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CREATING ALTERNATIVES

REDUCING THE USE OF SECLUSION AND RESTRAINT BY CREATING SENSORY MODULATION AREAS IN INPATIENT UNITS

“Anything that could help someone actually feel better in a moment of crisis was bound to be a winner.”
Mike Wilson, Research project lead - clinical services development, Te Pou.

AT A GLANCE
What: Using sensory modulation as a de-escalation tool.
Why: To reduce the use of seclusion and restraint.
How: By setting up sensory rooms in inpatient units and training clinicians in their use.
Target: Mental health inpatient unit service users.
Where: Four District Health Board areas.

THE PROFILE

“It’s using that principle of calming people through their senses rather than through cognitive means.”
Daniel Sutton, Senior lecturer, AUT.

In the last decade, sensory-based approaches have gained increasing credibility as a therapeutic intervention which offers a more collaborative and holistic alternative to the use of seclusion and restraint in mental health services (Champagne & Stromberg 2004). Using a sensory approach as an alternative to restrictive practices was integrated with the "Six core strategies" framework of the National association of State Mental Health Program Directors (USA).

Since then it has been adopted across Australia in their national initiative to reduce rates of seclusion. In 2007 the inpatient unit staff at Northland DHB in Whangarei (New Zealand) established the first sensory room, aimed at reducing the use of seclusion and restraint.

Based on initiatives already in place overseas and the pioneering initiative at Northland DHB, four more DHBs agreed to work with Te Pou to trial this approach in a structured research protocol. The trial involved setting aside a designated space in the inpatient unit, equipping each room with the same sensory inventory, and training staff in a standardised protocol for using the room.

Setting up the sensory rooms and delivering the training required a new enterprise model that saw a cross-sectoral team working together for this project. That team was formed by Te Pou project leader Mike Wilson in conjunction with Dr Daniel Sutton of Auckland University of Technology and Vanessa van Pomeren, Northland DHB’s senior occupational therapist. The research team collaboration extends to Dr Kirsten van Kessel of Auckland DHB’s Child and Family Unit, Jenny Long, researcher from Te Pou, and Mr Nick Garrett, biostatistician from Auckland University of Technology.
This collaboration across Te Pou, DHBs and the university sector approaches seclusion reduction from a different angle, drawing from the active leadership in the work in Northland DHB’s pioneering initiative.

THE BEGINNINGS

“When a person is in a high state of arousal he is functioning from a very primitive centre of his brain. Appeals to higher cortical function are therefore not likely to be very effective. In these times it can be more effective to work on the body/mind connection rather than the mind/body connection.”

Mike Wilson, Research project lead - clinical services development Te Pou.

There is significant evidence about the traumatic effects of seclusion and restraint on mental health service users (Mental Health Commission 2004). In 2008 Te Pou organised an establishment group of representatives from every stakeholder group in the mental health sector. Their role was to define the approach and aims of a national seclusion reduction project. One of the key aims that emerged from this group was to develop and evaluate interventions that reduced the use of seclusion and restraint.

Sensory modulation involves providing a range of activities that engage the senses in a safe environment. Smell, touch, sound, sight and even taste may be engaged as well as sensory motor functions, such as rocking or squeezing, to reduce distress, induce calmness and create a feeling of being in control. Until recently, sensory modulation has been most commonly used in the treatment of dementia and intellectual and developmental disorders in young people. However, evidence is beginning to emerge that this approach can be helpful in “avoiding the use of restrictive interventions and in promoting recovery-oriented treatment environments” (Champagne & Stromberg, 2004).

In 2009, with the support of Jane Vanderpyl, Te Pou’s national research manager, Mike Wilson began to investigate the evidence about sensory modulation. This included the early results from New Zealand’s first sensory modulation initiative at Northland DHB.

The evidence was not very strong, but it was consistent in associating this approach with seclusion reduction. Mike thought it would be worthwhile to test this association more rigorously while at the same time introducing this approach more widely. He quickly found like minded allies in a team of clinicians, academics and researchers to develop and support this venture. Vanessa van Pomerren agreed to provide clinical guidance for the implementation. Daniel Sutton, a senior lecturer at Auckland University of Technology (AUT) in Occupational Therapy agreed to help develop the training package and the research design and undertake qualitative data collection. Kirsten van Kessel of ADHB and Nick Garret of AUT along with Jenny Long from Te Pou’s research team brought the quantitative and data management muscle to the project. The AUT Research Office provided significant financial support, and its manager, Sara Metcalf, helped to steer the process through the Multi-Region Ethics Committee.

In February 2009, four DHB’s (Capital and Coast, MidCentral, Counties Manukau, and Auckland) were chosen from a national expression of interest to set up sensory modulating areas in their inpatient units, including a service for children and adolescents, thus completing the cross-sectoral partnership.

THE PROCESS

“I see sensory interventions as helping people develop strategies that they can not only use in the unit but also when they go home for self regulation and de-escalating ...”

Daniel Sutton, Senior lecturer AUT.

The process of setting up sensory modulating rooms comprised of three main components.

1. Choosing and purchasing the equipment and setting it up onsite.
2. Identifying project champions in each unit, and providing some basic tools for them. Each of these champions participated in the final Beacon Project forum in Sydney, which introduced them to how seclusion reduction was being accomplished all across Australia.
3. Developing a training package.

While the participating services had agreed to provide suitable rooms, equipment for the initiative was funded and provided by Te Pou. The team developed a baseline inventory of the equipment use, based on the standard equipment used overseas and experiences in Northland DHB.

Some of the equipment (ambient lighting, massage chairs, sound systems) was expensive, so developing relationships with vendors was important. The team were impressed by the goodwill they received from the private sector including discounts on freight and multiple purchases. Other items such as soft toys, stress balls and low key music CDs were less expensive and could be purchased locally.

The team worked with local clinicians to develop the areas at each unit and decide on the particular sensory tools they would use. At the same time local project leaders and champions to carry out the implementation of sensory room were identified.

In May/June of 2009 nearly 200 clinicians from the four DHB inpatient services were trained in sensory modulation theory and the use of sensory tools. The training was carried out in a series of 34-hour modules delivered to as many staff as possible at each site. The training covered four main areas:

- the background to the project
- the theoretical basis of sensory interventions
- information about the interventions themselves including the environment and equipment
- the assessment process.

The final aspect of the training was the guidelines and protocols for using the interventions. The training sessions were interactive and involved clinicians experiencing the equipment and using the rooms. Clinician’s concerns about safety and timing were worked through as part of the training sessions.

While there were local differences in the size and placement of the rooms, each unit was equipped with a massage chair, bean bags, rocking chair, ambient lighting that can be softened or changed in colour, access to music, weighted blankets, scented oils and objects such as soft toys and faux-fur wraps which provide a sense of comfort. Use of the room was tailored to individual service users’ preferences that are routinely assessed on admission. Service users who found sensory modulation helpful were encouraged to use similar techniques when they return home.

“What impressed me about this approach, over some of the other strategies to reduce seclusion, was that this one could be fun because it involved a sense of play”
Mike Wilson, Research project lead - clinical services development, Te Pou.
THE UNIQUE APPROACH

• Providing sensory rooms at inpatient units for the first time in New Zealand.
• Different therapeutic focus.
• Cross-sectoral partnership between Te Pou, AUT and DHB clinicians.
• Flexibility of the DHBs involved in providing the opportunities to undertake a new initiative that was basically untested in New Zealand.
• Project champions from the DHBs participated and presented in Australia’s seclusion reduction initiative, Project Beacon.

THE RESULTS

Early results from those sites that have engaged with the intervention suggest the initiative is having a positive effect in reducing the use of seclusion and restraint. While the impact of the use of sensory rooms is still being evaluated, anecdotal evidence points to the following.

• Clinicians are positive about the rooms’ effects and are developing protocols tailored to the needs of individual service users.
• Service users report liking the rooms and feeling comfortable in them.
• The ‘fun’ aspect of the intervention has had a positive effect on both clinicians and service users.
• Some service users have been able to use sensory modulation strategies when they return home.

The evaluation of this project, the results of which will be reported on by February 2010 will include:

• the impact of the sensory rooms on levels of seclusion and the use of restraint
• the correlation between types of mental health diagnosis and response to using sensory modulation
• the relationship between using the sensory rooms and the use of per-required-needs (PRN) medication
• the effects of the sensory rooms, as assessed by the comparing levels of arousal before and after using the room
• ways to make the sensory rooms culturally relevant
• levels of service user and staff satisfaction with the intervention
• changes to levels of clinician confidence with experience with the intervention.

The Lessons Learnt

“Addressing arousal from a sensory rather than cognitive level by providing an environment where sensory input is under one’s own control can create a sense of empowerment. This provides a new tool for de-escalation so that aroused behaviours can then be addressed cognitively”

Mike Wilson, research project lead - clinical services development, Te Pou.

• Academic expertise, clinical expertise and practical experience can be brought together with positive results.
• Presenting the details of initiatives in a clear and concise way from the outset is important to the success of new initiatives like this one.
• Working alongside clinicians produces the best results.
• Finding local champions and leaders is important.
The experiential aspects of the training sessions were most influential in getting clinicians on board.

MORE INFORMATION

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Website
- Sensory rooms in mental health
- Seclusion: time for change

References

Mike Wilson, Research project lead - clinical services development, Te Pou.