

George Psychiatric Hospital, the program attained 93% patient satisfaction.

Solution-focused therapy facilitates application of recovery principles, instills hope, and serves as an impetus for healing in patients. Dialectical behavior therapy is another approach that can be used alone or in combination with patient-centered care to improve the odds of recovery.

PMH nursing and gains in professional satisfaction are evolving through the practice of proven core standards. The solution-focused therapy program showed that patient-centered therapy enables PMH nurses to optimize care and assist clients to hone tools for recovery.

Solution-focused strategies and other approaches, such as cognitive-behavioral treatment and dialectical behavioral therapy, have added to the armamentarium of mental health tools that can support patients in their recovery journey toward healthier, happier, and more productive lives.

## Soothing Rooms Reduce the Need for Restraints for Inpatient Mental Health Patients

Written by Mary Beth Nierengarten

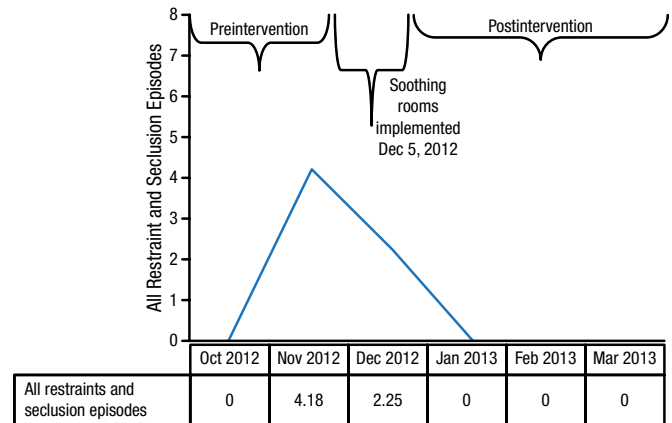
Implementation of soothing rooms for adults and adolescents in an acute mental health unit in a Midwestern regional hospital resulted in a 35% reduction in the use of restraints among the adult patients, demonstrating a benefit to both patients and mental health nurses by reducing restraint usage and suggesting a new standard of care.

The effectiveness of soothing rooms was evaluated in an acute 32-bed mental health care unit at the SwedishAmerican Center for Mental Health, Rockford, Illinois, USA. Representatives from leadership and unit staff presented the results of implementing this new standard of care that the Center for Mental Health provided for nurses.

Defined as a safe and calming environment with sensory objects where escalating patients may self-soothe, soothing rooms incorporate a holistic approach based on a caring attitude, a caring environment, and the development of a trusting nurse-patient relationship.

Patients admitted to mental health facilities should be introduced to a soothing room, and the rooms should be further used during routine patient interactions, during psychological educational groups, at the first sign of patient escalation, and at all other appropriate opportunities.

Figure 1. Results of the Use of Soothing Rooms on Restraint Usage



Results of the SwedishAmerican Center for Mental Health soothing rooms' impact on restraints/seclusion episodes. Analysis indicated that incidences of restraints and seclusion decreased after soothing rooms opened.

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In the planning stages of these rooms, representatives of all disciplines—including clinical nurses, recreational therapists, behavioral therapists, and the leadership—designed 2 soothing rooms partially based on ideas from a 2009 guide published by the New York State Office of Mental Health [MacDaniel M. *NYSOMH*. 2009]. The rooms were painted in neutral and peaceful color schemes with minimal décor and lighted blue-sky ceiling tiles. Positive wall messages, recliner chairs, and a private bathroom with a nature-scene door added to the soothing aesthetic environment.

To further help patients self-soothe, the rooms included sensory objects, such as art therapy tools, DVDs with nature scenes, games and puzzles, music, raised sandboxes for the adult room, weighted blankets, and stress balls.

The soothing rooms were used on a voluntary basis only, and nurses offered them to patients at the first sign of patient distress. When a patient was in the room, he or she was monitored every 15 minutes and allowed to stay in the room for a maximum of 30 minutes. The soothing rooms were not used as a reward or punishment, nor for patients who were unable to use the room safely. The study showed a 35% reduction in the use of restraints (Figure 1).

According to presenters, prior to the implementation of the soothing rooms, there had been limited alternatives to restraints. After implementation of the soothing rooms, presenters said, restraints are no longer the norm and are only used in crises situations.



Presenters emphasized that the 35% reduction in the use of restraints has also reduced the degree of trauma for patients as well as staff.

To validate the evidence, the clinical nurses gathered subjective data from the adults and adolescents through written evaluation that rated their stress levels before and after use of the soothing rooms. The presenters said that this feedback validated the results of the study and overall validates implementation of soothing rooms as the new standard of inpatient care.

## Drug-Related ABI in the Prison Population

Written by Nicola Parry

There is very little scientific research that focuses on investigating the severity of drug use associated with acquired brain injury (ABI). Isaac Daramola, MACNP, MACN, University of Newcastle, Callaghan, New South Wales, Australia, presented data from a study demonstrating high prevalence rates of drug-related ABI among prisoners in the Australian state of Victoria [Jackson M et al. *Acquired Brain Injury in the Victorian Prison System*. Department of Justice, Melbourne, Victoria, Australia. 2011].

According to Mr Daramola, correctional agencies have not recognized ABI as an issue of specific concern. Additionally, he noted that current understanding of the prevalence of ABI is limited to its association with head trauma. Consequently, this study was conducted—with limited scientific evidence that proves that drug use can cause ABI and significantly affect frontal lobe function—to investigate the prevalence of ABI and test for drug-related ABI among prisoners in Victoria.

The study enrolled adult male (n=110) and female (n=86) prisoners from 2 Victorian prisons. Only sentenced prisoners were included. Those in transit or remand were excluded from the study, as were prisoners with an intellectual disability or those from a culturally and linguistically diverse background.

The following 3-stage screening process was used to evaluate participants. In stage 1, an ABI screening tool was used to identify individuals with possible ABI. In stage 2, a clinical interview was used to verify risk factors identified during screening. In stage 3, a comprehensive neuropsychological test battery was used to provide a more objective indication of ABI.

Stage 1 data demonstrated that alcohol and drugs were the most commonly recorded risk factors for ABI in both men and women. Compared with male prisoners, female prisoners were more likely to screen positive

Table 1. Select Data From Prisoners Who Completed All 3 Stages of the Screening Process

Finding	Male Prisoners, %	Female Prisoners, %
Positive indicators of acquired brain injury	66	75
≥Current or past psychiatric diagnosis	63	79
Drug-related acquired brain injury		
Mild	55	72
Moderate	39	21
Severe	6	7

Source: Jackson M et al. *Acquired Brain Injury in the Victorian Prison System*. Department of Justice, Melbourne, Victoria, Australia. 2011.

for drugs (41.3% vs 61.6%) and were less likely to report alcohol as a risk factor (24.8% vs 15.1%).

Of the participants who originally undertook stage 1 of the screening process, only 74 male and 43 female prisoners completed stage 3. Final results were processed only from those participants who completed all 3 stages (Table 1).

Mr Daramola indicated that of the prisoners who had ABI, 95.6% of men and 94.3% of women reported alcohol use, while 75.6% and 83.0%, respectively, reported cannabis use.

He emphasized that the study results demonstrated a high prevalence of drug-related ABI in the prison population compared with the general population. He also noted that the impact of drug-related ABI differed among men and women, as indicated by their different cognitive profiles. While male prisoners presented with more widespread and generalized impairments in all areas, female prisoners particularly showed impairments in spatial abilities, complex attention, and working memory.

In summarizing, Mr Daramola indicated that when most prisoners with drug-related ABI leave prison, they leave with severe ABI, and if this goes undetected, it can have significant implications for public safety. These results necessitate the inclusion of ABI screening tools (stage 1) at entry-level assessment points (eg, mental health clinics, family practices, emergency departments, hospitals). He concluded that because severe ABI restricts the prisoners' ability to recognize the potential consequences of their actions, this can increase risk of reoffending, particularly violent reoffending.