoen 2008; Clark *et al*. 2008; Cleary 2003; Walsh & Boyle 2009).

Effective trauma-informed services are services not just designed to treat symptoms or syndromes related to significant sexual, physical, or emotional abuse; they are services where staff are aware of, and sensitive to, doing no further harm to survivors (Jennings 2004). With a growing body of evidence to support the proposition that many acute inpatient units are experienced as counter-therapeutic for clients (Cleary 2003; Commission for Healthcare Audit and Inspection 2008; Elliott *et al*. 2005; Gatz *et al*. 2007; Ryan & Bowers 2005; Walsh & Boyle 2009), the intent to do no further harm must drive a continued discourse for acute inpatient services staff in trauma-informed care. The review of the literature, with the exception of specific training and screening recommendations, highlights that effective trauma-informed care in acute inpatient settings involves the use of strategies that most would consider basic ingredients of contemporary, effective mental health care. Trauma-informed care starts with, and goes to the heart of, the enabling nature of the nurse–client relationship, and the value services place upon client-centred care.

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