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Advancing Compassionate Nursing Models: Integrating Trauma-Aware Approaches in Acute Psychiatric Hospital Environments for Holistic Care Reform

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Abstract
This paper relates to the application of the trauma-informed care (TIC) nursing model in the acute inpatient mental health unit using a systematic practice development framework. Trauma-informed care recognizes the prevalence of trauma and incorporates this knowledge in clinical practices to establish an empowering, healing, and safe community among the patients and employees. This was done through the means of staff education, cultural change programs, leadership promotions, and parental feedback processes in order to incorporate TIC concepts into daily practice. The results were a higher patient engagement level, the decreased number of restraint and seclusion, better staff-patient relations, and greater confidence of the staff in addressing traumatic behavior. The importance of mental health nursing practice to integrate the concept of trauma-informed into practices to create a therapeutic environment that enhances recovery and resilience is noted in the study.
Keywords: ***Trauma-informed care, mental health nursing, acute psychiatric unit, practice development, patient-centered care, staff engagement, recovery-oriented practice, therapeutic environment, nursing model, psychiatric care transformation.***

1.Introduction
This has seen the landscape of mental health nursing change so much in the last few decades as we have shifted towards a more elaborate, evidence-based escrow mode of care-giving with a major premise being on autonomy, therapeutic relationships and recovery-oriented results. Nonetheless, irrespective of all these developments, most acute inpatient mental health units still suffer due to the lack of clearly defined, internationally described care models based on a system of philosophy capable of directing nursing practice within the complicated clinical setting. The healthcare organization has not developed clear consistent methodologies regarding care delivery thus in most situations mental health nurses tend to use traditional ways of doing things that could be problem-oriented and task-centered, as opposed to holistic and person-centered(1). This tendency of default is an important lost chance of professional growth and the best outcomes of patient care.

This is a problem that is especially sharp in inpatient mental health, as nurses struggle to determine the right approach to safety and therapeutic involvement, and where even the physical setting itself can accidentally reproduce trauma instead of supporting the healing. In the absence of a common philosophical base through which decisions are made, behaviors should be determined in the care of patients, and clinical intervention, the nursing team might be working towards different theoretical orientations, which might result in the inconsistency of care interventions, the dissimilarity between professional discomposure, and a suboptimal clinical response. Introduction of an explicit care framework is effective in a number of ways: it helps to clarify the role and responsibilities of nursing staff in their professional activities, provides standardized patient-related activities, offers a possibility of clear professional development, and eventually, improves the quality and consistency of care provided on all shifts and by all staff members.

It is always shown in research that when mental health nurses work in clearly defined, philosophically sound care models, they experience higher job satisfaction levels, better sense of professional efficacy, as well as a stronger belief in their clinical decision making powers. Moreover, patients also experience fewer inconsistent, unpredictable interactions and more aligned to the treatment related communication with other members of the nursing team, which increases their level of engagement with treatments, shortens their stay, and has a positive effect on the overall recovery process. However, choosing a suitable care framework should be done baring in mind not only the philosophical background but also the potential implications to the everyday nursing practice so that the adopted framework would be both evidence-based and practicable in the context of acute inpatient settings(2).

Cognizing the concept of Trauma-Informed Care as an Indifferentiated Nursing Philosophy

Trauma-Informed Care is a paradigm based shift in the delivery of healthcare that inherently re- conceptualized the relationship between those who provide and care recipients, and places less emphasis on the more traditional medical approaches where the question usually asked is; What is wrong with you? to more universal treatment which asks the question, What happened to you? This philosophical orientation appreciates the ubiquitous presence of trauma in the lives of mental health care service recipients where traumatic events acute or chronic, recent or historical, have a strong effect on the ways individuals perceive, interpret, and react to the healthcare settings and the care provided to them. Universal trauma among mental health users of services needs no explanation, many studies have established that mental illness patients seriously affected by mental illness are traumatized at exponentially higher rates than the average population and the trauma may start as early as childhood and be persistent in the lifespan of the affected individuals.

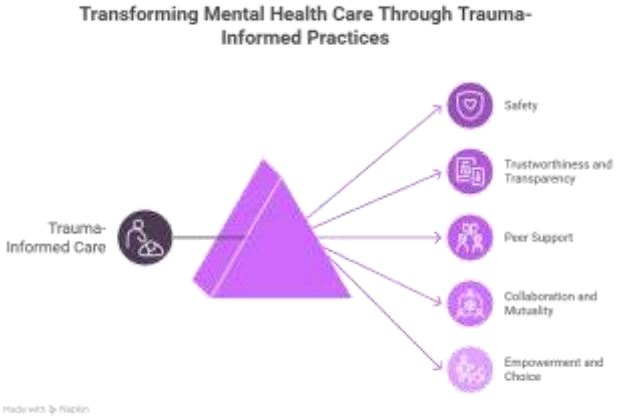

FIGURE 1 Transforming Mental Health Care Through Trauma-Informed Practices

Neurobiologically, the effects of trauma are much more than short-term psychological consequences, as they change the very structure and functioning of the brain, with the implication reaching the levels of emotional control, cognitive computations, interpersonal communications and stress regulation organs(3). The neurobiological process impacts significantly on how individuals perceive, and react to healthcare settings especially those which can unknowingly alarm the conscience of the traumatic experience by actions and reactions like the use of coercion, restraint, isolation and power struggles. Such traditional ways of providing healthcare that frequently focus on efficiency and the power to control more than the mental or psychological safety and partnership can expose vulnerable people to retraumatization, which can worsen symptoms and hinder the recovery progress.

Trauma-Informed Care resolves these issues by setting five basic principles that should be used in all service-related processes: safety (avoiding physical and psychological harm of patients and employees), trustworthiness and transparency (using trust to ensure effective communications and organizational activities), peer support (using shared experiences to achieve healing), collaboration and mutuality (meaningful patient participation in every element of care) and empowerment and choice (embracing patient empowerment and skill building). These principles form the basis of a foundation to reimagine the delivery of healthcare in the way that would reduce the possibility of the retraumatization and would provide the maximum number of opportunities to be healed, resilient and become strong as a result.

Introducing TIC in acute mental health needs a complex organizational commitment, which is not limited to the clinical interventions of individual practitioners but should cover policies, practices, physical units and organizational culture. Such a systemic orientation acknowledges that the issues of successfully implementing trauma-informed practices lie in their wider embedding in the broader organizational structure and processes, which are constantly reinforcing the main principles in any part of the organization through its every level.

2.Methods

The methodological design applied in the exploration of this study included the use of a mixed-methods comprehensive case study design, which was selected, in particular, to reflect the multi-dimensionality of the Trauma-Informed Care implementation task in the complex healthcare setting. The choice of design was guided

by the fact that organizational change interventions, especially those characterized by a paradigm shift in care philosophy and practice, cannot be effectively comprehended using a single-method design, which does not allow grasping the complexity that surrounds how individuals, teams, and organizations interact. Case study approach allowed the needed flexibility in the discussion across the varying levels of analysis and provided the concentration in the particular contextual factors that impacted the result in this very setting(4).

Mixed method approach allowed combination of qualitative and quantitative approaches to data collection so that the implementation process could be understand and the outcomes could be seen comprehensively. Qualitative approaches were given pride of place to record the rich contextual nature of the experiences of nursing personnel in going through the transition process towards trauma-informed practices although quantitative measures gave objective measures of the implementation experience and the effects it showed on the workforce. This type of methodological triangulation added validity of results and their reliability as well as presenting various angles on investigation in such a complicated phenomenon. Iterativeness of data-collection enabled continual development of research questions and data-collection actions conducted according to the results of data collected and the developing needs of implementing the concepts.

2.1 Selection and Sampling of the Participants

The method used in the selection of the participants was the purposive sampling approach that aimed at identifying a wide range of voices and experiences that could be connected to the TIC implementation initiative. The range of selection criteria was attentively generated, as to represent multiple dimensions, such as the time of nursing experience (both new practitioners with less than two years of experience and the veterans with more than 20 years of practice), engagement with the TIC implementation project (both the adopters and champions and those who are doubtful and remain resistant), shift pattern and schedule (representing day, evening, and night shifts, to ensure coverage of all the units operations), and the perceived level of influence within the nursing workforce of the unit. The sampling method knew that the experience and results of implementation can be really diverse depending on the personal traits, professional background, and trauma history of the individual. In order to mitigate the problem of bias and to guarantee natural representation of a variety of perspectives a recruitment process was specifically aimed at including nurses with a different level of interest in the TIC initiative by including those who were strong supporters of the project as well as those who were the loudest critics(5). It also took into account a wide variety of opinions consciously in order to gain the whole gamut of the responses of different members of the workforce to organizational change and to build information on the factors that could make a successful implementation or those that could hinder the implementation in different parts of the nursing workforce population.

2.2 Procedures and Instruments of Data Collection

Methods of data collections were developed to record individual experiences and trends in TIC implementation and to cause minimum interference with clinical operations and time requirements of participants. The main activity of information collection was the use of semi-structured interviews based on well-designed interview guides aimed at balancing between the guided nature of asking questions and the flexibility that allows the participants to tell their personal stories and express their personal viewpoints in detail. The main themes in the interview questions are the reaction to the TIC concept as a whole, the perceived difference in daily practice routines, the observations of patient reactions and results, team feelings and communication patterns, personal experience in professional development, and suggestions of the ways to facilitate implementation.

Trauma-informed ideas were used in the interview procedure, acknowledging that questions about trauma-informed care could possibly induce some individual trauma experiences. The interviewers were specialized with specific training on trauma-sensitive strategies of interviewing, such as the strategies of establishing and maintaining a psychologically safe interview environment, understanding symptoms that may be a sign of distress or activation, and offering strategies to provide the necessary support and resources at the given moment. The questionnaire was applied through interviews on a one on one basis in comfortable and non-public places that would be freely selected by the participants and at flexible timings depending on the work patterns and preferences of participants. The counter measure used was interviewee availability and the quality of responses as time allowances were between 45 to 90 mins, and all sessions recorded on an audio tape with express permission to transcribe and analyze them later.

2.3 Method of Data Processing and Analytical Framework

The analytical method was a form of inductive content analysis, which was selected in order to enable the themes and patterns to be discovered in the respondent accounts, avoiding the inclusion of preconceived theoretical

concepts and assumptions. The analytical approach used was quite suitable in this case due to the exploratory nature of the research study and the low amount of available literature regarding TIC implementation in the acute mental health nursing population. The analysis process involved first up transcribing all recordings of the interviews verbatim and then reading and rereading the transcript with the purpose to become immersed into the data and cultivate some initial awareness of the predominant themes and patterns(6).

The coding processes were conducted both in terms of open-coding (establishing preliminary concepts and categories using the data), and focused-coding (reducing and distilling the category into larger themes and patterns). The analysis was reflexive and continuous, and several members of the analysis team re-reviewed transcripts and compared coding choices to increase consistency and decrease individual influence. Analysis work was done on a regular basis through meetings whereby discussion, debate and agreement on emerging themes and interpretations were done. Emphasising on negativity was also part of the analytical frame, such that, the results would not just document the negative examples (that may confront or complicate emerging understandings), but there must also be negative or contradictory cases as evidence to the completeness of the implementation experiences, as opposed to simplistic or rosey accounts.

2.4 Risk Management and Ethical Considerations

The Sydney Local Health District Ethics Committee acted in the capacity of an ethical body to oversee this research, with specific concern to those ethical considerations that are normally unique to research among the mentally ill population and among healthcare workers that may have their own histories of personal trauma. The ethical review covered various aspects of risks and protection which included procedures to follow in case of informed consent, safeguards of confidentiality and anonymity, measures of data security and storage, risks to the participants and their potential psychological assessment and handling of dual relationship with both the researchers and the clinical colleagues. Since the research is conducted based in a workplace, extra steps were made to ensure that the participants are not at risk of being retaliated against or facing some adverse outcomes as a result of their participation in the research or the views they expressed.

TABLE 1 Research Methods Summary

Component	**Details**
Study Design	Mixed-methods case study
Setting	38-bed acute mental health unit, Sydney, Australia
Timeframe	October 2012 - May 2014 (18 months implementation)
Participants	5 registered nurses (purposive convenience sample)
Inclusion Criteria	• Varying experience levels (1-25+ years) • Different engagement levels with TIC project • Availability during data collection period
Data Collection	Semi-structured interviews (45-90 minutes) Audio-recorded and transcribed verbatim
Interview Topics	• Changes occurring on unit • Day-to-day practice effects • Consumer experience impacts • Team dynamics • Role satisfaction
Analysis Method	Inductive conventional content analysis (Hsieh & Shannon, 2005)
Ethics Approval	Sydney Local Health District Ethics Committee
Data Management	Audio recordings, transcripts analyzed for themes Confidentiality maintained through de-identification

The informed consent processes were aimed at making the participants understand completely the job of the research, its process; its risks and its potential gains and their rights as research subjects. Of specific note was the effort to impress that volunteer involvement was at interest and not injunction, that anybody could pull out at any time without any repercussions and that the answers of the participants were to be held with sophisticated confidentiality measures. The procedures of data de-identification were used to strip all personally identifiable information out of transcripts and analytical data, leaving only the research staff with the access to linking codes connecting individual participants with their responses(7). All information was kept safe in electronic password-secure and limited access forms and hard copy data were kept in locked filing cabinets in restricted research spaces.

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3.Results

The Perceptions that the Nursing Staff has towards the Organization Change and Implementation Process

Semi-structured interviews provided complex and multifarious answers concerning the realization of the Trauma-Informed Care as a nursing model in the acute mental health unit. The model of business change described by the participants was attended to a high degree of sensitivity in the sense that they both revealed the seriousness of specific theoretical underpinnings of TIC and the equally serious issues with regard to application. The general idea that came out of the narrated stories was the realization that successful organizational change comes with time, patience, and continuing efforts of all participants as well as the acceptance of tensions between the ideals of perfection versus the realities of the acute inpatient mental health care.

Nurses were always keen on noting that the implementation process should be step by step to be long-lasting and positively positioned to gain lasting adoption among the nursing workforce. A more experienced participant explained this perspective saying, I think there are quite a lot of good things and I was not sure whether it was the misinterpretation but we lost some things as well which is rather common with change. I am worried that safety may fly out the window.. it is all about who is on top or rather where the power is vested.. the main difference is we are going to leave the consumers with more control and freedom but on the other hand it is not really true in the real sense. This is where the struggle is on my part... but when everything is settled then it will be good." With deeply regulated healthcare settings, where safety and institutional policy can work against the trauma-informed principle of empowering consumers and allowing their choices, this quote captures the challenge of making philosophical change a reality(8).

One of the participants was in great mood about the TIC implementation and at the same time recognized the difficulties of the process of organizational change: I think it is very promising and a good thing. I believe the reason being slightly resistant, the process will be slow with some members of staff but I believe it is a good thing and it does take time, there is a lot of uncertainty on how we should practise and what this means to them but I believe will make my position more rewarding and satisfied that I am fulfilling my role as a mental health nurse. I do not see anything wrong." This reaction points out the advantages of professional identity that nurses expected TIC implementation would bring in, especially the possibility of role satisfaction and professional gratification via an alignment on evidence-based, ethically sustainable methods of practice.

3.1 Controversies Between Innovation and Continuity in Nursing Practice

One of the most important discoveries which appeared in the interview material concerned the interpretation of TIC implementation as seen by the nursing staff as it is possible to note that a discussion concerning whether TIC implementation was also an innovation or just a formalisation of good practice was a continuous process. This discussion showed that there were significant conflicts between those nurses who recognized TIC as just a natural extension of what they had been doing all along and those nurses who saw TIC as a deeper paradigm shift that necessitated sweeping changes in practice patterns and professional identity. The answers to this question are of relevance in the success of implementation given the fact that nurses who consider TIC as compatible with their other values and practices will be more inclined to accept the change process.

Some of the respondents challenged the implication that the changes that TIC implementation entailed were monumental as the leaders of the organization had put it. One of the veteran nurses who has been experienced explained, We have been trying here over the years, we are trying to be less traumatic, okay we did not name it but we were the whole philosophy of the majority of staff who have been here a long time is to do no harm or to do less harm, if you can the fact that it is more coordinated and somebody is driving it and has authority and importance, you know what I mean. That is wonderful, but I used to believe in trauma informed care well before the term was traumal infomred care…And are we not ever in a state of change? I mean there is no perfection, but we only have to be moving on constantly. Well this is merely the following title to it as far as I am concerned. This lens implies that a certain part of the nurses considered TIC implementation as a formalization and organizational sponsorship of the practices, which were already being tried to conduct on an informal level.

The other participants however had different opinions regarding the correlation between current practises and TIC principles. One nurse said, "I love the transformations that have taken place... but it is mainly that I do not think there is anything that we should really be doing any other way other than what we are doing." This response means that there may be some resistance to change as it can be found on the basis that the present ways are already working within the principles of TIC and thus any implementation effort that will necessitate changes to such generally established ways and practices may prove to be problematic. Continuity-change spectrum was found to

be an important theme that implementation leaders have to tread carefully helping to avoid problems with staff engagement and encouraging required improvements in practice.

3.2 Hierarchy and professional and organizational structure issues

The qualitative evidences collected during the interview pointed out huge issues concerning structure and professional hierarchy in an organization that would possibly hinder successful implementation of TIC. The need to achieve clarity, consistency and clear expectations on the role during the implementation of trauma-informed care parameters was a recurrent answer given by the interviewees and at the same time, the interviewees raised concerns about continuing conflicts experienced within the multidisciplinary team that could create frustrations to the collaborative implementation efforts(9). These interests were symbolic of macro concerns in healthcare organizations in terms of professional boundaries, decision control, allocation of power and responsibility among the various categories of professionals.

Several interviewees stressed that they wanted to be guided systematically and have the real explanations of roles they have to play within the TIC framework. This was captured in one word by one nurse who said: "I like structure, that is all I could say. Just tell me your rules on what you desire and I can do it." This reaction points to the significance of offering realistic and moveable directions to front line staff through the course of actualization procedures, instead of depending only on abstract philosophical themes that could be hard to move into definite actions of practice. The desire to be given structure also implies that perhaps, there is some uncertainty among the nurses on how best TIC concepts can be operationalized in their day-to-day practice life.

The enquiries that were made about medical superiority and hierarchical group structure were of great concern to many participants. One nurse gave a good description of these dynamics: Doctors are always viewed as being the head of the team.so I guess that makes it a struggle but I think that nurses are going to just have to gain confidence in the fact that they know what they are doing...So there will be those individuals who may work more medically...either you realize that you do and that is fine or that you don;t realize you do and it is going to be a resistance factor...when you are trying to change the way you practice and you also know you should, it is so much energy to continually be challenging it everyday that sometimes This quote gives insight into the affective and psychological struggles that the nurses have in trying to use new practices in the organizational structures that have a long-standing order and, therefore, may not advocate the use of trauma-informed approaches fully.

3.3 Projected Results and Benefits of the Employee

Nonetheless, although the identified difficulties and issues were outlined in the stories of the nurses, all the research subjects were optimistic about the possibilities of changing the outcomes of their work through the implementation of TIC. The expected advantages would have covered various areas, such as better uniformity and continuity in the provision of nursing services, better personalization of and adaptability to treatments, more chances of professional communication and cooperation, and less use of medication-based therapies and more use of relationship-based ones(10).

The other participant gave a detailed description of what she expects to be positive and beneficial about the implementation of TIC: "I expect that it will make our practice less drastic and more unique…It would be utterly positive. And hopefully it can lead to a more talk about various ways of handling people in various situations, and their distress, or aggression or whatever it is that staff might deal with. And it will hopefully open communications and ideas can be thrown off each other as opposed to lets just medicate, which is a big thing, in my experience. This reaction proves that nurses understand that TIC has a potential to change individual practice behaviors as well as team communication patterns and collaborative ways of solving problems.

The interviews were characterised by a general perception by the interviewees that the implementation of TIC was significant in improving more professional, evidence-based and ethically derived nursing practice in spite of the identified difficulties and uncertainties surrounding the change process. The participants showed advanced familiarity with the advanced factors that affect effective organizational transformation and a realistic view of the amount of time and effort needed to transform the clinical practice patterns and the organizational culture to sustain it.

4.Conclusion and Future work

The entirety of the analysis conducted during the implementation of Trauma-Informed Care in this acute mental health inpatient unit does not merely represent the tapestry of outcomes of professional development in graduate-level studies but lays out a complex coat of challenges of the organization as well as the potential to truly transform.

The results confirm that the introduction of TIC as a paradigm of nursing care is a radical change in the nature of work, treatment, and organizational culture that demands long-term persistence, appropriate infrastructure equipment and awareness of the complex nature of the range of variables that lead to effective practice change. The nursing workforce statistics points to a tentative positive result in terms of staff experiences, where there is ample evidence of heightened professional satisfaction, augmented therapeutic confidence, and an improved appreciation of the effects of the effects of trauma on patient care, and at the same time raising the points where there remains pockets of resistance, skepticism, and doubt that need continuous attention and support.

The process of implementation shed light on the highly sophisticated nature of addressing both personal and group levels of professional change as nurses had to balance between personal perception of current practices patterns and the new organizational demands and group functions at the same time. The emergence of philosophical discursive arguments about whether TIC amounts to parade innovation or formalization of currently-existing good practice come as indications of the complexity of professional identity transformation and imply that effective implementation of change initiatives involves paying detailed attention to change-initiative framing and eventual integration with professional values and commitments. Moreover, the described contradictions between the safety requirements and the principles of empowerment evidence the current difficulties in proving the philosophy of trauma-informed care as the longitudinal clinical practice phenomenon in the background of strict healthcare regulation frameworks.

Implications of the workforce development go beyond immediate current improvements on clinical practice itself to raise broader questions regarding professional education, the practice of leadership in the organization and sustainable strategies of bringing about change. These results indicate that TIC implementation can be used as a lever of improved professional activity, improved communication in a team, and a more advanced insight into the relationships of therapeutic bonds, but, at the same time, needs significant investment in continuous learning and supervision as well as organizational support systems. Having established the existence of hierarchy-related hurdles and the desired role expectations makes it apparent that the implementation of a TIC is best achieved through top-to-bottom organizational change and not through mere conversion to using new terminology or adopting bespoke practice changes.

Systematic Evidence and Advice in Sustainable Implementation Strategies

Resting on the empirical evidence and the theoretical discussion performed throughout the current investigation, a number of evidence-based recommendations can be formulated about health care organizations that are thinking of using TIC as a nursing model of care in acute mental healthcare units. To start with, organizations should be aware that the TIC implementation is a long-term process that demands long-term leadership, proper resources, and change management plans to manage not only the individual, but also the systemic issues at play to influence the transformation of practices. The advice to employ the slow, positively coded introduction plans is based on the understanding that as far as professional transformation is concerned, it is not something that can be introduced administratively; rather, it must be fostered through joint action, continuing education, and flexible response to new challenges and opportunities.

The absolute significance of cross-functional collaboration and organizational dedication was one of the main topics that should be considered strategically on the part of implementation leaders. The results are indicative of the prospect that nursing-centered implementation initiatives are beneficial to the construction of expert confidence and experience yet in the end, the expenses of such initiatives could be more constrained without organizational-level impacts that integrate both medical personnel and allied health experts and administrative direction. Further implementation efforts should focus on early involvement of all stakeholder groups, creation of a common understanding about TIC principles and practices, and the creation of collaborative governance, in which the commitment of all stakeholders is guaranteed long term across the professional lines as well as areas authority.

Professional and educational development approaches should incorporate continuous and comprehensive methods that can respond to a heterogeneous population of learners with different educational backgrounds and professional skills in the nursing workforce. The existence of uncertainty and confusing roles identified in some of the participants ensures that the implementation efforts should incorporate tangible advice on particular practice behaviors, certainty in the expectations of professional performance, and sound supports on any problem experiencing nurses in the process of transition. Moreover, the identification that certain staff might have their personal histories of trauma implies the implementation strategies that focus on the wellbeing of a workforce and

that offer the necessary support resources to nurses who can be activated or distressed through the implementation process.

Future Research and Methods Implications

The result of this study sheds light to a number of relevant directions in future research that may lead to a considerable contribution in the knowledge regarding TIC implementation process, outcome, and factors contributing to sustainability in acute mental health nursing practice. Longitudinal studies based on greater samples and a wide range healthcare-based settings would be of benefit to understand the possibility of long-term effects of TIC implementation on nurses workforce, patient care quality and change in organizational culture. Various measurement methods, such as a recognized tool to evaluate the fidelity of implementing trauma-informed care, professional well-being and burnout, the communication and collaboration patterns in the team, and patient-reported data on safety, empowerment, and the quality of therapeutic relationships should also be included in such studies.

CE/CER of various implementation strategies and approaches to organizational structure would be essential direction to healthcare leaders when adopting TIC in their organisations and within their contextual and organisational limitations. Research in the matter should focus on the comparative performance of the top-down implementation methods and bottom-up implementation techniques, the best possible time and sequence to use an educational intervention, the effect of the external consultation and guidance on helping an implementation to be successful, and the effect of the organizational getting-ready factors on the outcome of implementation. Also, the study focusing on the cost-effectiveness of the TIC implementation will be helpful in informing the healthcare administrators and policymakers in deciding the investment in trauma-informed care programs.

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Conflicts of interest

The authors have no conflicts of interest to declare

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