



Ministry of Public Health Afghanistan
General Directorate of Curative Medicine
Directorate of Central Hospitals
Kabul Mental Health Hospital

Mental Health Guidelines



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1. CODE OF CONDUCT

Mental Health Hospital, Kabul, Afghanistan

The Mental Health Hospital in Kabul provides quality Mental Health Services to patients with mental health difficulties at all ages. Problems can be treated with or without hospitalization and we make every effort to minimize disruption of jobs and home life. Privacy is carefully protected.

Our Mission:

Our mission is to improve the lives of people with mental illness and their families through the provision of accessible, acceptable and high quality mental health care in Afghanistan.

Introduction

This Code of Conduct is for all employees of the Mental Health Hospital in Kabul. The Code is not meant to answer every question that might come up for the employee at MHH, it is clinics, or other providers with whom we have business agreements. The Code does provide guidelines and direction in responding to circumstances and issues that may arise in our daily work. In addition THE CODE also contains a series of frequently asked questions with answers that have been developed with the input of staff. We encourage you to use this resource if you have any questions.

General Principles

Assets: All assets of the hospital shall be used solely for the benefit and purpose of the MHH and the service users. Personal use of corporate assets is not permitted, unless disclosed to, and approved by the Mental Health Hospital Compliance Committee. Hospital assets include, but not are limited to; financial data, equipment, furniture, vehicles, office supplies, petty cash, employee time and computer supplies.

Medical records : Clinical staff are oriented and trained and have to adhere to their clinical medical records responsibilities. Although retraining occurs on a regular basis through clinical supervision and more formal trainings, clinical staff have an obligation to ask questions and continuously update themselves on documentation requirements and regulations regarding service delivery. Administrative and clinical staff have an obligation to work together to make sure that services are authorized. The authorization process provides initial confirmation of the medical necessity of the services being provided. Both staff have an obligation to understand the authorization process to complete their part of work timely, and to notify their supervisors if there is a problem. Frequency of services are determined by clinical judgment and documented in a current treatment plan. It is the responsibility of the clinical staff and their supervisors to ensure that treatment plans are current, that they have formulated the plan with the individual receiving the services, and that the plan represents medically necessary services. Services are provided by clinical staff according the treatment plan and the rules of

MHH. Clinical staff are responsible for making sure that all information and patient data are correct.

Bribes, gifts and gratuities: No person associated with the MHH shall accept any incentive in the form of bribes, gifts and gratuities intended to persuade business decisions, solicit an unfair advantage, or reward special attention or service.

Cash: No person with access to cash accounts shall mishandle or otherwise misappropriate funds of MHH. All internal control procedures shall be adhered to all the times.

Confidential information: Client information will be kept strictly confidential

The MHH will only disclose protected health information to authorized persons or entities and according to applicable law. All employees, volunteers, and business associates within MHH shall respect the confidential nature of client information, and shall refrain from disclosing or discussing issues inappropriately. Information obtained through employment or association with MHH must not be used to benefit other employees or organizations.

Protection of clients and families: Clients affected by mental illness and their families are especially vulnerable to rights violations and abuse and they deserve special protection. No employee of MHH shall engage in one type of intimidation, aggression or violence (mental or physical) or sexual harassment or sexual contact (regardless of whether consensual or not) towards clients and their families seeking care at MHH.

Conflict of Interest: All employees shall disclose any potential conflict of interest and refrain from any activity that represents an unfair business advantage by virtue of their business interest or employment with MHH. Employees may hold a second job in addition to employment with the MHH, as long as it does not affect the employees performance or represent a conflict of interest. Questions should go to the director of MHH. No individual associated with MHH shall engage in any unlawful acts of accepting payments or benefits in return for generating business activities.

Financial and statistic reports: Expense reports, reimbursement request, financial and statistic statements and cost reports shall be completed thoroughly and accurately. No individual shall willfully or purposely misrepresent any financial reports or reimbursements.

Financing: The MHH shall maintain a familiarity with the terms, conditions and covenants contained in any financing agreements and shall refrain from engaging in any activity in direct conflict or breach of these terms and conditions or contracts.

Non-discrimination: All persons associated with MHH shall adhere to prohibiting discrimination based on age, race, gender, color, marital status, disability, sexual preference or national origin while providing services or conducting business activity of the MHH.

Quality of Care: The goal of MHH in serving patients is to provide high quality services that meet generally accepted standards of care in the industry, are

compliant with regulation and law, maximize wellness and promote recovery. MHH will recognize and respect a patient's right to participate in decisions involving his or her health care. All staff of the MHH are obliged to contribute to the overall quality of the service delivered. All Staff have an obligation to report any concerns or questions about the quality of care being delivered at the MHH to their supervisor or hospital management.

Research : Research will only be conducted with the expressed and written approval of the hospital management. Research on human subjects will be a relevant Institutional Review Board (IRB) and obtain informed consent from the client or the designated representative of the client.

Responding to Audits: All MHH staff will refer all external requests and inquiries from government and other oversight agencies to the hospital director. Staff will cooperate with all government audits and investigations and provide accurate and timely information to internal and external audits and investigations in accordance with legal requirements. No documents will be destroyed which have been requested as part of an investigation or audit.

FAQs and Ethical Considerations

If I report something suspicious, will I get in trouble if I was wrong about what I reported?

As long as your concern is honest, the Mental Health Hospital Corporate Compliance Plan prohibits you from being reprimanded or disciplined. Part of your responsibility as an employee of the MHH is to report suspected problems or concerns you have. In fact, you may be subject to discipline if you witness something but do not report it. The only exception is if you intentionally report something that you know it is false or misleading in order to harm someone else.

Who should I talk to first about a concerns?

Since many of the laws and regulations that apply to us are complex, it would not be unusual for you to have questions or concerns. We encourage you to discuss the situation with your supervisor first. However, you may go directly to the Corporate Compliance Officer or to the MHH director with your concern.

What shall I do if my supervisor asks me to do something that I think is illegal or violates the Code of Conduct?

No matter who asks you to do something, if you know it is wrong you must refuse to do it and immediately report the request to a level of management above your supervisor or to the Director or the Corporate Compliance Officer or another manager within the hospital.

What kind of patient information should be kept confidential?

All forms of patient information must be kept confidential whether it is written, spoken, recorded electronically or printed. Staff should be aware of their surroundings when discussing patient information. Patient information should not be discussed in public areas if the information can be overheard. Caution should be

used when conducting conversations in semi-private rooms, waiting rooms, corridors and stairwells, cafeterias or restaurant and/or on public transportation.

How do I know if I have sufficiently documented the service I have given a client?

The purpose of maintaining medical records is to preserve information to the mental health care of our clients. Notes in the medical record should be completed at the time of service or event or as soon as possible. All notes should be signed, dated and timed. Notes should describe the services provided and events that occur during the provision of health care in factual, objective, clear and concise manner. Often, specific requirements are needed. An example is that a family psychotherapy service must be directed exclusively to the needs of the identified client. The documentation must support this.

May the department accept gifts such as a luncheon sent by a company or cookies given to us by a client?

Gifts to entire departments may be accepted if they are consumable or perishable such as the lunch or the cookies. However, gifts to individuals should not be accepted without consulting first your supervisor.

There is a clinician in our department who sometimes request clinical records when he is not involved in the clients treatment. Is he allowed to do this?

No. Only the attending, covering or consulting clinicians(s) may have access to a clients record. Clients are entitled to expect confidentiality of their protected health information

I volunteer for the human rights organization when I am off. May I copy a fundraising leaflet using the office copier?

MHH equipment should not be used for non- business purposes.

I have read this Code of contact, I have understood the rules and any questions I have at this time have been answered. I know , this is a part of my contract.

Kabul

Employee
Resource department

Kabul

Dr. Mussamin, MHH Director

Kabul

MHH Human

2. Patient Rights in Mental Health Hospital, Kabul

Access

A right to access healthcare services that means the right to see a doctor, get medications and advices free of charge.

Safety

A right to receive high quality health services provided with professional care, skill and competence. Receive treatment in a clean and hygienic environment that does not expose them or their family members to further risk of disease or infection. Personal safety for themselves and their family members while at the hospital.

Respect

A right to be provided with care that shows respect to culture, beliefs, values and personal characteristics. Receive quality healthcare without discrimination because of race, creed, gender, religion, national origin or source of payment.

Communication

The right to receive open, timely and appropriate communication about health care in a way that can be understood.

Participation

The right to participate in making decisions and choice about care and about health services planning.

Privacy

A right to the privacy and confidentiality of personal information.

Comment

The right to comment on or complain about care and have concerns dealt with promptly and properly without the fear of retaliation or compromise of access or quality of care.

3. Guidelines and Principles of Rapid Tranquillisation

Fourth article: AFGHANISTAN Mental Health Act

Health establishments and all related foundations are bound to consider decrees of this article and all legislative documents in their behaving towards people with mental disorders.

Drugs for rapid tranquillization, particularly in the context of restraint, should be used with caution because of the following risks:

- Loss of consciousness instead of calming or sedation
- Over-sedation with loss of alertness
- Possible damage to the therapeutic partnership between service user and clinician
- Specific issues in relation to diagnosis
- Respiratory depression

- Cardiac dysrhythmia
- Loss of consciousness instead of calming or sedation
- Resuscitation equipment and drugs, including flumazenil, must be available and easily accessible where rapid tranquillisation is used.
- Because of the serious risk to life, Patient/client who are heavily sedated or using the effect of illicit drugs or alcohol should not be **secluded**.
- If a Patient/client is secluded, the potential complications of rapid tranquillisation should be taken particularly seriously.
- Violent behaviour can nearly always be managed without the prescription of unusually high doses or 'drug cocktails'. The minimum effective dose should be used. The BNF recommendations for the maximum doses should be adhered to unless exceptional circumstances arise.
- With growing awareness that involuntary procedures produce traumatic reactions in Patient/client, following the use of rapid tranquillisation, Patient/client should be offered the opportunity to discuss their experiences and should be provided with a clear explanation of the decision to use urgent sedation. This should be documented in their notes.

MEDICAL EQUIPMENT

A crash bag (including an automatic external defibrillator – a bag valve mask, oxygen, annuals, fluids, airways, pulse oximeter, vital signs monitor, suction and first-line resuscitation medications) should be immediately available (NICE recommends within 3 minutes) in clinical areas where rapid tranquilisation may be used. The equipment should be maintained and checked daily to make sure it works when needed).

PHYSICAL OBSERVATION

Physical Observations should be carried out until the Patient/client becomes active again.

The following should be monitored **continuously** (and documented regularly) during the period of restraint:

- Pulse
- Blood pressure
- Respiration rate
- Temperature
- Hydration levels

Where possible the Patient/client should be cared for in the recovery position.

If the Patient/client is asleep, a more frequent and intensive monitoring by nursing staff is required and should be recorded in the appropriate documentation.

Particular attention should be paid to the Patient/client's respiratory effort, airway and level of consciousness.

ROUTE OF DRUG ADMINISTRATION

- Oral medication should always be offered before parenteral medication.

- If parenteral treatment proves necessary, the intramuscular route is preferred over the intravenous one from a safety point of view. Intravenous administration should only be used in exceptional circumstances.
- Vital signs **must** be monitored after parenteral treatment is administered. This is mandatory and recorded. Blood pressure, pulse, temperature and respiratory rate should be recorded at 15 minute intervals and agreed by the multidisciplinary team, until the Patient/client becomes active again. If the Patient/client appears to be or is asleep, **more intensive monitoring** is required.

Pharmacological Agents In Rapid Tranquillisation

- The intramuscular (IM) preparations recommended for use in rapid tranquillisation are lorazepam and haloperidol. Wherever possible, a single agent is preferred to a combination.
- When rapid tranquillisation is urgently needed, a combination of IM haloperidol and IM lorazepam should be considered.
- IM olanzapine is now also available as an option for moderate disturbance in psychotic patients only. However, clinical experience is limited.
- IM olanzapine and IM lorazepam should **not** be used in combination as IM olanzapine produces much higher plasma concentration as compared to oral olanzapine. There is a risk of excessive sedation and cardio respiratory depression when used in combination.
- IM diazepam and IM chlorpromazine are **not** recommended for the pharmacological control of behavioural disturbances.
- When using IM haloperidol (or any other IM conventional antipsychotic) as a means of behavioural control, an anticholinergic agent may be needed to reduce the risk of dystonia and other extra pyramidal side effects, and these symptoms/signs should be monitored for.

RISKS ASSOCIATED WITH BENZODIAZEPINES

- Loss of consciousness
- Respiratory depression or arrest (benzodiazepine antagonist and flumazenil should be available)
- Intramuscular diazepam is erratically absorbed and should not be used

RISKS ASSOCIATED WITH ANTIPSYCHOTICS

- Loss of consciousness
- Cardiovascular complications e.g. arrhythmias, hypotension and collapse
- Seizures
- Specific adverse effects including – subjective experience of restlessness (akathisia), acute muscular rigidity (dystonia), and involuntary movements (dyskinesia), neuroleptic malignant syndrome
- Chlorpromazine is a local irritant if given intramuscularly. There is also a greater risk of hypotension, cardiovascular complications and seizures

Special consideration need to be on the following Articles of Islamic republic of Afghanistan's mental health Act when making decisions.

Tenth article:

To protect the interest of person with mental disorder at the capital and provinces level some delegations (commission) will establish:

1. Director mental health as head of commission
2. Authorized person from curative medicines department as member of commission
3. A person form attorney office as member
4. A psychiatrist as member of commission

Commission delegations are authorized for the followings:

1. Is working under framework of mental health to proceed and develop the research and promotion of capacity and knowledge of psychiatry
2. Receiving complain from mentally ill patients, care them and taking decision for them
3. Assessing development of mental condition of mental offenders and whom receiving involuntary treatment
4. Asking for proxy for people with mental retardation from court
5. Checking the reports receiving from mental health facilities regarding involuntary treatment of people with mental disorder
6. Checking and approving national mental health plan

Eleventh article:

The commission has the following authorities and obligations:

1. Listening to complaints of people with mental disorders, providing care to them and taking decision about them.
2. Assessing improvement in psychiatric condition of criminals with mental disorders and of people who are put under involuntary treatment.
3. Demanding proxy through court for mentally retarded people.
4. Assessing reports of involuntary treatment of people with disorders from centers of psychiatric services.

4. Guidelines for Aggression Management

The World Health Organization definition (2002) relates to *‘incidents where staff are abused, threatened or assaulted in circumstances related to their work.’*
www.who.int/topics/violence

Aggressive and violent incidents in the health-care setting are increasing phenomena around the world. The evidence from current literature suggests that changes in health-care access, nursing staff shortages and patient acuity are some of the possible causes.

Violence may be caused by many different factors and should not be viewed as acceptable from mental health service users. It should be viewed as an exception rather than the norm.

The most common factors include:

- Use of alcohol or drugs (including illicit drugs);
- Over or under stimulating environment e.g. boredom;
- Service user has a previous history of aggression;
- Medical diagnosis of psychotic disorder;
- Command hallucinations, paranoid delusions;
- Stressful environment or situations;
- Difficulties in communicating;
- Confusion and disorientation e.g. dementia;
- Poor impulse control;
- Physical ill health.

The following points can help in predicting and reducing future risk:

1. De-escalation
2. Medication intervention

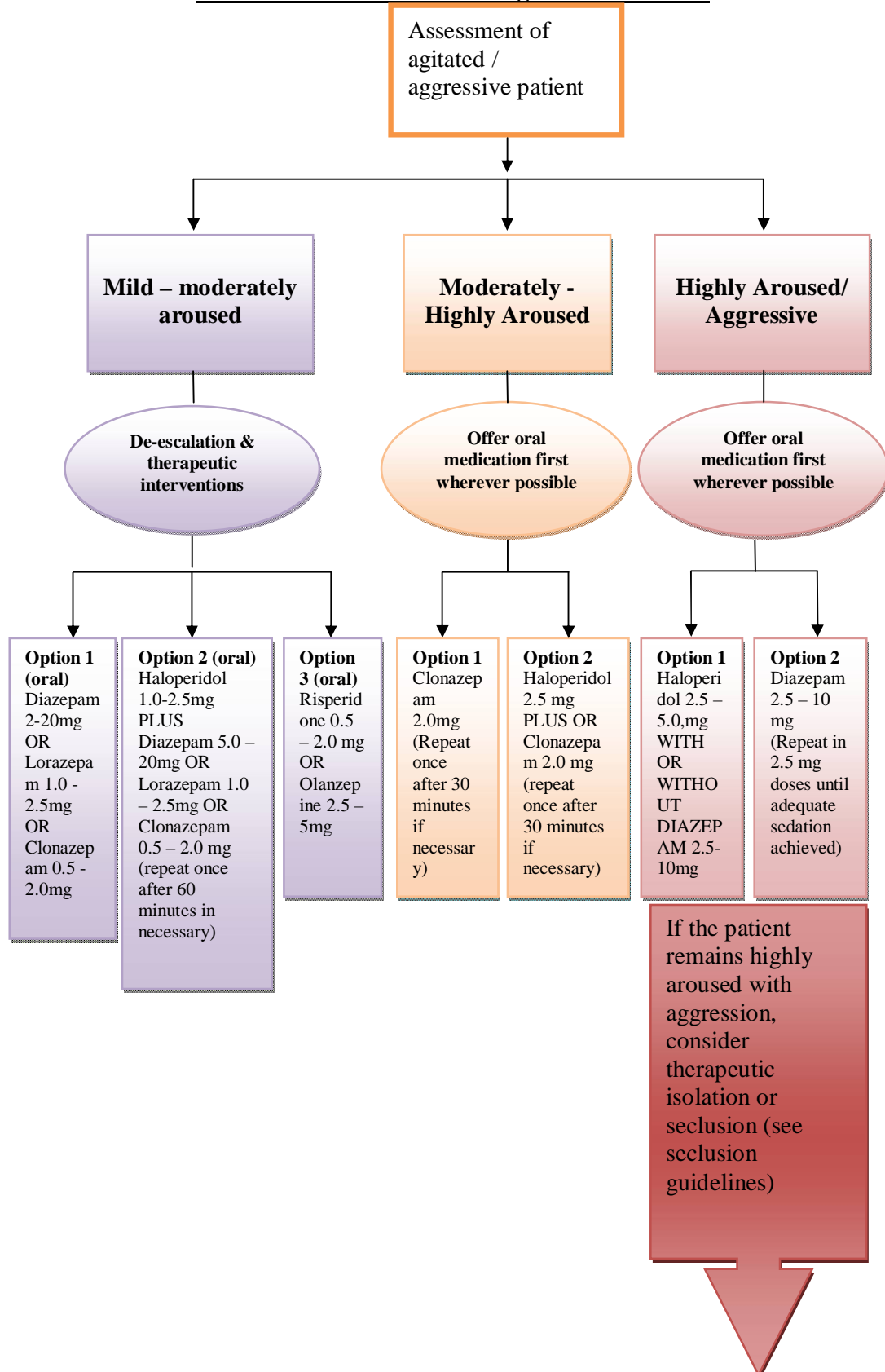
De-escalation

De-escalation is a valuable intervention that can be used by nurses to help counter the growing problems of aggression and violence.

De-escalation, or diffusion, is the term applied to a combination of verbal and non-verbal interactions, which can, when used appropriately, reduce the threat of violence including the patient's anger and return them to a more calm state of mind the principles involves:

- Identifying trigger factors in each service user and ensuring that this information is available and communicated to all relevant staff involved in the service user's care;
- Documenting management strategies from the trigger factors that are identified clearly on the patient's care plan;
- Engaging the patient as an active participant in their care planning;
- Communication with the patients, allowing for the development of positive solutions or alternatives for dealing with frustrations;
- Sensitivity to ethnic, cultural, religious and gender values should be shown;
- Awareness of non-confrontational and/or aggressive body language by patients and/or staff;
- Importance of boundaries and consistency of staff approaches.

Decision tree with Pharmacological interventions



PROCESS	ACTION	REFERENCE
Assessment	<p>1. May include any or a combination of the following;</p> <ul style="list-style-type: none"> • Loss of control by the patient which may include any of the following; <ul style="list-style-type: none"> - Physical assault of others - Forceful damage to property - Forceful injury to others - Injury to self • Body Language <ul style="list-style-type: none"> - Clenched fists - Clenched jaw - Rigid posture - Tautness indicating intense effort to control emotions - Agitation - Increasing motor activity - Pacing • Hostile threatening verbalisations • Possession of a potential weapon • Provocative behaviour <ul style="list-style-type: none"> - Argumentative - Dissatisfied - Over-reactive - Hypersensitive - Poor impulse control. <p>2. Risk assessment for aggression</p> <ul style="list-style-type: none"> - In collaboration with the treating multi-disciplinary team and other health professionals - Antecedents and warning signs - Conduct an assessment for imminent aggression using the Broset Violence Checklist 	<p>Xeniditis et al (2001) Blair (1991) Fry et al (2002) Beck et al (1984) Stuart GW et al (1987)</p> <p>National Collaborating Centre for Nursing and Supportive care (2005)</p>
<p>Treatment</p> <p>Mild – Moderately Arousal</p> <p><i>Mildly aroused – pacing , still willing to talk reasonably</i></p> <p><i>Moderately aroused – agitate, becoming more vocal, unreasonable or hostile (implement de-escalation techniques first) if not successful then look</i></p>	<p>Administer (oral therapy)</p> <ul style="list-style-type: none"> • Option 1 <ul style="list-style-type: none"> - Diazepam 2-20 mg Or <ul style="list-style-type: none"> - Clonazepam 0.5 – 2mg Or <ul style="list-style-type: none"> - Lorazepam 1 – 2.5mg <p>Repeat after 60 minutes if necessary. If ineffective consider Option 2.</p> <ul style="list-style-type: none"> • Option 2 <ul style="list-style-type: none"> - Haloperidol 1.0 – 2.5mg <p>PLUS</p> <ul style="list-style-type: none"> - Diazepam 5 – 20mg <p>Or</p>	<p>SCGH Emergency medical Guidelines (2004) Western Australian Drug & Therapeutics Committee (2003) Rose et al (2002) Shaw et al (2003) Marcantonio (2005) Byrne (2005) Bateman (2003) Gareri et al (2003)</p>

<i>at pharmacological</i>	<p>- Clonazepam 0.5 - 2.0 mg Or - Lorazepam 1 – 2.5mg Repeat after 60 minutes if necessary. If ineffective consider Option 3 and/or parental route. • Option 3 - Olanzapine 2.5 – 5 mg Or - Risperidone 0.5 – 2.0mg</p>	
Treatment Highly Aroused <i>Highly aroused – distressed, fearful, noisy and may include overt violence</i>	<p>Administer (IMI or IV) • Option 1 - Haloperidol 2.5 – 5 mg WITH OR WITHOUT • Option 2. - Diazepam 2.5 – 10 mg Repeat in 2.5mg doses until adequate sedation is achieved.</p>	<p>SCGH Emergency medical Guidelines (2004) Western Australian Drug & Therapeutics Committee (2003) Rose et al (2002) Shaw et al (2003) Marcantonio (2005) Byrne (2005) Bateman (2003) Gareri et al (2003)</p>
Precautions	<ul style="list-style-type: none"> • Resuscitation and experienced staff need to be available at all times to ensure first-line management in the event of respiratory depression. • The patient's respiratory function needs to be monitored when benzodiazepines are administered. • Consideration of the patient's usual medications are likely to contribute to the patient's mental state. 	<p>SCGH Emergency medical Guidelines (2004) Western Australian Drug & Therapeutics Committee (2003) Rose et al (2002) Shaw et al (2003) Marcantonio (2005) Gareri et al (2003)</p>
Ongoing management	<ol style="list-style-type: none"> 1. Once patient's arousal has subsided provide the patient with the opportunity to discuss / de-brief about incident and attempt to discover the reason for patient's arousal. This may include utilising skills such as listening skills and negotiation techniques. 2. Ensure that a pre-emptive management plan is in place for subsequent episodes of violence 3. Provide opportunity for staff to ventilate / de-brief post incident 	<p>National Collaborating Centre for Nursing and Supportive care (2005)</p>

AGGRESSION AND AGITATION DRUG FORMULARY in MENTAL HEALTH

Classification	Drug	Dosage	Adverse Effects
Antipsychotic	Olazepine	5.0 – 20 mg / 24 hours	Weight Gain Hypotension Anticholergic Effects
Antipsychotic	Risperidol	6.0 – 8.0 mg / 24 hours	Insomnia Agitation Extrapramidal Effects Anxiety Headache
Antipsychotic	Haloperidol	<i>Oral:</i> 1.0 – 100 mg / 24 hours <i>Intramuscular:</i> 2.0 – 10.0 mg initially then further doses given 30 – 60 minutely depending on patient response – should not exceed 100 mg / 24 hrs	Extrapramidal Effects Anticholinergic Effects Dystonic Reactions Akathesia
Benzodiazepine	Clonazepam	4.0 – 8.0 mg	Dependence CNS depression Anterograde amnesia Disinhibition Intoxication Respiratory depression
Benzodiazepine	Diazepam	5.0 – 20 mg	Dependence CNS depression Anterograde amnesia Disinhibition Intoxication Respiratory depression
Benzodiazepine	Lorazepam	2.0 – 4.0 mg	Dependence CNS depression Anterograde amnesia Disinhibition Intoxication Respiratory depression
Anticholergic	Benztropine	1.0 – 2.0 mg	Anticholergic Effects, including dry mouth, dilatation of pupils, flushing, worsening of glaucoma, urinary hesitancy, constipation, nausea and blurred vision Central effects including dizziness, hallucinations, euphoria and hyperpyrexia

(Therapeutic Guidelines: Psychotropic, 2000; Perry et al, 1997)

For a full step by step lead please refer to the nursing procedure manual

5. Guidelines for Anti-Psychotic Medications

Guidelines for use by: Doctors and Nurses

1. Key points for using antipsychotic therapy in clinical best practice

1.1. Indication:

- Ann oral atypical antipsychotic drug should be considered as first-line treatment for individuals with newly diagnosed schizophrenia.

1.2. Dose

- Doses should remain at the lower end of the therapeutic dosage recommendations.
- The lowest-effective dose should always be prescribed initially, with subsequent titration according to clinical response and monitoring of effectiveness of dose and ongoing need for therapy.
- The dosage of a typical or an atypical antipsychotic medication should be within the manufacturer's recommended range. Reasons for dosage outside of this range should be justified and documented.
- 'Rapid neuroleptisation' should not be used. Rapid loading doses should be used with extreme caution.

1.3. Choosing medication:

- Choice of medication should be made on the basis of prior individual drug response, patient acceptance, individual side-effect profile and cost-effectiveness, other medications being prescribed and patient co-morbidities.
- Antipsychotic medications, atypical or conventional, should not be prescribed concurrently, except for short periods to cover changeover.
- Depot formulations should be considered only where there is strong evidence for non-adherence.
- A trial of clozapine should only be offered to patients with schizophrenia who are unresponsive to at least two adequate trials of antipsychotic medications
- Prophylactic use of anticholinergic agents should be determined on an individual basis and re-assessment made at 3-monthly intervals

1.4. Duration

- Treatment trial should be at least 4-8 weeks before changing antipsychotic medication.
- Treatment should be continued for at least 12 months, and then if the disease has remitted fully, may be ceased gradually over at least 1-2 months.

1.5. Monitoring

- Routine blood and clinical monitoring should occur as recommended in these guidelines.

2. Special Considerations

2.1. Elderly patients and the use of psychotropic Medication

CAUTION: Effective therapy with psychotropic medications is normally achieved with lower doses in the elderly compared to younger adults.

Impaired renal or hepatic function also warrants use of lower doses. In addition to the use of smaller doses, the response of elderly patients should be carefully monitored.

- Cardiovascular/stroke risk factors should be checked at baseline and during therapy.
- Benzodiazepines may cause respiratory depression. Respiratory function should be monitored.
- Benzodiazepine use may increase the risk of confusion and falls in the elderly. Shorter acting benzodiazepines are preferred eg. lorazepam for oral use.
- Benzodiazepines and drugs with anticholinergic activity may potentiate arousal in the elderly and exacerbate prostatic hypertrophy and glaucoma.
- Haloperidol-induced extrapyramidal side effects may be treated as they arise with benztropine 500 micrograms either orally or intramuscularly.
- Always use pharmacological interventions in conjunction with appropriate nursing care e.g. “one to one” specials.
- Exclude physical causes for agitation e.g. full bladder, head injury.
- Consider the potential for postural hypotension and the risk of falls when using antipsychotic drugs.

2.2. Pregnant women and or breastfeeding E.g. (from mhGAP)

Explain the risk of adverse consequences for the mother and her baby, including the risk of obstetric complications and psychotic relapse (Particularly if medication is changed or stopped).

- Women with psychosis who are planning to get pregnant or breastfeeding should be treated with a low dose of oral haloperidol or Chlorpromazine.
- Avoid routine use of depot antipsychotics

3. Potential complications associated with the treatment

Agitation	Consider adding a short-term oral benzodiazepine e.g. clonazepam 1-2mg or diazepam 5-20mg or lorazepam 2.5mg .
Arousal	Consider adding a short-term oral benzodiazepine eg clonazepam 0.5-2mg, diazepam 5-20mg or lorazepam 1-2.5mg. If clinical situation justifies, use intramuscular clonazepam 2mg or midazolam 5-10mg. If unsuccessful use zuclopenthixol acetate (Clopixol-Acuphase), except where patient is antipsychotic naïve.
Insomnia	Consider adding a short-term oral benzodiazepine eg temazepam 10-20mg.
Acute dystonic reaction	Consider adding an anticholinergic agent eg benztropine 2mg intramuscularly or intravenously, up to a maximum of 6mg in 24 hours.
Tardive dyskinesia	(Tardive dyskinesia = involuntary, repetitive body movements) Consider long-term risks of tardive dyskinesia associated with ongoing prophylaxis. Consider changing to an atypical antipsychotic or clozapine.
Disinhibition	Disinhibition occasionally occurs up to 2-3 days after commencing benzodiazepine therapy. If so, consider other therapeutic options eg lower dose of atypical antipsychotic.
Akathisia:	(Akathisia is syndrome characterized by unpleasant sensations of inner restlessness that's observable through the client's inability to sit still or remain motionless: Caused by Antipsychotics) Reduce dose of antipsychotic if possible. If still present, add propranolol 10mg twice daily or clonidine 50-100 micrograms twice daily or a benzodiazepine.
Neuroleptic malignant syndrome (NMS):	(NMS is life-threatening neurological disorder commonly caused by an adverse reaction to antipsychotics. Consists of muscle rigidity, fever, autonomic instability, and cognitive changes such as delirium) After this syndrome has occurred and been treated consider an alternative atypical antipsychotic or clozapine.
Persistent negative symptoms of Psychosis	Consider changing to an alternative atypical antipsychotic or clozapine. Exclude depression. If appropriate, treat depression with an SSRI. (Antidepressant Guidelines).
Continual non-adherence	Establish reasons for non-adherence/non-compliance. Educate patient and family about rationale for ongoing treatment. Educate patient about side-effects of antipsychotic medication and treat these vigorously. Treat any underlying depression. Consider depot antipsychotic.

4. Detailed Guidance on Dosing and Side Effects

4. 1. Guidance on Conventional Antipsychotics Medication (Typical Antipsychotics)

The conventional antipsychotic medications are equally effective in the treatment of psychotic symptoms of schizophrenia (with the exception of mepazine and promazine), although they vary in potency and their propensity to induce side effects. The conventional antipsychotics can be classified into three groups according to their antipsychotic potency:

- The **high-potency** agents include haloperidol and fluphenazine;
- The **intermediate-potency** medications include loxapine and perphenazine;
- The **low-potency** agents include chlorpromazine and thioridazine.

The table below outlines the main classes of conventional antipsychotics, maximum BNF daily dosages and guide to their propensity to produce some of the most common side effects.

CONVENTIONAL ANTIPSYCHOTIC MEDICATIONS/ Typical Antipsychotic Medication :
KEY TO SIDE EFFECTS CHART :- (no reports = --)(Mild= +)(Moderate=++)(Severe = +++)(evidence not conclusive =?)

Group/ Class	Drug	Max Daily dose	Relative side effects at average dosage						Class D2 receptor blockade & Anti-cholinergic propensity
			EPSE	Anti Cholinergic	Cardiac	Hypotension	Sedation	minor O.D	
Phenothiazines									
Aliphatic	Chlorpromazine	1g	++	++	+	++	++	++	Moderate D2
	Methotri meprazine	1g	+	++	+	++	++	?	Moderate anti-Ach
	Promazine	800mg	+	+	+	+	+	+	
Piperidine	Thioridazine	800mg	+	+	+	+	+	+	
	Pericyazine	300mg	+	+	+	+	++	+	
Piperazine	Fluphenazine	20mg	++	+	+	+	+	+	Higher D2
	Depot	100mg-4/52	++	+	+	+	+	+	Higher D2

	Perphenazine	24mg	+	+	+	+	+	+	Lower anti-Ach
	Trifluoperazine	--	+	!	+	+	+	+	
Thioxanthines	Flupenthixol	18mg	+	+	!	!	+	+	
	Depot)	400mg - 1/52	+	+	!	!	+	+	
	Zuclopenthixol	150mg	+	+	+	+	+	?	
	Depot	600mg- 1/52	+	+	+	+	+	?	
Butyrophenones	Haloperidol	120mg	+	+	+	+	+	+	
	Depot	300mg- 4/52	+	+	+	+	+	?	
	Droperidol	120mg (P.O.) 90mg (I.V.)	+	+	+	+	+	+	
Diphenylbutylpi peridines	Pimozide (ECG prior & at >16mg)	20mg	+	+	+	+	+	+	
Dibenzoxazepine	Loxapine	250mg	+	+	+	+	+	?	
Substituted Benzamides	Sulpiride	2.4g	+	+	!	!	+	+	? specificity for D2 in A10 – mesolimbic system

4.2. Guidelines on use of Second Generation Antipsychotics (Atypical Antipsychotics)

Group	Drug	Max Daily dose	Relative side effects at average dosage Key :- (No reports= --) (Mild / low risk = +) (Moderate / medium risk = ++) (Severe/ High risk = +++) (evidence not conclusive =?)											
Atypical Antipsychotic medications			EPSE	Anti Cholinergic	Cardiac	Hypotension	Sedation	Neuroleptic malignant syndrome	Sexual dysfunction	Weight gain	Type 2 diabetes mellitus	Hyper-prolactinemia	seizures	Minor O.D
	Risperidone	16mg	+?	--	+	+	+?	+	++	++	+	++	+	?
	Olanzapine	20mg	--	+	--	--	++	+	+	+++	++	+	+	--
	Quetiapine	750mg	--	+	+	+	+	+	+	++	+	++	+	?
	Amisulpiride	800mg	+	--	+Bradycardia	--	--	--	--	--	--	++	+	--
	Clozapine	900mg	--	+++	+++	+	+++	+	+	+++	++	0	++	?

Most commonly used Atypical Antipsychotics Information Summary Sheet

	Formulations	Indications	Initial dose (by Psychiatrist)	Maintenance dose	Adverse effects
Olanzapine (Zyprexa,	2.5mg, 5mg, 7.5mg, 10mg film-coated tablets	Treatment of schizophrenia	Adults: 10mg nocte Elderly, hepatic/renal impairment: 5mg nocte	Adults: 15mg nocte (range 10-20mg nocte)	Common: Somnolence, weight gain Other: Dizziness, increased appetite, peripheral oedema, orthostatic hypotension, constipation, dry mouth, transient asymptomatic elevations of ALT/AST, transient increase in prolactin (rarely symptomatic) Rare: NMS, blood dyscrasias, tardive dyskinesia, seizures
Risperidone (Risperdal,	1mg, 2mg, 3mg, 4mg, 6mg scored tablets and 1mg/1ml liquid	Treatment of acute & chronic schizophrenic psychoses, and other psychotic conditions, in which +ve and/or -ve symptoms are prominent	Adults: Day 1-3: 1mg bd or 2mg od Day 4-6: 2mg bd or 4mg od Day 7 on: 3mg bd or 6mg od. Elderly, hepatic/renal impairment: 0.5mg od increased every 5-7 days in 0.5mg increments	Adults: 3mg bd or 6mg od (range: 4-8mg/day) NB. Doses > 8mg/day are no more effective but do increase risk of EPSE & hyperprolactinaemia	Common: Insomnia, agitation, anxiety, headache Other: Somnolence, fatigue, dizziness, hypotension, tachycardia, weight gain. EPSE and hyperprolactinaemia are dose related and increase at doses above 8mg/day. Rare: NMS, blood dyscrasias, tardive dyskinesia, seizures.
Quetiapine (Seroquel,	25mg, 100mg, 150mg, 200mg filmcoated tablets	Treatment of schizophrenia	Adults: Day 1: 25mg bd Day 2: 50mg bd Day 3: 100mg bd Day 4 on: 150mg bd Elderly, hepatic/renal impairment: 25mg nocte increased every 2-3 days in 25mg increments	Adults: 300-450mg per day in two divided doses (max 750mg/day)	Common: Somnolence, dizziness, constipation, postural hypotension, tachycardia, dry mouth, asymptomatic elevations of ALT/AST Other: Weight gain, asthenia, rhinitis, dyspepsia Rare: NMS, seizures, blood dyscrasias

Table 4. Monitoring Protocol for Patients on Second-Generation Antipsychotics*							
<i>Assessment parameter</i>	<i>Baseline</i>	<i>4 weeks</i>	<i>8 weeks</i>	<i>12 weeks</i>	<i>Quarterly</i>	<i>Annually</i>	<i>Every 5 years</i>
Medical and family history, including cardiovascular disease	X					X	
Weight (body mass index)	X	X	X	X	X		
Waist circumference	X					X	
Blood pressure	X			X		X	
Fasting plasma glucose level	X			X		X	
Fasting lipid profile	X			X			X

6. Guidelines for Use of Benzodiazepines (Doctors and Nurses)

Before prescribing:

- Take a full history including an alcohol and illicit drug history.
- Inform the patient of the side-effect profile of benzodiazepines
- Consider and treat the underlying causes, if possible.
- Consider alternative therapies. The use of benzodiazepines for short term mild anxiety is inappropriate while for insomnia, the symptoms have to be severe and disabling before benzodiazepines can be used.

When prescribing for the first time:

- Initiate with the lowest recommended dose, but this may need to be adjusted depending on patient's response.
- Do not prescribe for longer than 4 weeks.
- Record all details of medication prescribed and duration of treatment.

For patients dependent upon benzodiazepines or patients in receipt of continuing prescribing

- Issue small quantities at a time (usually not more than one week) for OPD patients.
- Review regularly (usually monthly).

- Use a long acting benzodiazepine in dosages no higher than diazepam 5 mg three times daily or equivalent.
- Ensure that all patients are made aware of the risks of long term benzodiazepine use and document this communication.
- Encourage all patients/clients with dependency to withdraw and offer them a detoxification programme at regular intervals (at least annually) and document all communication. A significant number of requests for repeat benzodiazepine prescribing are associated with addiction problems such as opiate misuse.

Indications:

Anxiety

Benzodiazepine anxiolytics should be prescribed primarily for the short-term relief of anxiety and related symptoms when it is disabling and severe resulting in significant distress or problems in social functioning. Other forms of anxiety may be treated by psychological means or pharmacological treatments suitable for long-term use. The underlying cause should be determined and addressed.

Benzodiazepines should not usually be prescribed for longer than one month.

There are circumstances in which longer-term prescription of benzodiazepines may be considered desirable because the alternative is considered less beneficial. This may be in conditions such as chronic treatment-resistant anxiety or in patients who have established dependency and are unable to withdraw successfully. There are other situations where anxiety is complicated by other illnesses and where the risk of dependence may be considered acceptable because of the severity of the other disorders.

Sleep

Benzodiazepines are effective, safe and approved hypnotics for the short-term treatment of insomnia. The following guidelines should be noted:

Prescription should be:

- limited to between 2 and 4 weeks;
- At the lowest effective dose;
- Prescribed intermittently.

Care should be taken to exclude any other primary condition such as depression or substance misuse as a cause for insomnia.

It may be useful to inform the patient when treatment is started that it will be of limited duration, and explain precisely how the dosage will be progressively decreased. Moreover, it is important that the patient be made aware of the possibility of rebound insomnia, thereby minimising anxiety over such symptoms should they occur while the medication is being discontinued.

Before starting any pharmacological treatment it is important to discuss sleep problems with patients and present them with information which may help them to overcome their sleep difficulties:

- The normal amount of sleep varies widely and usually decreases with age
- Temporary sleep problems are common at times of stress or physical illness
- Worry about not being able to sleep can worsen insomnia
- Stimulants (including tea and coffee) can cause or worsen insomnia

Because sleep disorders are often caused by inappropriate sleep habits, it is important to give careful advice about a healthy sleep routine as benzodiazepines tend to lose efficacy as a hypnotic after 4-6 weeks of continuous nighttime use

Agitation

Benzodiazepine may also be prescribed to control acute agitation, for akathisia. Short-term use of these medications to sedate the patient may be the most effective way to defuse a potentially dangerous situation, e.g., lorazepam 0.5 to 1mg IM. Long-term use of a benzodiazepine may produce confusion, excitation, or disinhibition that will actually worsen agitation and aggression. The long-term use of benzodiazepines is not effective for insomnia or nocturnal agitation.

Most commonly used Benzodiazepines

When prescribing and administering benzodiazepines, it is recommended that the first choice is **ORAL**, then **IV** and last resort is **IM** where applicable

Medication	Equivalent doses	Min dose	Max daily dose	Elderly Max daily dose	IV dose	IM dose (last resort)
Diazepam	5mg	2mg	30mg divided dose	1/2 adult dose 15mg	5mg/min rate 4hrly	5mgx2 4hrly
Lorazepam	500 micrograms	1mg	4mg	1/2 adult dose 2mg	1.5-2.5mg 6hrly	2mg 6hrly
Temazepam	10mg	10mg	40mg	1/2 adult dose 20mg	---	---
Chlordiazepoxide	15mg	10md	100mg /3 times	1/2 adult dose 50mg	---	---
Nitrazepam	5mg	5mg	10mg nocte	1/2 adult dose 5mg nocte	---	---
Oxazepam	15mg	15mg	50mg	1/2 adult dose 20mg	---	---
Clonazepam	250 micrograms	1mg	8mg	1/2 adult doses	---	---
Alprazolam	---	250mc	3mg	750microgram/ 3doses	---	---
Chlordiazepoxide for alcohol withdrawal		Min 10-30mg QDS gradual reduction over 7 days				Max 10-50mg QDS gradual reduction over 10 days

Medication properties

KEY :- This key is for the diagram below			
Strong:	Moderate:	Weak:	
+++	++	+	

		Medication	Anxiolytic	Sedative/Hypnotic	Potency
Short Acting	Midazolam		+	+++	
	Lorazepam		+++	++	High
	Oxazepam		++	+	Low
	Temazepam		+	+++	Low
	Chlordiazepoxide		++		Low
Long-Acting	Nitrazepam		+	+++	-
	Clonazepam		++	+	High

Immediate side effects

Most common side effects	Drowsiness, lightheadedness, confusion, ataxia (lack of muscle control), amnesia, paradoxical increase in aggression, muscle weakness
Occasional side effects	headache, vertigo (dizziness), hypotension, salivation changes, gastro intestinal disturbances, visual disturbances, dysarthria (having problems with articulating in dialogues), tremor, changes in libido, incontinence, urinary retention, blood disorders
Rare side effects	Apnea (brief pause in breathing)

Side effects due to long term use

Side effect	Brief description
Development of tolerance	Many people develop tolerance to benzodiazepines' effects and gain little therapeutic benefit from chronic consumption
Dependency	Development of dependent on benzodiazepines is both physical and psychological
Withdrawal syndrome	The withdrawal syndrome may be prolonged and can develop at any time up to 3 weeks after cessation of a long-acting benzodiazepine, or a few hours after cessation of a short-acting one. The syndrome includes anxiety, depression, nausea and perceptual changes.

CAUTION

Client group	recommendation
Hepatic impairment	<ul style="list-style-type: none"> caution due to risk of precipitating coma
Pregnancy	<ul style="list-style-type: none"> risk of neonatal withdrawal symptoms
Breast feeding	<ul style="list-style-type: none"> Benzodiazepines are well known to filter into milk when used (avoid if possible)
Elderly	<ul style="list-style-type: none"> low doses recommended Benzodiazepines may cause respiratory depression. Respiratory function should be monitored. Benzodiazepine use may increase the risk of confusion and falls in the elderly. Shorter acting benzodiazepines are preferred eg. lorazepam for oral use. Benzodiazepines and drugs with anticholinergic activity may potentiate arousal in the elderly and exacerbate prostatic hypertrophy and glaucoma.
Children	<ul style="list-style-type: none"> not recommended

7. Seclusion Policy Guideline

Fourth article: Afghanistan Mental Health Act

“Health establishments and all related foundations are bound to consider decrees of this article and all legislative documents in their behaving towards people with mental disorders.”

☐ **Definition**

Seclusion is the supervised confinement of a patient in a room, which may be locked to protect others from significant harm. Its sole aim is to contain severely disturbed behaviour, which is likely to cause harm to others. Seclusion should be used as a last resort; for the shortest possible time. Seclusion should not be used as a punishment or threat; as part of a treatment programme; because of shortage of staff; where there is any risk of suicide or self-harm. Seclusion of an informal patient should be taken as an indicator of the need to consider formal detention.

In other words, it is the formal placing of a service user in a specially designated room for the short-term management of disturbed/violent behaviour.

☐ **Criteria/condition for seclusion**

The principal aim of this Policy is to outline the requirements for safe, legal and humane practice to manage severely disturbed behaviour that is likely to cause harm to the patient and/or others. The decision to seclude a patient should be regularly reviewed to determine when safer alternatives for the management of violence and aggression can be implemented.

- If the patient is actively and physically fighting other patients, staff members, or his/her relatives.
- To reduce risk from self harm or harm from others which may be brought upon by the individual's mental health problem (this can be in the form of patients behaviour towards others or self)
- The individual is presenting with verbal threats, staff should wait for evidence of such and try other forms of aggression management such as psychological interventions or pharmacotherapy.

The use of Seclusion, Restraint, and IV Sedation in psychiatric in-patient facilities involves the curtailment of the freedom of the patient. As a result these interventions should only be used in extreme circumstances as a last resort, where no other less restrictive form of treatment is available. These interventions could be viewed by the patient as a form of assault and should only be used severe cases.

□ **Hierarchy leading up to seclusion**

Before a patient is secluded, there should be documented evidence showing that all the other intervention have been tried and failed and these are as follows:

- De-escalation techniques
- Pharmacological intervention has been tried
- The patient has been given the option to go in the seclusion voluntarily (to act as therapeutic isolation)

□ **Authorisation**

- Seclusion can be initiated by the duty Doctor and the duty Nurse working together on that shift. It should not be initiated by the duty nurse alone.
- Termination of seclusion in consultation with the Trainer Psychiatrist in-charge of the patient, the Nursing director or their nominated deputies/representatives

□ **Contra-indications:**

Seclusion should not be used in the following circumstances. These factors should be considered during ongoing clinical assessment and care planning:

- As a punishment or threat;
- Not as a prison
- Should be implemented by indication
- Not for agitation due to alcohol withdrawal
- Patient with General medical condition such as delirium or unconscious patients should not be secluded
- As a management strategy to compensate for a shortage of staff;
- Where there are clinical or medical conditions requiring physical proximity/monitoring by staff.

□ **Special considerations**

- There are some general population groups who may have particular risk factors when secluded:
 - Older patients may be at particular risk of adverse events resulting from physical health problems or frailty and should be monitored closely if seclusion cannot be avoided.
 - Patient with a history of trauma (physical or psychological) may be at particular risk of compounded trauma through the use of seclusion. This should be noted in the patient care plan when known and alternative strategies such as early behavioural and medication interventions should be implemented

□ Care principles

All Mental Health interventions should be characterized by respect for the Individual and empathetic decision-making. The practice of seclusion should always incorporate:

1. Thoughtful and considerate treatment of the patient as an individual including an explanation of the procedure given to the patient;
2. Respect for the patient's privacy and promotion of his/her self-respect;
3. Respect for the cultural and language needs of the patient; and
4. Consideration of and provision for any special needs the patient may have.
5. For the need to remove any clothing (such as belts or ties) should be provided to the patient, emphasising safety.
6. Meals: Food should be provided at usual times and monitoring safety due to utensils or use plastic utensils.
7. There should be a ready supply of fresh, clean drinking water available to the patient where possible, or else offered at minimum hourly intervals, based on the need to maintain the safety of all staff.
8. If the seclusion period lasts more than two hours or if there is evidence of dehydration or metabolic disturbance, a fluid balance chart should be introduced for the duration of the seclusion.
9. If seclusion period leaps into the evening time, safe bedding should be provided to provide the patient with warmth.

• Hygiene:

- If the patient requires use of the toilet, for safety reasons this should be managed under supervision, by an appropriate number of staff, one of whom should be the same sex

• Dignity:

- No patient should be placed in seclusion without clothes.
- The patient should be provided with adequate toilet arrangements and with an opportunity to wash.

• Physical wellbeing:

- If the seclusion period lasts more than four hours, consideration should be given to interrupting the seclusion to allow the patient to walk around outside the seclusion room, to bathe or to use the toilet if this can be safely managed.
- Additional staff and security officers may be required, and should operate under the instructions of the nurse in charge. This period out of seclusion may be considered a trial out of seclusion. If successful, the seclusion period may be discontinued.

□ Duration and frequency

- If seclusion needs to continue reviews should take place as follows:
 - Every 2 hours by 2 members of staff, where at least one of them should be a nurses as this will be a nurse led review
 - Every 4 hours by the above and a doctor (Junior Doctor led review)
 - 8 hours consecutively a multi-professional review should be completed or by the Trainer Psychiatrist or their nominated deputy.
 - 12 hours intermittently, the review should be conducted by the Trainer Doctor at least once within this period or at this point. The Head of Psychiatric Department should be informed of the situation and he should be updated every 24hrs should the seclusion goes beyond 24hrs
 - If seclusion goes beyond 24hrs a trainer doctor should have contact with the patient at least once or at least provided some direction to the junior staff.
 - If the 8-hourly review takes place out-of-hours, the Duty Trainer Psychiatrist should be consulted for advice. This review may be carried out by the Duty Doctor; plus the Shift Co-ordinator; plus Ward Staff; in discussion with the Duty Trainer Psychiatrist.

□ What happens in the case of prolonged seclusion

- If seclusion is still continuing at the start of the next normal working day a review should be carried out as soon as possible by the usual Trainer Psychiatrist in person, assisted by a Junior Doctor; the Shift Co-ordinator (Nursing supervisor); and other health care professionals.
- If there is no agreement on a subsequent course of action within the Review Team, the matter should be referred to the On Call Senior Manager at Senior Level.
- As soon as the risk of serious assault is sufficiently diminished, Seclusion should be discontinued. This will usually be indicated by the patient being verbally / none verbally calm. However, due regard will be given to the patient's history if it is known that this is not necessarily an accurate indicator. The decision to discontinue is the responsibility of the Shift Coordinator and will be made after appropriate consultation with the shift team and the Authorising figure.

□ Nursing observations (based on safety of the patient)

- The minimum observation periods by nursing staff should be every 30 minutes and the nurse should record factual observation which are non-repetitive and justification why seclusion should be continued.
 - The nurse looks at the behaviour of the patient, the condition of the patient, signs of any physical health problems as well as the signs of life if the patient is asleep.
- If rapid tranquilisation was used during seclusion, every 1 hour, a nurse should check vital signs whenever possible. Attempts to do so should be well documented and justifications highlighted should the nurse fail to check on the patient's basic vital signs. These basic vital signs includes:

- Body temperature
 - Pulse rate (or heart rate)
 - Blood pressure
 - Respiratory rate
- If seclusion has gone beyond 1hour 30minutes, either 2nurses or one nurse and one hospital assistant (cleaner) should enter the seclusion room to offer the patient a drink and toilet facilities. Depending with the risk, as part of the hospital rules, they can also involve the PROXY should they require a third person to minimise risk. This three man team should always be led by the nurse in charge and it is his/her responsibility to brief the other two on how to approach the seclusion.
 - Should the patient request to use the toilet, the team (either two hospital staff as stipulated above or with the aid of a PROXY) should escort the patient and stand within reaction distance so as to cover for unexpected risks.
 - During this period, a nurse should do a full assessment on the patient's mental health state, behaviour, physical health and make a judgement as to whether the patient should remain in seclusion or to contact the authorising Doctor/ on-call senior manager to terminate seclusion.
 - Should the seclusion goes beyond 3hrs and 30minutes, it is the nurse's duty to inform the duty doctor to come and conduct a full assessment.
 - If the seclusion goes beyond 7hrs 30minutes the nurse and the duty doctor should inform the trainer doctor in-charge to prepare to conduct a full assessment at the 8hr mark.
 - Should the seclusion go beyond 12 hrs; it is the responsibility of the Nursing Director or his deputy to inform the Head of Psychiatric Department of the phenomenon.

Termination of seclusion can be authorised over the phone following a discussion with the authorising professionals

☐ **Use of labourers for safety observation**

- During the night, the duty labourer should check the patient's signs of life and safety once every hour using the spy glass and document in the checklist
- The seclusion room should be cleaned at least twice a day or whenever necessary

☐ **Psychological interventions**

- A psychologist should complete a risk assessment after 5hrs of seclusion and at least twice a day in the event of prolonged seclusion.
- A daily Mental State Exam (MSE) should be completed paying special attention to:
 - Orientation

- Thoughts
 - Perception
 - Judgement
- A psychologist should spent at least 30-45 minutes with the patient while assessing Risk, MSE and introducing some CBT interventions to either assess or reduce the level of distress.

□ Termination and Review of findings

- Termination of seclusion should be done in consultation with either the responsible trainer doctor or Nursing director or their nominated deputies/representatives. All the information leading to the termination of seclusion should be well documented.
- They should also reflect on their actions and the success and failures of their actions in order to plan for and effective care plan
- After the termination of seclusion, members of the Multi- disciplinary team should sit together and formulate a care plan to implement should the same incident happen again.

Special consideration need to be on the following articles of Islamic Republic of Afghanistan's Mental Health Act when making decisions.

Tenth article:

To protect the interest of person with mental disorder at the capital and provinces level some delegations (commission) will establish:

5. Director mental health as head of commission
6. Authorized person from curative medicines department as member of commission
7. A person form attorney office as member
8. A psychiatrist as member of commission

Commission delegations are authorized for the followings:

7. Is working under framework of mental health to proceed and develop the research and promotion of capacity and knowledge of psychiatry
8. Receiving complain from mentally ill patients, care them and taking decision for them
9. Assessing development of mental condition of mental offenders and whom receiving involuntary treatment
10. Asking for proxy for people with mental retardation from court
11. Checking the reports receiving from mental health facilities regarding involuntary treatment of people with mental disorder
12. Checking and approving national mental health plan

Eleventh article:

The commission has the following authorities and obligations:

5. Listening to complaints of people with mental disorders, providing care to them and taking decision about them.
6. Assessing improvement in psychiatric condition of criminals with mental disorders and of people who are put under involuntary treatment.
7. Demanding proxy through court for mentally retarded people.
8. Assessing reports of involuntary treatment of people with disorders from centers of psychiatric services.

No	Daytime Seclusion	Time	Comments	Remark	Signature
1	1 st 30 minutes			Visual observation	
2	1 st hour			Visual observation	
3	1 hour 30 minutes			Visual observation	
4	2 hours Nursing review			Offer Toilet facilities, drinks and an addition of snacks if available	
5	2 hours 30 minutes			Visual observation	
6	3 hours			Visual observation	
7	3 hours 30 minutes			Visual observation	
8	4 hours Doctor led review			Offer Toilet facilities, drinks and an addition of snacks if available	
9	4 hours 30 minutes			Visual observation	
10	5 hours Psychologist Assessment			MSE & Risk	
11	5 hours 30 minutes			Visual observation	
12	6 hours Nurse led review			Offer Toilet facilities, drinks and an addition of snacks if available	
13	6 hours 30 minutes			Visual observation	
14	7 hours			Visual observation	
15	7 hours 30 minutes			Visual observation	
16	8 hours MDT/ Trainer Psychiatrist led review			Offer Toilet facilities, drinks and an addition of snacks if available	
17	8 hours 30 minutes			Visual observation	
18	9 hours			Visual observation	
19	9 hours 30 minutes			Visual observation	
20	10 hours Psychology & Nurse led review.			Offer Toilet facilities, drinks and an addition of snacks if available	
21	10 hours 30 minutes			Visual observation	

22	11 hours			Visual observation	
23	11 hours 30 minutes			Visual observation	
24	12 hours Doctor led review			Offer Toilet facilities, drinks and an addition of snacks if available	

No	Night Time Seclusion	Time	Comments	Remark	Signature
1	1 st 30 minutes			Visual observation by Nurse	
2	1 st hour			Visual observation by Nurse	
3	1 hour 30 minutes			Visual observation by Nurse	
4	2 hours Nursing review			Offer Toilet facilities, drinks and an addition of snacks if available	
5	2 hours 30 minutes			Visual observation by Labourers	
6	3 hours			Visual observation by Nurse	
7	3 hours 30 minutes			Visual observation by Labourers	
8	4 hours Doctor led review			Offer Toilet facilities, drinks and an addition of snacks if available	
9	4 hours 30 minutes			Visual observation by Labourers	
10	5 hours Visual Psychology Assessment			MSE & Risk	
11	5 hours 30 minutes			Visual observation by Labourers	
12	6 hours Nurse led review by Nurse			Offer Toilet facilities	
13	6 hours 30 minutes			Visual observation by Labourers	
14	7 hours			Visual observation by Nurse	
15	7 hours 30 minutes			Visual observation by Labourers	
16	8 hours MDT/ Trainer Psychiatrist led review			Offer Toilet facilities	

17	8 hours 30 minutes			Visual observation by Labourers	
18	9 hours			Visual observation by Nurse	
19	9 hours 30 minutes			Visual observation by Labourers	
20	10 hours Psychology & Nurse led review			Offer Toilet facilities	
21	10 hours 30 minutes			Visual observation by Labourers	
22	11 hours			Visual observation by Nurse	
23	11 hours 30 minutes			Visual observation by Labourers	
24	12 hours Doctor led review			Offer Toilet facilities	

8. Admission of a Psychiatric Patient

1. Welcome the patient and his/her carer and offer them seats (To enhance comfort, relaxation and promote cooperation)
2. Check validity of the admission legal documents. (To ensure the patient is legally admitted in the hospital and to ensure patient's protection)
3. Take history from the patient and/or carer (See history taking procedure) (As part of assessment to establish data base, make psychiatric and nursing diagnosis)
4. Perform mental state assessment (see procedure) (As part of assessment to make psychiatric and nursing diagnoses and plan for interventions.)
5. Perform physical examination (See procedure), and take vital signs- (see procedure) (To detect other co morbid medical conditions. (To determine presence of any injuries sustained and establish baseline data).
6. Explain the possible modes of treatment .
7. Complete request forms for routine investigations such as Liver functioning. (Investigations are necessary to rule out other medical conditions that are commonly overlooked. These include Diabetes and dehydration.)
8. Inspect all the valuables and identify items to be taken home by relatives. (Ensure safety of patients property)
9. Label, make a list and appropriately store items that must be left in the ward. (To ease identification of patients property and avoid loss.)
10. Introduce the patient to staff, other in –patients and ward annexes as appropriate. (To promote quick adjustment to hospital environment, relieve anxiety and promote security. Improve patients image and hygiene's status)
11. Ensure patient takes a bath (If necessary) and changes into hospital uniform.
12. Give due treatments. (To aid recovery)
13. Develop a nursing care plan. (For systematic, organised and quality care)

14. Keep the patients file in the file cabinet. (Ensure safe custody of legal documents for reference.)
15. Keep emergency trays in the respective cupboards.(Ensure safe custody and readiness for subsequent use.)
16. Store the vital signs observations equipment in the cupboard
17. Dispose the used equipment and supply according to disposal procedure.(To prevent transfer of microorganism to patients and staff

A. EVALUATION

Evaluate

1. Patients interaction with other staff
2. If patient can locate the various ward premises.
3. If the assessment done is adequate for diagnosis and plan of care
4. The feeling of relatives about admission.

B. DOCUMENT

Record:

- The history obtained
- Findings of physical and mental state examination
- Any treatment given; dose, time, route and any adverse reactions
- Priority interventions
- Findings of evaluation

PSYCHIATRIC HISTORY TAKING

Steps

Introductory phase

1. Assume a relaxed sitting position that demonstrates availability and not in a hurry. (Makes patient and carer feel accepted, relaxed and promote disclosure).
2. Explain to patient the approximate time history taking is likely to take and what is required of them.(Prepare patient for concentrations).
3. Inquire from the carer(s) the relationship with patient.
4. Discuss general topics for about one minute.(Allow for relaxation and promote disclosure)

Working phase

5. Observe principles of interviewing techniques.
6. Observe patient for non verbal communication and validate them.
7. Ask open ended questions and use simple language
8. Obtain, interpret and record complete information on the following;-
 - a) Biodata, - Reasons for referral: state in everyday language why the patient has been referred- chief complaint: (allegations and patient response)- mode of admission-
 - b) History of past illness (psychiatric, medical, surgical, obstetric for women- Prenatal history-
 - c) Prenatal. Infancy, Childhood, adolescences, adulthood, education, religious, occupation/work record, and socio-cultural background; -

- d) Psychosexual: Begin sexual history by tactfully asking how the client acquired information about sexual matters. Ask whether the patient's sexual life is satisfying or not.
- e) Habits: tobacco, and other substances of abuse;
- f) Pre-morbid personality-Leisure activities, Mood, Character, Attitude and standards towards the body, health, illness, religious and moral standards.
- g) Early childhood signs of emotional disorders (sleep walking, stammering)

Terminal phase

- 9. Explain to the patient that the information required for the time being has been obtained, however, if more information is required then he/she may be called. (Prepares patient and carer for end of history taking so that they don't feel rejected).
- 10. Ask patient and carer if they have questions to ask.(Encourages the patient/carers to clarify their issues of concern)
- 11. Thank patient and carer(s) and release them.(To signal the end of the working session while still maintaining a therapeutic relationship)
- 12. Keep patients' notes and files in respective cabinet.(For safe custody and confidentiality of patient's notes.)
- 13. Wash and dry hands. (Prevent transfer of microorganisms)

A. EVALUATE

Evaluate

- 1. Quality of history obtained.(To determine if further history is required)
- 2. Adequacy of history in planning interventions. (Adequate history is required to help plan interventions.
- 3. Client's reaction during interview.(Reveals relationship between patient and carer helps evaluate effectiveness of patient preparation for the procedure)
- 4. Consistency of verbal and non verbal communication and diagnostic investigations.(Validity of data for accurate diagnosis)

B. DOCUMENTATION

Record:

- Record full history obtained
- Specific issues of concern to patient and carer
- Any anxiety observed from patient or carer
- Areas of history that require further investigation
- Relationship between carer and patient during interaction

MENTAL STATE EXAMINATION/ASSESSMENT (MSE/A)

Steps

- 1. Assume relaxed sitting position at an angle of 90(Makes the patient feel accepted and enhance patient's concentration)

2. Maintain adequate space as tolerated by patient(Patient may interpret being too close as intruding into his/her personal space and this can precipitate irritability)
3. Explain to patient the approximate duration of assessment and what is required of him/her.(Prepare patient for concentration and cooperation)
4. Discuss general topics for about one minute(Allows for relaxation and encourages patient to answer questions without feelings of interrogation)
5. Observe principles of interviewing techniques.(Promotes effectiveness in obtaining information)
6. Observe patient for non- verbal communication and validate them.(Reveals information and mental process that patient may not be able to express verbally)
7. Ask open ended questions and use simple language.(Facilitates understanding and enhance self expression)
8. Obtain, interpret and record complete information on the following;(Enables the nurse to identify and classify the mental disorder the patient is suffering from, mental capabilities and establish a data base for planning and evaluating effectiveness of interventions, rehabilitation and follow- up care.)
 - Appearance: Physical handicaps, Dressing(whether appropriate, symbolic), grooming(kempt or unkempt), eye contact held, facial expression, posture and walk, body build, indication of recent weight loss
 - Behaviour and psycho – motor activity: Restlessness, agitated, lethargic, mannerisms, tics, echopraxia (compulsive imitation of others' actions), Parkinson like symptoms including, akathisia and dyskinesia
 - Rapport: Whether established and maintained or not.(friendliness, cooperation, or hostility and defensive)
 - Speech: Normal flow rate, pressure of speech, spontaneous or non spontaneous, poverty of speech, mute, monosyllabic
 - Mood: Depressed, irritable, anxious, angry, expansive, euphoric, elation. Diurnal/ daytime variation, labile etc
 - Effect: Appropriate, constricted, flat, blunted, etc
 - Form of thought/thought process:
 - Logical, coherent, understandable
 - Neologisms
 - Word salad
 - Circumstantialities and tangentiality (relevance)
 - Confabulation
 - Loosening of association
 - Flight of ideas
 - Thought content: Contents of the patients thoughts including overvalued ideas, delusions, obsessions, compulsions, phobia and suicidal ideas
 - Perception: Illusions, hallucinations, view of self (self concept)
 - Sensorium and cognition: Including abstract reasoning, judgement, consciousness, orientation, memory, alertness, concentration and attention
 - Insight: Whether present/complete or absent
 - Vegetative symptoms:
 - Appetite increase or decrease
 - Insomnia or Hypersomnia

- Loss of interest or energy in everyday activities
- 9. Explain that information required for the time being has been obtained.(Prepare patient for end of mental state examination so that patient does not feel is being rejected).
- 10. Ask patient if she/he has any questions to ask.(Encourage the patient to clarify his/her issues of concern)
- 11. Thank patient and release him/her.(Demonstrates appreciation and promotes cooperation)
- 12. Keep patients notes and files in respective cabinet. (For safe custody and confidentiality of Patient's notes)
- 13. Wash and dry hands.(Prevents transfer of microorganism)

A. EVALAUTION

Evaluate

1. Quality of information obtained
2. Clients reaction during examination

B. DOCUMENTATION

Record:

- Record full findings of mental state examination
- Time taken during examination
- Specific issues of concern to patient identified
- Any anxiety observed from patient
- Areas of examination that require further clarification
- Comparison of findings from previous mental state examination(if applicable)

PHYSICAL EXAMINATION

Steps

1. Wash and dry hands.(Reduces transfer of microorganisms)
2. Place equipment and instrument within easy reach. (To promote efficiency)
3. Review clients history (See psychiatric history taking)-(The first step in holistic assessment. Provides important clues on areas of focus or follow-up during physical examination.
4. Take vital signs (To ascertain the haemostatic assessment. Provides important clues on areas of focus or follow-up during physical examination)
5. Place patient in appropriate position. (To ensure patients comfort and easy accessibility of the areas to be examined)
6. Start systemic examination using a combination of head to toe and body systems approach; using the techniques of inspection, palpation, auscultation and percussion) (Ensure that no body system are overlooked and that time is used effectively)
7. Present any appropriate findings. Ask for additional information and discuss with client/patient issues of concern to him/her (Provides closure for examination and communicates feedback information)

8. Formulate a nursing care plan.(Facilitate provision of quality and evidence based individualised nursing care)
9. Clean, replace and discard equipment according to institutional waste disposal and decontamination protocol (Promotes safety for clients, patient and staff)
10. Wash and dry hands.(Reduces transfer of microorganism)

A. EVALUATION

Evaluate

1. The quality of data obtained from the client(Determine if data is adequate for formulating accurate nursing diagnoses)
2. If the client's needs have been identified(Effective management depends on accurate identification of clients needs)
3. The client's behaviour during the examination.(Determines if client was adequately prepared for examination)

B. DOCUMENTATION

Record:

- Outcome of the evaluation.
- Date , time, and duration of assessment
- Chief concern of the patient and findings during examination abnormalities
- Interventions implemented

Establish a Therapeutic Nurses- Patient Relationship

Steps

1. Welcome the client/patient to the seat.(Facilitate patient comfort and cooperation)
2. Sit squarely.(Allow for observations and eye contact without intimidation)
3. Maintain eye contact(conveys ones interest in the client/patient)
4. Speak with the client/patient on an appropriate (adult/child) level of development(Patient feels recognised and not intimidated thereby enhancing participation)
5. Give full concentration to the patient/client and avoid interruptions during interaction(Communicate respect for client/patient and builds trust that promotes concentration and disclosure)
6. Start the interaction with general topics which should not take more than two minutes(Puts patient/client at ease and allows for patient to give information)
7. Speak slowly and distinctly using appropriate tone variation(To maintain the client/patient interest and concentration)
8. Use open ended questions when asking client/patient what his/her concerns are. (Covey respect and gives client/patient a feeling of direct control over his/her issues. It also promotes self esteem).
9. Give the patient time to respond, exercise tolerance and patience(Allow patient/client to reflect on his thoughts and promote effective communication)
10. Observe facial expressions(To identify any conflicting messages conveyed)

11. Establish regular meeting times and observe punctuality.(For consistency and confidence that promotes a trusting relationship)

Introductory phase

12. For new patients, introduce a summary of the need or interaction session(To orientate client/patient and encourage participation)
13. For old client/patient (one with whom interaction session are already in progress), briefly review the previous discussion and then introduce the topic of today
14. Observe client/patient behaviour during this phase(To determine if client/patient is moving at expected pace and provides direction of interaction)
15. Help client/patient identify his/her needs and challenges(Promotes client/patient insight and perception which encourages his/her active participation)
16. Discuss the details of expectations and responsibilities of both nurses and client/patient(Encourage client/patient to take responsibility minimize his/her tendency of becoming dependent)
17. Gather more data from client/patient and identify patients strengths and limitations(To build strong data base and reduce possibility of client/patient being frustrated by too much expectation than he can perform)
18. Formulate nursing diagnosis, set goals that are agreeable to both patient and nurse(Provides bases for evaluating effectiveness of the relationship)
19. Develop a plan of action that is realistic for meeting established goals.(Enhances motivation and minimizes frustrations)
20. Explore feelings for discomfort and anxiety(Interactions remain on a superficial level until anxiety subsides)

Working Phase

21. Guide the client/patient along topics of discussion. (To prevent deviation and circumstantialities)
22. Discuss client/patients problems and reality orientation.(Promote client/patient's insight and perception and helps client/patient learn problem solving technique)
23. Observe client/patient for signs of anxiety that may arise in response to discussion of painful experience(Provides data for planning interventions for reduction since high level of anxiety leads to client/patient resistance)
24. Continuously observe if clients/patient is ready for termination phase(Objectives of termination phase are not achieved if client patient is rushed)
25. Ask open ended questions(To allow client to elaborate details)
26. Offer silence and other appropriate therapeutic techniques of communication to obtain more information from client/patient(Communicate concerns, presence and promotes client's initiative to take lead on problem solving)
27. Deal with needs that require immediate attention(Facilitate forward movement in the therapeutic relationship)
28. Evaluate and set goals from time and change them where necessary(Ensure that goals are realised and client/patient benefits)

Termination phase

29. Recognize and explore feelings of client/patient about termination(To detect signs of sadness and loss associated with termination phase)
30. Encourage client/patient to discuss the identified feelings (Helps the client/patient to learn that his/her feelings are normal experience which may promote growth process during termination)
31. Continuously evaluate the outcome of the set objectives during each session(Ensure that the activities undertaken are correct)
32. Summarize what has been discussed with the client/patient and allow him/her to ask questions(Clarify any factors that may hinder interaction)
33. Refer the client/patient depending on the outcome of the objectives.(Ensure maximum benefit to the patient/client)
34. Thank the patient for being tolerant and release as appropriate.(Covey appreciation and respect)
35. If the interaction sessions are to continue, then set the time and date of meetings with client/patient(For consistency and confidence)
36. Explain to client/patient that the meetings are over.(Allays client/patient's anxiety)
37. Give room for consultation as necessary.(Builds patients confidence in seeking further help if needed.

NB: When the client/patient experiences feelings of sadness and loss, behaviour to delay termination may become evident. If the nurse experiences the same feelings, he or she may allow the patients behaviour to delay termination. For therapeutic closure, the nurse must establish the reality of the separation and resist being manipulated into repeated delays by the patient by observing the following:

- Several interaction sessions from a therapeutic nurse- patient relationship
- Avoid a social type of relationship during any interaction session
- Avoid excessive writing during a interaction session as it may distract the patients attention and may prevent the therapist from eliciting important information from patient.
- Maintain confidentiality through the interaction sessions
- Keep to the set time(15-20 minutes per session)
 - A very short session may not enable time therapist to meet objective
 - A very long session may be boring for client/patient
- If the client becomes restless during any phase of interaction session
 - Terminate immediately and thank him for his cooperation, then handle the immediate problem appropriately
 - Ask if the patient would like to have another session

A. EVALUATION

Evaluate

1. If the patient was satisfied with the interactions. (Determine the effectiveness of the relationship)
2. The extent to which patients is able to solve or cope with similar situations in future(Confirm that patient growth was effective)
3. If the patient verbalized his /her problems. (Confirm that trust was achieved in orientation phase)

4. Whether the patient is comfortable with termination. (Determine the effectiveness of therapeutic closure)

B. DOCUMENTATION

Record:

- Outcome of evaluation
- Any concerns verbalized by the patient
- Any concerns that need follow-up care by health care team or other professionals

Electroconvulsive Therapy (ECT) Care

Pre- ECT

Steps

1. Educate, patient on basic concepts of ECT. (Ensure patient gets factual information about ECT)
 - Benefits
 - Side effects
2. Take vital signs (To detect any physiological abnormalities and set a baseline data for comparison)
3. Establish base line memory for short and long time events(To detect any memory loss after the procedure)
4. Urinalysis (To detect any renal and or diabetic conditions that may complicate the procedure)
5. Nil by mouth (food) for six hours. (To prevent regurgitation during the procedure and reduce risk of aspiration pneumonia post the procedure)
6. Ensure a good night sleep. (To provide rest in readiness for ECT)
7. Ensure the patient has taken a bath. (To maintain hygiene and prevent infection)
8. Ensure the patient has emptied the bladder/bowel. (For patients comfort and prevention of release or urine/faeces during fits)
9. Check patient for denture, jewellery. (To prevent any interference of the procedure, reactions to the metals (jewellery) and for ease of manipulation during procedure)
10. Change patient into a theatre gown. (Minimize transfer of microorganism to the operating room)
11. Administer pre medication 30 minutes before the procedure. (To calm down patients and dry secretions)
12. Assemble patient's documents (file, nursing notes, and treatment sheet)

A. EVALUATION

1. The level of anxiety during pre ECT period. (To determine effectiveness of pre-ECT Preparation)
2. Interpret the vital signs. (Determine whether physical status of the patient can withstand the procedure)

3. Patient's readiness for ECT procedure. (Readiness will enhance the recovery process)

E. DOCUMENTATION

- Completed pre- ECT checklist
- Any adverse observations made
- Condition of patient during handing over to the ECT room nurse

INTRA –ECT CARE

Steps;

1. Greet patient by name. (To identify patient positively)
2. Introduce self and other staff to the patient. (To allay patients anxiety and promote comfort)
3. Assist patient on to ECT table/surface. (Ensure safety and readiness of patient)
4. Place patient on supine position with hyperextension of the neck. (To allow for the intubation and fixing of ECT, EEG, ECG and oxygenations machines)
5. Explain to the patient in simple language steps of the procedure/activities being performed on him/her while still conscious. (Allays patients anxiety and promotes patients cooperation)
6. Ensure ECG machine and pulse Oximeter are accurately placed. (Allow for accurate measurements and readings of brain activity and oxygenation status of patient during ECT)
7. Provide suctioning if needed. (Maintain patent airway and adequate air entry to the lungs)
8. Monitor the vital signs, cardiac activity, oxygenation, electrical activity of the brain. (To detect signs of acidosis, and other abnormalities indicative of homeostatic imbalance in electrical activity of the brain and cardiovascular systems)
9. Provide gentle firm support to patient's arms, legs and joints when Electroconvulsive current is commenced until seizure are over. (To prevent possible fractures and dislocations from the effect of induced seizures, prevents patient from falling off the bed)
10. Observe the nature and duration of seizures, body parts affected and intensity. (Determines success of procedure)
11. After the procedure place patient in the recovery position in bed and transfer patient to recovery room if SaO_2 is $\geq 95\%$. (To ensure a patients safety and allow for post ECT observation as patient gains consciousness before transfer to the ward. Ensure patient doesn't leave ECT table in acidosis state)

E.EVALAUATION

Evaluate:

1. If vital signs and pulse Oximeter level remain within normal levels during ECT procedure and before returning to the ward. (Indication that adequate perfusion was maintained during treatment)

2. Observe any crackling sounds and abnormal joints. (To determine if patient sustained fractures/dislocation during seizures.)
3. If EEG machine indicated expected Alteration in brain activity. (To determine if required seizures levels were observed)

E.DOCUMENTATION

Record:

- The condition of the patient as received in ECT room
- Treatments given during the procedure
- The success of the procedure
- Vital signs, ECG and SaO2 readings
- Nature and duration of seizures during procedure
- Any adverse observations and intervention measures taken during the procedure

POST –ECT CARE

Steps

1. ¼ -1/2 hourly observations of respirations, pulse and blood pressure. (To determine adverse changes in the homodynamic state of the patient)
2. Maintain patient in recovery position. (To facilitate the flow of secretions, prevent tongue from falling back and ensuring patent airway)
3. When awake explain to patient his/her whereabouts. (Promotes orientation, allays anxiety and facilitates cooperation)
4. Assess the level of memory. (To determine memory loss associated with ECT)
5. Stay with the patient until he is fully awake and oriented. (Ensure patients safety)
6. Escort patient back to ward(Ensure patients safety and facilitates effective handing over patient for continuity of care)
7. Allow patient to verbalize experiences, fears and anxiety related to ECT. (Helps patient cope with ECT experiences and promotes recovery and compliance with care)
8. Assist patient to a quite place or low bed(Allows adequate rest and promoted comfort and safety)
9. Take vital signs observation every 4 hours and reduce to once a day where appropriate (To monitor progress on recovery from the effects of anaesthesia and ECT)
10. Provide patient with highly structured schedules of routine activities.(To promote recovery and minimize confusion)
11. Observe the patient for the following: (To detect signs of confusion and loss of memory which are common post ECT)
 - Ability to perform self care activities
 - Ability to remember ward routines
 - Ability to remember staff and other patients
12. Observe the gait of the client/patient when walking (To detect signs of fracture post ECT)

13. Perform mental state examination regularly. (To establish if patient has achieved full orientation and determine whether the patient benefited from ECT)

B. EVALUATION

Evaluate

1. Mental status of the client/patient. (To determine success of ECT)
2. If patient's level of anxiety was maintained at manageable levels. (To determine if patient's psychological preparation was achieved pre- ECT)
3. If the patient/family can verbalize understanding of the procedure. (To determine if patient/family learning needs were met)
4. If patient recovered from effects of ECT within expected time and without/minimal complications. (Evaluate effectiveness of pre-, intra-, and post- ECT care)

C. DOCUMENTATION

Record:

- The general progress of the patient and memory status
- Treatment given pre- during and post –ECT
- Findings of all the vital observations taken
- Signs of fractures

Concerns verbalized by the patient/family members

PATIENT WITH SUICIDAL BEHAVIOUR

Steps

1. Allocate specific nurse (s) to attend client/patient during crisis period until the patient gains self control (For close monitoring, provision of security and support)
2. Search the patient's and his roommates belongings and remove all items considered unsafe (Patients may use these items for self – harm/suicide)
3. Encourage client/patient to verbalize and explore feelings (Promotes feelings of acceptance, improve self esteem with subsequent ability to evaluate options and develop problem solving skills)
4. Secure a “no suicide contract” from the patient (Demonstrates client/patient's commitment to abide by therapeutic decision made by both client/patient and nurse)
5. Discuss with client/patient's and give a message of hope that life is worth living. (Allows clients/patients an opportunity to have a wider perspective on issues and helps him/her deal with ambivalent feelings of living/dying)
6. Assign client /patient recreational activities such as volley ball/ table tennis.. e.t.c. (Helps patient release tension/feelings of aggression and enhances healing process)
7. Ensure client/patient is always within view of the nurse at all times and the accompanying relative is also fully aware (Promotes close observation and assures client/patient safety)

8. Do not seclude or allow patient to sleep alone. (Staying with other people reduces the possibility of attempting suicide)
9. Maintain suicide precaution card observations and recordings including 20 – minute visual check on the client/patient; carefully observe and record mood and suicide indicators. (Signs and attempts of suicide are recognised early and appropriate interventions carried out promptly)
10. Physically hand over client/patient at end of each shift. (Evidence of close monitoring and assurance of client/patient safety/security)

A. EVALUATION

Evaluate:

1. Patients self concept. (Positive self image is a sign of improvement and reduces contemplation of suicide)
2. Patients plan to cope with suicide and other challenges in future. (Determine if effective coping and problem solving skills have been successfully developed)
3. Patient's ability to interact with other people. (Indicates the patient/clients ability to integrate into the family and community)

B. DOCUMENTATION

Record:

- Any suicidal attempts or verbal threats. Interventions and their outcome
- Summary of every 20 minutes recording on suicide precaution and no suicide contract
- Visitors received; relationship and nature of their interactions with the patient/client

ALCOHOLIC WITHDRAWAL DELIRIUM (DELIRIUM TREMENS)

Steps

1. Assist patient to the prepared room and settle him in bed. (Minimal stimulation ensures that patient's anxiety is controlled to minimal levels; Adequate light helps reduce illusions.)
2. Remove any dangerous objects with the patient or in the environment. (Patient experience episodes of hallucinations and may use objects to harm self or staff)
3. Administer prescribed anxiolytics/antipsychotics. (Anxiolytics have sedation and calming effects, Antipsychotic help to control hallucinations through their dopamine antagonistic effects.)
4. Assign staff to stay with the patient. (Promotes patients safety)
5. Conduct and record mental status examination and vital signs observations four hourly. (Monitor mental functions to help evaluate progress for appropriate interventions for control; Monitors hyperactivity of the autonomic nervous system and plan)
6. Explain to patient the experience he had and the intervention carried out. (Knowledge of the condition promotes client participation in care and increases compliance)

7. Obtain an informed consent from the patient once they can understand what is expected of them. (Prevents feelings of self blame and facilitates compliance/cooperation; observe clients rights of autonomy)
8. Organize for individual/group counselling. (To ensure a therapeutic process aimed at assisting the clients to control/stop alcoholic ingestion habits)
9. Wash, dry and store equipment. (Ensure the equipment is ready for subsequent use)

A. EVALUATION

Evaluate

1. Outcome of intervention: any injuries sustained during the management
2. Preparedness of the patient to continue with the care
3. Whether an informed consent was obtained

B. DOCUMENTATION

- Duration of acute confusion, agitation and autonomic nervous system hyperactivity
- Intervention including drugs, restraints measures and their outcomes
- Summary of vital signs and mental state examination findings
- Outcome of evaluation
- Recommended plan for further action

ACUTE PANIC ATTACKS

Steps;

1. Wash and dry hands. (Minimize spread of microorganism)
2. Take patient to a quiet room with minimum stimulation and explain to patient all actions being taken. (Understanding of actions and a quiet room minimize levels of anxiety)
3. Remove dangerous items within the environment. (To ensure safety to both patient and the nurse/staff)
4. Stay with the patient and encourage him/her to discuss his/her experiences. (Reduce feeling of abandonment; nurse's face may be the only contact with reality when overwhelmed with anxiety; Disturbing experiences allows patient to deal with unresolved issues likely to cause anxiety)
5. Maintain calmness and patience when attending to patient. (Nurse acting with anxiety and in a hurry can cause escalating of anxiety in the patient; Calmness promotes trust, a feeling of security and safety)
6. Take vital signs observation 2 hourly and reduce to 4 hourly as appropriate. (Provides for an objective measurement of anxiety levels and base line data for assessing progress of patient)
7. Administer the prescribed anxiolytics and B-adrenergic receptor antagonistic. (Anxiolytics have sedative effects; B – adrenergic receptor antagonistic reduce anxiety symptoms by reducing sympathetic stimulation)
8. Assess patient's mental status every 4 hours. (To monitor the progress of the cognitive functions)
9. Use simple brief words and messages spoken calmly and clearly.

10. Reinforce reality if distortions occur. (High levels of anxiety obscure clients awareness of physical needs)
11. Attend to physical needs as necessary (Most anxiety states may manifest with severe physical needs)
12. When levels of anxiety are reduced, explore reasons of occurrence. (Recognition of precipitating factors helps in planning intervention for preventing future re- occurrences)
13. Teach patient signs of escalating anxiety and how to interrupt them. (Patient can recognize signs and interrupt progression to panic state)
14. Dispose syringes and used needles according to infection control measures. (Promotes patient and staff safety)

A. EVALUATION

Evaluate:

1. Vital signs were maintained within the normal parameters. (Determine effectiveness of drugs given and other interventions)
2. Patient's ability to control the anxiety levels. (Anxiety can be reduced by focusing on and validating happenings in the environment; Prevents future occurrence)
3. Patient's feelings about his/her care. (Determine presence of quality of quality management.)

B. DOCUMENTATION

Record:

- The range of vital signs during the panic attack
- Findings of the evaluation
- Current state of the patient in general

AGGRESSIVE AND VIOLENT PATIENTS

Steps

1. Approach patient carefully at arm's length. (Ensure safe margin and avoids encroaching upon patients personal space)
2. Address patient by name. (Help orientate patient and demonstrate respect and minimize provocation)
3. Request other patients to leave the room. (To maintain a safe environment for all patients and avoids aggravating the situation further)
4. Keep verbal communication briefs when talking with the patient; don't fold arms maintain an open posture. (Demonstrates acceptance and encourages verbalization)
5. Talk calmly, clearly and firmly keeping voice neutral; ask open questions using 'how' and 'where' to help clarify the problem. (Gives an opportunity to patient to express anger verbally by initiating conversation in a non over stimulating environment; 'why' questions are perceived as provocative)
6. Slowly show the patient that there is nothing in your hands. (Helps the patient to feel that he is not being pursued thus reducing tension)

7. Adopt an attentive expression but do not stare at the patient. (Enables the nurse to gauge the patients level of frustration; staring can be interpreted as an attempt to dominate the patient)
8. Call for assistance by shouting, using any signal system or request another patient relative to summon help. (It is unsafe to manage the situation alone)
9. Ask colleague to lead other patients away when the patient is being restrained. (Violent incidence may distress other patients (
10. Organize staff and identify a leader who gives direction on how to contain the situation. (Ensures coordination and efficiency)
11. One psychiatric nurse to prepare and administer prescribed parental antipsychotic or benzodiazepines. (Helps calms the patient)
12. Give clear instructions on how to restrain the patient. (Promotes coordination and efficiency)
13. Explain to each staff what part of the patient to hold and from where to approach the patient. (To facilitate efficiency in full immobilization of the patient)
14. Allocate one member of the group whom the patient is more familiar with to talk with him/her throughout the procedure. (For sustaining a therapeutic communication of the patient)
15. Minimize force used for restrain to be appropriate to the degree of resistance. (Avoid risk of injury to the patient)
16. Take the patient to a comfortable and isolated room. (Provides safe environment and facilitates recovery)
17. Ensure that the restrain is realized gradually by releasing one limb at a time. (To minimize the possibility of the patient striking the staff)
18. Observe patients respiratory rate half hourly and change gradually until the condition improves. (Determines progress of the patient by allowing for observation of mood and behaviour. It also monitors the effectiveness of sedatives/anxiolytics)
19. Withdraw staff from patient gradually. (To facilitate recovery and reduce anxiety)
20. Withdraw patient from isolation as soon as he is no longer violent.(Observe patients right of associations)
21. When patients calms down discuss the incident with the patient. (Allow the patient to verbalize experiences and identify provoking factors; promotes planning for interventions that prevent repeat of violence and aggression)

A. EVALAUTION

Evaluate

1. Determine if the patient suffered any injuries during the restraint(Plan for appropriate intervention)
2. The feeling of the patient towards the restraint (To allow the for correction of any negative perception)
3. Feeling of the staff towards the management of the incident. (To determine effectiveness of the restraint methods used and to identify areas of future improvement)

B. DOCUMENTATION

Record:

- The duration of restraint
- Drugs given during restraint and the effect
- Any adverse effects of the restraint on the patient
- Outcome of the evaluation

ACUTE DYSTONIA

Steps

1. Wash and dry hands. (Minimise the transfer of microorganisms)
2. Quickly and gently move the patient to the prepared room. (Life threatening situation must be managed urgently)
3. Quickly assess the airway patency and breathing patterns of the patient. (Delay in oxygen administration may lead to hypoxia)
4. Administer oxygen if necessary. (Ensure SaO₂ level is maintained at $\geq 95\%$.)
5. Administer I.V benzodiazepine and anticholinergics as appropriate. (Facilitates muscle relaxation; counteract extrapyramidal effects of antipsychotic thus realising the acute Dystonia)
6. Perform vein puncture and administer IV fluids. (To rehydrate the patient since pharyngeal muscle spasms may interfere with feeding)
7. Take vital signs observations half hourly, gradually changing to one hourly until Dystonia is over and vital signs are normal. (To determine the degree of physiological functioning and plan for future intervention)
8. When patient recovers from the dystonic reaction, perform mental assessment status examination. (To monitor the psychological status of the patient. Helps to monitor the patients recovery from neuropsychiatric symptoms)
9. Discuss with the patient his/her experience. (Improve patients knowledge of the cause of his/her experience and enables the patient to seek help in future occurrences)
10. Explain to the patient that acute Dystonia is a side effect of antipsychotic drugs. (Improve the patients understanding of the cause of his/her experience and enables the patient to seek help in future occurrences)
11. Explain to the patient how to recognize its early signs, the need to notify the nurses and how to control it with anticholinergics and muscle relaxant. (Reduces patients anxiety and enhances compliance with treatment)
12. Clear all equipment used during the procedure:
 - Store the equipment in accordance with hospital policy
 - Dispose waste material according to the infection prevention and control procedure

A. EVALAUTION

Evaluate:

1. Patients level of consciousness (To establish the seriousness of the side effects and the need for further neurological evaluation)
2. Effectiveness of the treatment given. (The intervention can be used in similar future experiences)

3. Patient feeling of the experience (Determine the effectiveness of the interventions)
4. Patient feeling of how he was managed during the experience. (For quality improvement in patient care to facilitate quick recovery)

B. DOCUMENTATION

Record:

- The duration of the dystonic reaction
- Findings of the evaluation
- The vital signs taken during the dystonic reaction
- Treatments given and outcomes: For drugs indicate dosages
- Current physiological and psychological state of the patient

Conducting Nurses' Ward Round in a Psychiatric Unit

Steps

1. Prepare the room and welcome the patient, offer a seat, introduce self and staff and establish rapport. (Allays anxiety and promotes cooperation)
2. Explain to patient that a report about him will be given and discussed and that he/she is free to ask questions and give suggestions concerning his/her care
3. Allow the key nurse to give full report on the progress of the patient including:-
 - Psychiatric nursing assessment and findings
 - Both medical/nursing diagnosis
 - Objectives set for management
 - Interventions
 - Evaluations. (Provides information on current situation of the patient and guides discussion and planning further intervention)
4. Allow time for response from the rest of the staff and students while maintaining patient's privacy and confidentiality. (Promotes discussion on management and evaluation of effectiveness of intervention implemented to date; Identifies gaps and guides plans for appropriate interventions, Offers a learning opportunity for students and staff.
5. Allows the patient to verbalize any concerns about his/her care. (Encourages patient's participations in care, Clarifies misconceptions and promotes compliance)
6. Explain to patient respectfully that his turn is over and release him from the room, (Allows the patient to attend to other duties and prepare the room for next patient)
7. Clear the room and equipment and store them in accordance with the institutional protocol after all patients have been reviewed. (Reduces transfer of microorganism)

A. EVALUATION

Evaluate

1. Feeling of patient during the ward round. (Determine if patient benefited from the rounds)

2. Any interventions that had been planned for but remained outstanding during the ward round. (To identify cause and prevent future repeats that delay recovery)
3. If staff benefited from the round. (Determine if clinical objectives of the round were met and subsequent adjustments required.)
4. Any areas of improvement identified during the round. (Promotes quality of patient care)

B. DOCUMENTATION

Record:

- Current mental status of the patient
- Physical examination results
- Any investigations ordered/done
- Evaluation outcome
- New plan of management

Giving a Report about a Patient

Steps

1. Move to the first patient and ensure that information is given in a logical, organised and conscious manner. (Facilitate understanding of report and reduces chances of skipping other patients)
2. Give the following information about each patient:-(Identify information for accuracy)
 - The room number, the bed number, identification data
 - The psychiatric nursing and psychiatric/medical diagnoses, Key Psychiatric nurse and psychiatrist of the patient(For comparing the relevance of the interventions being implemented)
 - Investigations done and findings, investigations due and preparations required
 - Treatments given during the last 24 hours and patients response
3. Patient on special instructions and requirements including: (Enables the psychiatric nurses to plan for close monitoring for the specific patient)
 - Input/output measurements
 - Blood transfusions
 - Suicidal alert
 - Seclusion
4. Current needs for the patient:
 - Any severe pain
 - Assistance needed with activities of daily living(To enable the nurse prioritize care for these patients)
 - Mental status requiring immediate interventions (Ensures new treatment are not overlooked)
 - Scheduled treatment
 - Need for change of treatments. (Facilitates quick recovery)
 - Any visitors for the patient and significant changes on patient's behaviour after the visit. (To evaluate effectiveness of intervention and if they can be continued)

- Significant changes in the client's condition during the shift, interventions measures taken and outcomes. (Facilitates planning for patient oriented goals and interventions)
- Current prescribed orders. (For continuity of care)
- 5. For newly admitted patients, give the following additional information:(Facilitates planning for quality nursing care)
 - Referring agent
 - Legal admission requirements
- 6. Give summary of discharge/transferred patients:
 - Reasons for discharge/ transferred patient. (Explains the reasons for patients' absence from the ward)
 - The destination. (Explains the additional patients in the ward)
- 7. Do not elaborate on routine background data. (To avoid wasting time)
 - Give the report for each patient within 2-3 minutes. Ensure the report is given in low tones. (For effectiveness, efficiency and confidentiality)

A. EVALUTION

Evaluate

1. Completeness of information given. (Determine quality of the report and helps to identify gaps for inclusion)
2. Area of concern during the report giving, (To identify areas of improvement)
3. Duration of the report. (To improve efficiency in subsequent reports)

B. DOCUMENTATION

Record:

- Changes made in interventions
- New drugs
- Investigations scheduled and preparations required
- Concerns raised by patient during the round
- Progress made by patient
- Any other important information

Discharging a Psychiatric Patient from a Psychiatric Unit/ Hospital

Steps

1. Provide the patient with a comfortable place to sit on. (Promotes concentration and readiness to receive information)
2. Explain the discharge procedure to the patient/guardian. (To allay anxiety and facilitate understandings of the patient's/guardians role in follow – up care)
3. Discuss with the patient his/her experiences from previous discharge. (Identify strategies that were successful and can be reinforced and those that are likely to precipitate relapse)
4. Carry out physical and mental state examination. (To confirm that the patient's physiological and mental state is suitable for discharge)
5. Share information with the patient on his/her mental disorder including treatment and follow – up care. (Promotes compliance to treatment while promoting healthy behaviours)

6. Give instructions on how to take and store drugs. (Ensure compliance to safe drug use. Ensure the safe storage of drug to preserve drug potency and reduces incidences of drug poisoning by family members.)
7. Educate the patient on the expected side effects and how to manage them. (Helps patient to gain control of his care and promotes compliance)

A. EVALUATION

Evaluate

1. The patient's understanding of his/her role in the treatment at home. (Determine if the patient requires further clarification concerning his/her treatment)
2. The extent to which the patient was ready for discharge. (Determine the need for immediate assessment of the home environment and plan intervention for prevention of relapse)
3. Content of discharge notes, medication and follow-up care schedules. (To determine if there was legal authority for discharge and quality of documentation and care given)

B. DOCUMENTATION

Record:

- Physical and mental state of the patient on discharge
- Drugs on discharge
- Carer of the patient and relationship
- The follow up schedule
- The date/time of discharge
- The expected destination of the patient

Conducting Follow – up Care

1. Review the patient's records. (To determine appropriate intervention)
2. Attend to self-identified needs. (For effective therapeutic relationship)
3. As you meet the family introduce self and explain your agenda for the follow up. (To gain acceptance and recognition)
4. Observe the relationship between the client/patient and family members. (To determine the patient's acceptance or rejection in the family)
5. If it is second follow up session, give the health message and evaluate the outcome of the previous visit. (To determine the impact of the previous visit and the care to be given to patient/family)
6. Encourage the patient and family members to ask questions. (To correct misconceptions and allay fears)
7. Plan with patient/family the follow up session and leave them satisfied with the session. (For continued care)
8. Fill in the details of the visit in the card and file record in the register book and indicate the date/time of the next visit
9. Plan for any other necessary intervention that may need other expertise. (For further referral management)

A. EVALUTION

Evaluate:

1. If the objectives of the follow up were achieved. (Determine the effectiveness of the visit)
2. Readiness of the family for follow- up (Demonstrates appreciations for the services offered and understanding of the previous discussions on importance of follow – up visit)
3. Patient's compliance with medication. (Demonstrates participation in his/her care)
4. Strategies used in dealing with challenges. (Determines if effective coping skills are developed)

B. DOCUMENTATION

Record:

- Information obtained during the family interaction with therapist
- Non – verbal communication
- The interaction carried out
- The date/time of the next visit

EVALUATION CHECKLIST

Evaluation of the Procedure manual from the Hospital Directorate

Psychiatric Nursing Guidelines	YES	NO	COMMENTS
1.All procedures in Mental Health and Psychiatric nursing included in the chapter			
2.Procedures are placed under their relevant functionality pattern/system			
3.Procedures arranged from simple to complex within the respective functional pattern/systems			
4.Procedure correctly defined			
5.Purpose of the procedure stipulated clearly			
6.Indications for the procedure are correct			
7.Steps in procedure are accurate			
8.Nursing process correctly applied:			
• Assessment			
• Planning			
• Implementation			
• Evaluation			
• Documentation			

9. Psychology Departmental Procedure Manual

Chapter 1: Introduction

1.1: Purpose of the guideline

The purpose of this guideline is to establish a standard of practice for the psychologists of Kabul Mental Health Hospital. Also, this guideline will help enabling them to provide standard and high quality psychological services to the clients of the In-Client and Out-Client departments.

This guideline is open to any suggestions and recommendations from any mental health specialist regardless of their specialty e. g. Psychologists, Counselors, Psychiatrists, Social Workers and any other individual expert working in the field of mental health in Afghanistan. This guideline could also serve as a basis for further standards of practice and guidelines which the Mental Health Department of the Ministry of Public Health might develop for use at a national level.

1.2: Target audience

The primary user group of this guideline is psychologists at Kabul Mental Health Hospital and the primary beneficiaries of this guideline are clients visiting this hospital.

1.3: Core principles

1. **Human rights and equity:** Psychologists are expected to respect the rights of all humans and exhibit equity in their practice. Human in this document is referred to every single person who visits the hospital and seeks professional mental health services.
2. **Justice- and equality:** Psychologists are expected to be fair and treat clients equally regardless of their race, ethnicity, religion, sect, language, sex, age and socio-economic status.
3. **Autonomy:** Psychologists are expected to honor the client's right to independence and freedom in their decision making regarding receiving or refusing any specific psychological services.
4. **Beneficence: Doing Good To Others -** Psychologists are expected to treat the clients in a way that is beneficial to the clients at all time.
5. **Non-Maleficence: Do No Harm -** Psychologists are responsible in avoiding any harm to clients. They are expected to avoid any possible harm to the clients via their decisions and actions.
6. **Fidelity:** Psychologists are expected to practice honesty and loyalty to their clients during and after the course of treatment.

Chapter 2: Guidelines for psychological services in Kabul Mental Health Hospital

Adopted from: American Psychological Association's "Guidelines for psychological practice in Healthcare Delivery Systems".

In Afghanistan, similar to other parts of the world, systems in which health care are being delivered is rapidly increasing. These systems provide health care in a multidisciplinary manner in which several professions work together to ensure providing proper health services for clients. Mental health services in Kabul Mental Health Hospital are also provided to the clients through a multidisciplinary team of Psychiatrists, Psychologists, Psychiatric Nurses, Social Workers and Occupational therapists. It is very important that each profession should be aware of their own roles and responsibilities in such contexts.

This document intends to help psychologists, other health care providers, and administrators in Kabul Mental Health Hospital to better understand the roles of psychologists in this hospital.

1. "Psychologists remain cognizant of their ethical and legal obligations as members of a distinct and autonomous profession".
 - Patients* should receive the highest quality psychological services so psychologists are expected to be aware of their roles and maintain their professional identity and responsibilities in order to ensure such services.
2. "Psychologists seek to understand the internally and externally imposed expectations and requirements of the systems within which they practice".
 - In order to offer high quality, effective and appropriate psychological services to the patients, psychologists should be fully familiar with the hospital's expectations of them and also the requirements of proper psychological services, i.e. group therapy, individual therapy, etc. Psychologists should do their best to balance between hospital expectations and the needs of the patients.
3. "Psychologists are prepared to clarify their distinct roles and services and how these relate to those of other health care professionals".
 - It is very important for the success of a treatment plan that psychologists express their ability and willingness to contribute to diagnosis, consultation, treatment and rehabilitation of patients. Other professionals' understands of the skills and contribution of psychologists is based upon psychologists' reciprocal understanding their roles, skills and contribution.
4. "Psychologists are encouraged to seek appropriate staff appointments and clinical privileges within health care delivery systems".
 - Psychologists should be very much aware and have clear understanding of their training, expertise and their abilities. They also should strive to reach better understanding of other professions training, expertise, and privileges. Psychologists, as well as other professions, should always strive to keep the

boundaries of their professional competence and clarify the nature of their involvement in a multidisciplinary team.

5. “Psychologists strive to be involved in the development of institutional policies regarding professional scope of practice and participation in service delivery”.
 - As part of the multidisciplinary team, psychologists’ active contribution is vital to the success of the courses of treatment. It is important for the psychologists to be involved and contribute to the development, monitoring and implementation of the institutional policies and procedure that directly affect the practice of psychological interventions. This will enable the hospital to utilize the psychologists’ expertise to a maximum level.
6. “Psychologists are encouraged to promote the optimal delivery of their services through effective and timely communication with other health care professionals”.
 - In the hospital, health care providers come from different disciplines. In order to ensure optimal patient care, psychologists should strive to learn and speak the language of the hospital which is a medical language. Also they should communicate psychological concepts to other professional in a manner that is understandable to them. Psychologists are also required to communicate in a timely manner with other professionals and participate in interdisciplinary team meetings, ward rounds, and case consultation.
7. “Psychologists involved in practice within health care delivery systems strive to gain and maintain appropriately specialized competence”.
 - In this hospital, Psychologists perform many different tasks which are related to their expertise and their educational background. These include but not limited to individual and group psychotherapy, participating in multidisciplinary team, psychosocial counseling and etc. It is very important that they keep themselves well informed of specific knowledge, skills and any scientific finding related to their specialty, job roles and duties within the hospital. Psychologist should be careful to only practice within the boundaries of their competence.

Chapter 3: Comprehensive Psychological Evaluation

3.1: Psychological History Taking:

Definition:

This is a systemic procedure of gathering subjective and objective data or information about the client’s state of health. This encompasses mental, biological and social aspects of the client’s life.

Purpose:

The purpose is to establish baseline data to facilitate psychological formulation and process of making psychological diagnoses and planning for therapeutic interventions. The history taking should be done for any client seeking mental health services on first contact.

Requirements:

- Provide safe environment so the clients feel safe and also prevent violent clients from harming self and others.
- Provide private environment to ensure the confidentiality of clients' information.
- Provide information regarding the procedure for clients and their companion/guardians and ensure their proper understanding.
- Seats should be arranged in a way in which psychologists, clients and companions seat at the same level and in front of each other. They should see each other with no barriers.
- There should be adequate equipments in the room such as chairs, table, pens, psychological assessment forms etc. The room should be properly lightened.
- For safety reasons, psychologists should ensure easy access to the door.
- Psychologists should have adequate knowledge of history taking and the contents
- Psychologists should have ability to properly communicate with clients and can control their own anxiety.
- Psychologists should fully explain the procedure to clients and companions/guardians.

Implementation:

- Assume a relaxed sitting position that demonstrates availability and not in a hurry.
- Explain to client the approximate time history taking is likely to take and what is required of him.
- Inquire from the companion/guardian the relationship with client.
- Observe client for non verbal communication and validate them.
- Ask open ended questions and use simple language
- Obtain, interpret and record complete information on the following:
- Biodata, reasons for referral
- Chief complaint
- History of past illness: (psychiatric, medical, surgical, obstetric for women, etc.)
- Developmental history: Prenatal, Infancy, Childhood, adolescences, adulthood
- Psychosocial history: education, religious and sectarian, occupation/work record, and socio-cultural background
- Psychosexual: Begin sexual history by tactfully asking how the client acquired information about sexual matters. Ask whether the client's sexual life is satisfying or not. Inquire about methods of contraception
- Habits: tobacco, and other substances of abuse
- Criminal history: Ask for any criminal offenses in the past.
- Pre-morbid personality: leisure activities, mood, character, attitude and standards towards the body, health, illness, religious and moral standards.

- Early childhood signs of emotional disorders: (sleep walking, stammering, conduct problems, etc.)
- Explain to the client that the information required for the time being has been obtained, however, if more information is required then he/she may be called.
- Ask client and companion/guardian if they have questions to ask.
- Announce the end of the session, thank client and companion/guardian them.
- Keep clients' notes and files in respective cabinet.
- Evaluate the quality of history obtained in order to determine if further history is required.
- Evaluate adequacy of history in planning interventions
- Evaluate client's reaction during interview.
- Evaluate consistency of verbal and non verbal communication and diagnostic investigations.

Documentation:

Psychologists are required to record the following information:

- Record full history obtained
- Specific issues of concern to client and companion
- Any anxiety observed from client or companion
- Areas of history that require further investigation
- Relationship between companion and client during interaction

3.2 Mental Status Examination:

Definition

This is a formal and systematic assessment of client's cognitive functions, thought process, perception, speech, mood, appearance and behaviour.

Purpose:

The purpose is to establish baseline data necessary for diagnostic formulation and therapeutic intervention. A full mental status examination (MSE) should be performed by the psychologists for any client seeking mental health services on first contact and upon discharge.

Requirements:

- Provide safe environment so the clients feel safe and also prevent violent clients from harming self and others.
- Provide private environment to ensure the confidentiality of clients' information.
- Provide information regarding the procedure for clients and their companion/guardians and ensure their proper understanding.
- Seats should be arranged in a way in which psychologists, clients and companions seat at the same level and in front of each other. They should see each other with no barriers.

- There should be adequate equipments in the room such as chairs, table, pens, mental status examination forms etc. The room should be properly lightened.
- For safety reasons, psychologists should ensure easy access to the door.
- Psychologists should have adequate knowledge of the procedure and the contents of mental status examination.
- Psychologists should have ability to properly communicate with clients and can control their own anxiety.
- Psychologists should fully explain the procedure to clients and companions/guardians.

Implementation:

- Assume relaxed sitting position and maintain adequate space as tolerated by client
- Explain to client the approximate duration of assessment and what is required of him/her.
- Observe principles of interviewing techniques.
- Observe client for non- verbal communication and validate them.
- Ask open ended questions and use simple language.
- Obtain, interpret and record complete information on the following
 - Appearance: physical handicaps, dressing (whether appropriate, symbolic), grooming (kempt or unkempt), eye contact, facial expression, posture and walking, body built, indication of recent weight loss/gain.
 - Behaviour and psycho-motor activity: Restlessness, agitated, lethargic, mannerisms, tics, echopraxia, waxy flexibility, parkinson like symptoms including, akathisia and dyskinesia.
 - Rapport: Whether established and maintained or not (friendliness, cooperation, or hostility and defensive)
 - Speech: Normal flow rate, pressure of speech, volume (soft or high), spontaneous or non spontaneous, poverty of speech, mute, monosyllabic
 - Mood: Depressed, irritable, anxious, angry, expansive, euphoric, elevated, diurnal variation, labile, etc.
 - Effect: Appropriate, constricted, flat, blunted, etc.
 - Thought process:
 - Logical, coherent, understandable
 - Neologisms
 - Word salad
 - Circumstantialities and tangentially
 - Confabulation
 - Loosening of association
 - Flight of ideas
 - Clanging (rhyming)
 - Thought content: Contents of the clients thoughts including overvalued ideas, delusions, obsessions, compulsions, phobia, suicidal and homicidal ideas
 - Perception: Illusions, hallucinations, view of self (self concept)
 - Cognition: Including abstract reasoning, judgement, consciousness, orientation, memory, alertness, concentration and attention

- Insight: Whether present, complete or absent
- Vegetative symptoms:
 - Appetite increase or decrease
 - Insomnia or hypersomnia
 - Loss of interest or energy in everyday activities
- Explain that information required for the time being has been obtained.
- Ask client if she/he has any questions to ask.
- Announce the end of the session, thank client and companion/guardian them.
- Keep clients notes and files in respective cabinet.
- Evaluate the quality of information obtained
- Evaluate clients reaction during examination

Documentation:

Psychologists are required to record the following information:

- Record full findings of mental state examination
- Time taken during examination
- Specific issues of concern to client identified
- Any anxiety observed from client
- Areas of examination that require further clarification
- Comparison of findings from previous mental state examination (if applicable)

3.3: Mini Mental Status Examination (MMSE):

Definition:

This is a shorter version of the full Mental Status Examination conducted in each psychotherapy session with clients. It is, similar to the full mental status examination, a formal and systematic assessment of clientss cognitive functions, thought process, perception, speech, mood, appearance and behaviour.

Purpose:

The purpose is to establish continuing data necessary for continuation, discontinuation and/or modification of diagnostic formulation and therapeutic interventions. A mini mental status examination (MMSE) should be performed by the psychologists for any client entering psychotherapy at the beginning, during or the end of each psychotherapy session.

Requirements:

- Provide safe environment so the clients feel safe and also prevent violent clients from harming self and others.
- Provide private environment to ensure the confidentiality of clients' information.
- Provide information regarding the procedure for clients and their companion/guardians and ensure their proper understanding.
- Seats should be arranged in a way in which psychologists, clients and companions seat at the same level and in front of each other. They should see each other with no barriers.

- There should be adequate equipments in the room such as chairs, table, pens, mental status examination forms etc. The room should be properly lightened.
- For safety reasons, psychologists should ensure easy access to the door.
- Psychologists should have adequate knowledge of the procedure and the contents of mental status examination.
- Psychologists should have ability to properly communicate with clients and can control their own anxiety.
- Psychologists should fully explain the procedure to clients and companions/guardians.

Implementation:

- Assume relaxed sitting position and maintain adequate space as tolerated by client
- Observe principles of therapeutic techniques.
- Observe client for non- verbal communication and validate them.
- Obtain, interpret and record complete information on the following
 - Appearance: physical handicaps, dressing (whether appropriate, symbolic), grooming (kempt or unkempt), eye contact, facial expression, posture and walking, body built, indication of recent weight loss/gain.
 - Behaviour and psycho-motor activity: Restlessness, agitated, lethargic, mannerisms, tics, echopraxia, waxy flexibility, parkinson like symptoms including, akathisia and dyskinesia.
 - Rapport: Whether established and maintained or not (friendliness, cooperation, or hostility and defensive)
 - Speech: Normal flow rate, pressure of speech, volume (soft or high), spontaneous or non spontaneous, poverty of speech, mute, monosyllabic
 - Mood: Depressed, irritable, anxious, angry, expansive, euphoric, elevated, diurnal variation, labile, etc.
 - Effect: Appropriate, constricted, flat, blunted, etc.
 - Thought process:
 - Logical, coherent, understandable
 - Neologisms
 - Word salad
 - Circumstantialities and tangentially
 - Confabulation
 - Loosening of association
 - Flight of ideas
 - Clanging (rhyming)
 - Thought content: Contents of the clients thoughts including overvalued ideas, delusions, obsessions, compulsions, phobia, suicidal and homicidal ideas
 - Perception: Illusions, hallucinations, view of self (self concept)
 - Cognition: Including abstract reasoning, judgement, consciousness, orientation, memory, alertness, concentration and attention
 - Insight: Whether present, complete or absent
 - Vegetative symptoms:
 - Appetite increase or decrease

- Insomnia or hypersomnia
- Loss of interest or energy in everyday activities
- Keep clients notes and files in respective cabinet.
- Evaluate the quality of information obtained
- Evaluate clients reaction during examination

Documentation:

Psychologists are required to record the following information:

- Record full findings of mini mental state examination
- Specific issues of concern to client identified
- Any anxiety or other psychological symptoms observed from client
- Areas of examination that require further clarification
- Comparison of findings from previous mental status examinations

3.4: Establish a Therapeutic Therapist- Client Relationship

Definition:

The process of establishing a goal oriented relationship that leads to positive change (growth and development) in the life of the clients.

Purpose:

To assist clients/clients to develop insight into their problems and develop effective problem solving abilities which enable them utilize their potentials and adapt to life situations.

Indication: Psychotherapy could be a choice treatment course for all clients experiencing emotional problems or mental disorders. Good therapeutic relationship between client and therapist is an essential part of psychotherapy.

Requirement:

- Language best understood by the clients.
- Presence of perceptual and thought disorders.
- Assessment of clients' cultural background to establish presence of cultural factors that affect clients/clients verbal and non- verbal interaction patterns.
- Amount of physical space and sitting arrangement preferred by clients/client.
- Assess any speaking or communication disabilities to determine provision necessary to accommodate the disabilities.
- Review clients notes to obtain full information about the clients
- Plan for specific points and information gaps for clarification with clients/client
- Reflect on own feelings and behaviour that are likely to negatively influence clients/clients response
- Greet client and introduce self
- Explain to client the activity that he/she is to be involved in (it should be done extensively during the first session and also during later sessions if necessary. Examples: transference, dual relationships, etc.)
- Set the date, time and place for the therapeutic sessions.

- Ensure a quite room or space free of disturbance and interruptions
- Provide comfortable, safe seats for the therapist and the clients
- For safety reasons, psychologists should ensure easy access to the door
- Organize sitting arrangement that allows the therapist to have full view of the client and yet not intimidating.

Implementation:

- Welcome the clients to the seat.
- Sit squarely and allow for observations and eye contact without intimidation
- Maintain eye contact (take cultural indications into consideration)
- Speak with the clients on an appropriate (adult/child) level of development
- Give full concentration to the clients and avoid interruptions during interaction to communicate respect for clients. This will help building trust that promotes concentration and disclosure
- Start the interaction with general topics which should not take more than two minutes
- Speak slowly and distinctly using appropriate tone variation in order to maintain the clients interest and concentration
- Use counseling skills in order to increase the rapport building with clients. Limit the question asking behavior since the clients might feel they are under interrogation. The major counseling skills are empathy, attending behavior, confrontation, paraphrasing, reflection, summary, and open ended questions.
- Use open ended questions when asking clients what his/her concerns are. (Covey respect and gives clients a feeling of direct control over his/her issues. It also promotes self esteem).
- In case a psychologist wants to ask a question they should try their best to use pen ended questions in order to allows clients to open up and actively participate in the interaction process
- Give the client time to respond, exercise tolerance and patience
- Observe facial expressions to identify any conflicting messages conveyed
- Establish regular meeting times and observe punctuality
- For new clients, introduce a summary of the need or interaction session (give them an orientation)
- For old clients (one with whom interaction session are already in progress), briefly review the previous discussion and then introduce the topic of present session
- Observe clients behavior during this phase to determine if clients is moving at expected pace and provides direction of interaction and communicate it back to them
- Help clients identify their needs and challenges in order to promote clients' insight and perception which encourages their active participation
- Discuss the details of expectations and responsibilities of both psychologists and clients in order to maximize assuming responsibility by clients.
- Gather more data from clients and identify clients strengths and limitations
- Formulate Psychological diagnosis, set goals that are agreeable to both client and psychologists

- Develop a plan of action that is realistic for meeting established goals in order to minimize frustrations
- Explore feelings for discomfort and anxiety
- Guide the clients along topics of discussion.
- Discuss clients problems and reality orientation
- Observe clients for signs of anxiety that may arise in response to discussion of painful experience
- Continuously observe if clients is ready for termination of the sessions/therapy
- Deal with needs that require immediate attention
- review set goals with clients from time to time to and modify them where necessary and requested by clients.
- Continuously evaluate the outcome of the set objectives during each session
- Summarize what has been discussed with the clients and allow him/her to ask questions
- Refer the clients depending on the outcome of the objectives
- Announce the end of the session and thank the client for being tolerant and covey appreciation and respect
- If the interaction sessions are to continue, then set the time and date of meetings with clients
- At the end of each session, evaluate if the client was satisfied with the interactions
- At the end of each session, evaluate the extent to which clients is able to solve or cope with similar situations in future
- If the client verbalized their problems. This might mean that the trust has been built

Documentation:

Psychologists are required to record the following information:

- Outcome of the end of the session evaluation
- Any concerns verbalized by the client
- Any concerns that need follow-up care by health care team or other professionals

3.5: Conducting Individual Psychotherapy

Definition:

A form of psychological treatment in which individual suffering from a mental disorder or emotional problem is carefully selected and meets regularly with a therapist to establish a professional relationship with the objective of removing, modifying or retarding the existing symptoms, mediating disturbed patterns of behavior and promoting personality growth or development.

Purpose:

- To help the clients understand self and their current condition through relating the link between their feelings and behavior that may have been unrecognized previously.

- To strengthen the existing defenses while developing new mechanism of control and restoring the adaptive equilibrium.

Indications:

Psychotherapy could be a choice treatment course for all clients experiencing emotional problems or mental disorders. The decision of referring or beginning psychotherapy for a client should be made in consultation with other mental health professions. Psychologists are required to share their findings with the trainer psychiatrist at the Mental Health Hospital and reach an agreement on the individual treatment plan. If a client is referred by a psychiatrist for assessment and psychotherapy, the psychologist should complete a full psychological assessment and, with consultation with the client, begin the psychotherapy services. This decision should be communicated back to the psychiatrist as well.

Requirement:

- Psychologists should have a proper Self-Understanding in order to identify some of the needs/behavior that may affect the therapeutic process
- Psychologists should assess general condition of the clients and their general understanding of the procedure
- Psychologists should provide Environment for:
 - Privacy to ensure cooperation and confidentiality
 - Safety: A psychiatric client might cause harm to self and the therapist
- Determine the equipment required (progress notes, pens, etc.)
- Psychologists should review the individual psychotherapy procedure
- Psychologists should review clients history and previous interventions
- Psychologists should identify and attend to own feelings, fears and anxiety about working with a particular clients
- Psychologists should prepare information to share with the clients
- Psychologists should schedule the therapeutic sessions with the clients
- Explain the procedure to the clients and obtain informed consent (during the first session)
- Provide two seats, one for the clients and other for the therapist
- Arrange sitting spaces that allows for easy exist
- Inform colleagues about the room being used and organize for support if needed

Implementation:

Introductory (or orientation) phase:

- Create a conducive environment for the procedure and establish trust and rapport
- Review clients history together with client, identify his/her needs
- Together with clients, set goals that are comfortable for the client and therapist. Goals set too high are a source of frustration and leads to failure in the therapeutic process
- Draw a working schedule of the therapeutic process

Working Phase:

- Begin in therapeutic sessions on time since reliable schedule promotes compliance
- Win and maintain clients trust and rapport that was established in the earlier on.
- By use of appropriate psychotherapeutic techniques, help the client bring out gradually the suppressed experiences/emotions in the subconscious mind.
- Assist the client in pointing out on the expressed emotions in order to create awareness of some of the deep emotions that may have contributed to the present behavior of the client
- Note both the verbal and non – verbal communication during the sessions.

Termination phase:

- Prepare the clients for termination of the session. Put them to rest/ calm anxiety associated with separation)
- Review the set therapeutic goals to determine to what extend the goals were met for appropriate interventions
- Discuss openly own and clients feelings of termination. Allow emotional growth for both the client and the therapist
- Recognize and explore feelings of clients about termination of the psychotherapy. Pick up the signs of sadness and loss associated with termination phase.

Evaluation phase:

- Determine effectiveness of the therapeutic process as to whether the set of goals were achieved
- Evaluate Readiness of the client to end the therapeutic sessions. Indication is that emotional growth was achieved by the client
- Feelings of independence and development of effective problem solving techniques (Indication of satisfaction with therapeutic process)

Documentation:

Psychologists are required to record the following information: (Progress Reports)

- Identified problems and how they were solved
- Method of psychotherapy utilized
- Any homework the client was asked to perform
- Results/progress during each session
- Clients response to therapy
- The quality of the termination phase

Important Note:

When the clients experience feelings of sadness and loss, the behavior to delay termination may become evident. If the psychologist experiences these feelings in the client, they may allow the clients behavior to delay termination. For therapeutic closure, the psychologist must establish the reality of the separation and resist being manipulated into repeated delays by the client by observing the following

- Several interaction sessions from a therapeutic therapist- client relationship
- Avoid a social type of relationship during any interaction session
- Avoid excessive writing during an interaction session as it may distract the clients attention and may prevent the therapist from eliciting important information from client.
- Maintain confidentiality through the interaction sessions
- Keep to the set time(45-50 minutes per session)
 - A very short session may not enable time therapist to meet objective
 - A very long session may be boring for clients

3.6: Conducting and Group Therapy:

Definition:

A type of treatment in which a group uses a particular activity as the structure around which the interaction of the group members is built, encouraging the growth of ego strengths and control.

Purpose:

To manage the behavior and emotional responses required for change in the individual and in the group members during the activity sessions. Anybody suffering from a mental disorder or emotional problem

Requirement:

- Psychologists should run an assessment for each client before admitting them to the group. The mental state of each client involved and the ability to participate and benefit from group activity should be determined
- Provide appropriate environment (Group Therapy Room)
- Psychologists should learn about each clients schedule activities and ensure their adherence to therapeutic process
- Psychologists should determine selection criteria for each group (depressed, females, anxious group, etc.)
- Psychologists should learn each client's psychological diagnosis which is useful for appropriate grouping into groups they can benefit from
- Group leader should have qualification and experience in running groups. This should be done by the psychology department.
- Psychologists should Review procedure of group therapy
- Psychologists should reflect on own fears and control them
- Identify 6-8 clients according to the criteria of selection and introduce self
- Explain to each client the time and venue of the therapeutic activity sessions
- Explain to staff the time, duration and venue of the activity
- Ask another psychologist to join as a co-therapist if possible
- Discuss with co- therapist his/her role during the activity
- Provide adequate number of comfortable seats
- Group leader should arrange seats where group members have clear view of one another if applicable

Implementation:

Introductory phase:

- Assemble the selected clients to the prepared venue
- Offer clients seats in a circle. Allow full view of one another and facilitators.
- Greet all clients, introduce self, co-therapist and explain the reason for the activity Invite every group member to do a self introduction session. This will promote feelings of acceptance and being part of the group
- Facilitate group members to select group chairman and secretary from among themselves. This reduces feelings of intimidation and facilitates coordination of group activity
- Identify group norms/rules and sign a working contract.
- Facilitate the group to exact schedule meeting times and duration.
- Facilitate group members to identify the life duration of the group.
- Facilitates the group to identify goal and objective of the group. This allows evaluation of effectiveness of activities at a later stage.
- Observe for signs of establishment of acceptance, respect and trust. Therapists should communicate this back to the clients.
- Guide members in their interaction and allow them to proceed at their own pace. This will help the group to remain focused while at the same time reduce feelings of intimidation.
- Practice proper amount of self disclosure.

Working phase:

- Observe the extent to which members show willingness to become involved with one another. Evidence any mutual trust and success of working phase.
- Use group pressure in facilitating behavior change. Clients are more likely to learn to modify their behavior in response to group pressure than to that of the individual therapist.
- Facilitate interaction between members by reflecting each member's questions and answers back to the group for discussion. This is called facilitating development of problem solving skills
- Show positive attitude to member's contribution however irrelevant they may appear. This conveys respect and encouragement.
- Interpret the various tasks and roles members assign to themselves and to other members. This will help therapists to get a broader perception of each member of the group; this can later be used to promote self esteem of each group member.
- Determine if the objective for each session are being met.

Termination phase:

- Provide members with opportunity to express feelings of separation from other members. This enables the therapist to observe for feelings of loss, episodes of regression and plan for appropriate intervention.
- Allow members to discuss any achievements made. This will help in evaluation of the therapeutic activity.

- Along with the group members, set date and time for the rest of the sessions of the group.
- Announce the end of the session is approaching and end the session at the exact time.
- Allow members to disperse to their respective activities and to prepare for next session
- Discuss with co-therapist observations and experiences during the session
- Return seats, stationary and group file to their respective places for safe custody.

Evaluation phase:

- Evaluate members' ability to address one another by name. This demonstrates clients' ability to show respect and establish an interpersonal relationship.
- Evaluate members' ability to self disclosure. This demonstrates the clients' ability to express their experiences and seek appropriate help.
- Evaluate members' ability of each client to discuss with group members challenges and develop strategies they plan to apply. This demonstrates achievements made in developing problem solving and copying skills)
- Evaluate members' ability to deal positively with feelings of loss and separation.

Documentation:

Psychologists are required to record the following information: (Progress Reports)

- Outcome of evaluation of each session
- Members who need close observation and recommendation to other mental health professionals regarding these clients.
- Recommendation of treatment course for members who need individual therapy besides group therapy
- Achievement made by each member

3.7: Documentation:

Introduction

This guideline is designed to educate psychologists in order to keep professional records. Article 33 of Afghanistan Mental Health Act states that “files and records of persons with mental health disorders are kept completely confidential” but before that there is a need for proper documentation in mental health settings. The nature of record keeping varies according to the purpose, setting and the types of psychological services.

Proper record keeping regarding treatment plans, services provided and the client progress helps the clients and psychologists at the same time. Records will help clients when there is long period of time between contacts with psychological services and if they seek psychological services from other professionals. For the psychologists, it is especially important to have better documentation since it is helpful for them to monitor their work including their planning, implementation, and appropriateness of the services. In case of legal or ethical issues, proper

records keeping will both clients and psychologists. Psychologists must always try to familiarize themselves with any existing legal and ethical requirements of record keeping in their work places.

There might be different record keeping policies and guidelines in different settings. This document tries to educate psychologists of the Kabul Mental Health Hospital in order to be more efficient in documentation. Psychologists should take the following points into consideration while working in the hospital:

1. Psychologists working in Mental Health Hospital should follow the record keeping policies and procedures of the hospital.
2. Psychologists are generally responsible for proper maintenance and transference of their records to the medical record section of the hospital.
3. Psychologists are responsible for documenting accurate, current and appropriate records of the psychological services provided to the clients. This may include information regarding the nature, delivery, progress and the results of the psychological services.
4. Psychologists are responsible for the confidentiality of their records and their safe delivery to the medical record section of the hospital. (Article 33, Afghanistan Mental Health Act)
5. Psychologists should communicate clearly to the clients the nature of their record keeping and issues related to confidentiality and release of information.
6. Psychologists are responsible to take relevant actions to prevent records of unauthorized access, damage and destruction while they are holding the records.
7. When seeing multiple clients such as in group settings, family and couple therapy, psychologists should carefully document the information of the clients in order to respect the privacy and confidentiality of information of all parties.

10. Motivational Interviewing

A Guideline developed for the Behavioral Health Recovery Management project

Daniel D. Squires and Theresa B. Moyers

University of New Mexico Center on Alcoholism, Substance Abuse and Addictions

Albuquerque, New Mexico

Daniel D. Squires, M.S. is currently a doctoral candidate in Clinical Psychology at the

University of New Mexico where he is also pursuing a Master's degree in Public Health.

His interests within the field of addictions research and treatment revolve around issues of motivation in the change process and policy issues involving program evaluation and dissemination. He is currently working with colleagues on developing a series of computer-based brief interventions for problem drinkers that will be evaluated in a series of upcoming controlled clinical trials.

Theresa B. Moyers, Ph.D. is a clinical psychologist who began her training in motivational interviewing with William Miller as a graduate student at the University of New Mexico in 1986. She is a founding member of the Motivational Interviewing Network of Trainers and has produced a series of videotapes demonstrating motivational interviewing with Drs. Miller and Rollnick. Dr. Moyers is an Associate Professor of Research at the University of New Mexico and works in both research and applied settings. She is the Primary Investigator for a grant investigating the dissemination and training of motivational interviewing. Her research interests focus on process variables in psychotherapy and training of motivational interviewing.

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Overview

Motivational Interviewing (MI; Miller & Rollnick, 1991; in press) is a therapeutic technique designed to engage ambivalent or resistant consumers in the process of change. Specifically, Miller & Rollnick (in press) define Motivational Interviewing as, "A client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence" (p. 30). MI incorporates an explicitly egalitarian style that abandons traditional confrontational treatment methods in favor of eliciting responses for change from consumers themselves.

This guideline will introduce clinicians to the use of Motivational Interviewing with consumers who present for substance abuse treatment. The job of the MI therapist is to prepare unmotivated consumers for change by encouraging change talk, and decreasing resistance to the notion of reducing the use of alcohol or drugs. While MI has proven to be effective with a variety of abused substances (Aubrey, 1998; Saunders, Wilkinson, & Phillips, 1995; Stephens, Roffman, Cleaveland, Curtin, & Wertz, 1994), given the brief nature of this guideline, we have chosen to focus largely on issues related to the use of MI with alcohol abuse and dependence. Therefore, while references to aspects of both drug and alcohol abuse will sometimes be made, examples and discussions will typically be related to the use of alcohol.

This guideline is intended to provide an introductory understanding of the basic principles of Motivational Interviewing. We will emphasize the first phase of MI, which focuses on addressing consumer ambivalence about change, and is specific to those consumers for whom change plans and treatment planning represent premature goals. Like any clinical skill, proficient use of MI will require far more than simply reading through this guideline. Additionally, MI should be thought of not as a programmed, point-by-point treatment approach but, rather, a diffuse *style* of clinical interaction. As a result, the acquisition of proficient Motivational Interviewing skills requires both extended study and practice. To this end, we have provided a thorough resource section at the end of this guideline. It is our hope that the resources provided will serve as useful references in your effort to become more skilled in both the science and the art of Motivational Interviewing.

Background for Motivational Interviewing

Typically, clinical interventions for addictive behaviors have relied heavily on approaches rooted in a medical, or disease model whereby healthcare professionals are regarded as “experts” in possession of knowledge that can remediate a variety of clinical ailments. However, over the past 20 years a growing body of evidence has emerged to suggest that a non-collaborative style of interaction serves to not only alienate the consumer from the process of treatment, but often results in poorer outcomes as well (Eisenthal, Emery, Lazare, & Udin, 1978; Miller and Rollnick, 1991; in press).

Even the effectiveness of treatment for addiction, and especially alcoholism, is frequently debated. Estimates regarding the remission of symptoms following alcohol treatment have been broad and span from as low as 20 percent (Costello, Biever, & Baillargeon, 1977) to as high as 80 percent (Miller & Hester, 1986). A recent review article by Miller, Walters, & Bennett (2001) suggests that across treatment modalities, the effectiveness of treatment for alcoholism is best summed up by the “law of thirds” (Emrick, 1974). Specifically, Miller et al., report that after a single episode of treatment, roughly one third of people will achieve sustained remission while another third will show substantial reductions in drinking and associated problems through 12-month follow-up. The last third appear unchanged.⁵

In contrast to the debate surrounding the efficacy of various treatments for addiction, a common anthem is emerging with respect to the process of change in addictive behaviors. A number of researchers have proposed the existence of a natural recovery process (see Sobell, Ellingstad, & Sobell, 2000 for review). Based on observed base rates of spontaneous remission between 2-3 percent per annum with another 1 percent of problem drinkers returning to moderate, asymptomatic drinking (Sobell et al., 2000; Vaillant, 1995), it appears that roughly 75 percent of problem drinkers recover without formal treatment (Sobell, Cunningham, & Sobell, 1996; Sobell, Sobell, & Toneatto, 1992). Orford and Edwards (1977) perhaps put it best when they recommended that, “In alcoholism treatment, research should increasingly embrace the closer study of natural forces which can be captured and exploited by planned, therapeutic intervention” (p. 3).

What is it that leads so many people to change their drinking patterns so abruptly, and why are younger age of onset and an acute course of dependence so often followed by earlier and more sustained periods of abstinence (Vaillant, 1995)? One reason for this pattern may be related to the phenomenon of “hitting the wall,” or “hitting bottom” whereby consumers experience extreme consequences of chronic or acute use that necessitate dramatic changes in order to avoid further, or ultimate, deterioration. In addition to the notion of “hitting bottom,” there is growing interest in the phenomenon of quantum change whereby individuals experience sudden insights or revelations that can serve to dramatically alter life course and, in many cases, the subsequent course of addiction (Miller & C’de Baca, 2001). In his partially autobiographical text, *On Writing*, the author Steven King (2000) describes exactly such an experience:

“One Thursday night I went out there [the garage] to toss in a few dead soldiers and saw that this container, which had been empty on Monday night, was now almost full. And, since I was the only one in the house who drank Miller Lite--

Holy Shit, I'm an alcoholic, I thought, and there was no dissenting opinion from inside my head—I 6

was, after all, the guy who had written *The Shining* without even realizing (at least until that night) that I was writing about myself. My reaction to this idea wasn't denial or disagreement; it was what I'd call frightened determination. *You have to be careful, then*, I clearly remember thinking." (pp. 94-95)

The process of natural recovery may have much to do with these types of revelations whereby patterns of drinking or drug use and associated consequences become suddenly clear, and give rise to discrepancy between continued use and other, more valued aspects of one's life. If it is, indeed, the case that such experiences are capable of dramatic shifts in thinking, and consequently motivation to change, then it would follow that a primary goal of any treatment for alcohol or drug abuse should aim to foster the occurrence of such experiences.

Motivational Interviewing

A relatively recent advancement in the field of treating addictions, Motivational Interviewing is a client-centered, directive, and explicitly egalitarian treatment approach. In an effort to foster an open exchange between the therapist and client, Motivational Interviewing actively incorporates a collaborative relationship by emphasizing consumer choice, self-efficacy, and the overall responsibility of the client to determine his or her own life goals.

Motivational Interviewing is firmly rooted in the transtheoretical model of change proposed by Prochaska and DiClemente (1982, 1984, 1985, 1986). In the transtheoretical model individuals vary with regard to change "readiness" by moving through 6 distinct stages including pre-contemplation, contemplation, determination (or preparation), action, maintenance, and relapse. For example, an individual in the pre-contemplation stage would be described as not considering change. On the other hand, a person in the "action" stage would be actively employed in an effort to reduce his or her drinking or drug use. Importantly, this is the arena in which there is often treatment incongruence between 7

providers and clients. Health care providers are frequently in an "action-oriented" state of mind while clients entering treatment are frequently contemplating change, or worse, in pre-contemplation. The result of such incongruence is reflected in the all-too-common scenario in which the health care provider is pushing the client to change as though he or she were in an action phase when, in fact, the client may have substantial ambivalence to do so. As Miller and Rollnick (1991; in press) point out, such a "persuading" on the part of the treatment provider will frequently result in the client becoming defensive and possibly more ambivalent. Obviously, such an outcome is counter-productive to the therapeutic process, and frustrating to all involved. Figure 1 below offers an illustration of the stages of change model.⁸

Motivational interviewing is based on four primary principles designed to avoid the persuasion dilemma that occurs when action-oriented providers encounter consumers in the contemplation stage of change (Miller and Rollnick, in press). The four principles of MI are: 1) Express empathy, 2) Develop discrepancy, 3) Roll with resistance, and 4) Support self-efficacy. By employing these principles, MI represents a focused response to ambivalence in the crucial stages of contemplation and determination and may also be useful if ambivalence recurs

further along in the change process. By relating to the client in a way that is both respectful and empathic, the provider facilitates an environment of mutual trust. By adopting a collaborative, stage-sensitive style, the provider is less likely to elicit resistance from the client and more likely to stimulate open, honest communication.

Importantly, variations within client gender, ethnicity, and socioeconomic status do not appear to affect (or predict) outcomes in studies of MI (Brown & Miller, 1993; Miller, Benefield, & Tonigan, 1993; Miller, Sovereign, & Krege, 1988; Smith, Heckemeyer, Kratt, & Mason, 1997), indicating that MI can be utilized as an appropriate clinical intervention for most consumers.

What Exactly is Motivational Interviewing?

Motivational Interviewing is a style of clinical interaction that can be utilized in response to consumer ambivalence whenever it should occur. In contrast to structured approaches derived from MI such as Motivational Enhancement Therapy (MET) (Miller, Zweben, DiClemente, and Rychtarik, 1995), MI itself is an approach to behavior change that rests on the four underlying principles mentioned above. Therefore, Motivational Interviewing does not explicitly refer to a delimited protocol, but rather to a variety of specific interventions used within an overall clinical style aimed at diffusing and resolving consumer ambivalence.

Expressing Empathy

Motivational Interviewing is based heavily on the client-centered work of Carl Rogers (1957, 1961). In his approach, Rogers focused on the client's awareness of their own thoughts and abilities in an effort to increase confidence in, and reliance on, their own decision-making skills. For Rogers, the client was the expert on how to make changes for him or herself and he facilitated this process through the use of three primary therapist "qualities" that included acceptance, positive regard, and genuineness-in essence, the core of empathic responding. The fact that numerous studies have found therapist empathy to be one of the most reliable predictors of outcome speaks to the importance of Rogers' work and highlights the existence of one of the most reliable of all common factors in psychotherapy (Beutler, Machado, & Neufeldt, 1994; Lafferty, Beutler, & Crago, 1989; Truax & Carkhuff, 1967).

Within the context of MI, empathy carries a very specific meaning. Rather than feeling sympathy, relating to similar experiences, or even agreeing with consumers, empathy is defined as "The ability of the provider to accurately reflect what the client is saying (Moyers, 2000; p. 155)." Truly empathic responding therefore requires that clinicians employ active listening skills.

Developing Discrepancy

The second principle component of MI is that of developing discrepancy. The process of developing discrepancies between substance use and other more valued aspects of one's life is intimately related to the consumer's values and belief

systems. Specifically, the goal is to elicit from the individual those aspects of his or her life that are important and 10

at odds with current behavioral patterns. For example, a consumer may state that he really looks forward to drinking with his buddies several nights a week to relieve stress.

However, in an earlier statement he also revealed how much he enjoys reading to his children at bedtime. In a situation like this, the therapist might offer what is called a double-sided reflection such as, "On the one hand you really look forward to blowing off steam with your friends at the bar, and spending that time with your kids each night seems really important to you as well."

In developing discrepancy, it is important for the treatment provider to gain a deep understanding of what really matters to the consumer both in terms of immediate and longterm life goals. Additionally, understanding value systems is also important. Once the provider has an adequate understanding of these areas, he or she will be better equipped to assist the ambivalent consumer with the process of clarifying important goals that can play a critical role in sound decision-making.

Rolling with Resistance

Rather than meeting consumer resistance with confrontation, providers are encouraged to utilize reflection in an effort to decrease it whenever possible. For example, when describing her drinking habits a consumer might report, "I don't know why my husband complains so much, all I have is a six pack each night when I get home." To which the provider might respond, "For you, drinking a six pack isn't a big deal." Additionally, it's often the case that many consumers are remanded to treatment for one reason or another.

In such a case, a consumer might come right out and say, "I don't need to be here and I'm not happy about being forced to come." The MI therapist might respond with, "I hear you loud and clear, you're not happy about being here and this seems like a waste of your time." 11

In rolling with resistance, it is often necessary to hear consumers express frustrations and even to make ridiculous statements without confronting them directly. Such a style implies that the treatment provider be flexible and willing to "lose the point" in disputes.

The interviewer recognizes that resistance typically points out substantial energy that may be harnessed in an effort to explore the reasons for ambivalence. When consumers are resistant, angry, or otherwise needing to make a point, rolling with these episodes increases the likelihood that the consumer will remain engaged and potentially more receptive to those aspects of the treatment process that they may, indeed, find helpful. In any case, the choice of what to take and what to leave is always theirs to make.

Supporting Self-Efficacy

The final principle of Motivational Interviewing is to support self-efficacy. Self-efficacy is an important aspect of motivation (Bandura, 1977; 1982) and has proven to be related to positive outcome in substance abuse treatment (DiClemente, 1981; Solomon & Annis, 1990). Specifically, the provider makes a

point to encourage the consumer based on the abilities and resources that they possess. This may be accomplished in a number of ways.

Particularly useful is the technique of examining past successes by the consumer to cut back or modify patterns of use. Questions such as, "What worked?" and, "What was it that enabled you to be successful that time?" can be very useful in attempting to discover various strengths and aspects key to success. Lessons learned from previous relapses are also a rich source of efficacy in the hands of a skillful interviewer.

Providers can offer genuine affirmations when consumers share successes. For example, a consumer might disclose that he was once able to moderate his drinking for six months by cutting down on the time that he spent with friends at the bar after work in favor of joining an evening volleyball league. In offering a genuine affirmation of this success ¹²

the provider might respond by saying, "It's wonderful that you were able to reduce your drinking like that. Most people find it challenging to initiate new activities where they don't know many people, but it sounds like that kind of thing is pretty easy for you." Providers may also find it useful to directly point out the existence of personal assets by saying, "Here's a characteristic of yours that could lead to success...". These efforts are important because the consumer must be able to imagine that a successful outcome is possible before legitimate attempts at change will be made.

General Practice

When the treatment provider begins to use Motivational Interviewing, there are five general skills guided by the above principles that should be utilized. They Include:

1. Asking open-ended questions
2. Listening reflectively
3. Affirming
4. Summarizing periodically
5. Eliciting self-motivational statements

When the consumer first enters treatment, these methods offer a useful starting point.

Specifically, while the first four skills are related to general clinical practice, they serve to form the essential foundation for the fifth essential skill for MI: *eliciting self-motivational statements*. Because of their importance, we will examine each in turn.

Open Questions

Open questions form an integral part of early rapport building with consumers. Rather

than asking a series of questions that frequently lead to short answers and little room for elaboration (also known as the "Question and answer" and/or "Expert" traps; Miller & Rollnick, 1991; in press), providers are encouraged to ask questions in such a way that it is ¹³

the consumer who does most of the talking and, in fact, is encouraged to do so. Some examples of open-ended questions might be, "What concerns do you have

about your long-term health, " and, "What reasons might you have to cut down on your drinking?" Conversely, closed questions (while sometimes necessary, but commonly over-used) might include, "Do you want to make a change in your drinking, " or, "How old were you when you first began to drink?" Generally speaking, Miller & Rollnick (1991; in press) recommend asking no more than three questions in a row with a majority being open ended in nature. By asking open-ended questions, the stage is then set to utilize aspects of reflective listening, affirmations, and summation.

Reflective Listening

Reflective listening is a foundational skill for MI, and is particularly useful for addressing resistance, or *countermotivational behaviors* (MINT, 1998). Reflective statements can range from simple, "You're feeling angry," to complex, "It sounds like you might be wondering what impact your drinking is having on your marriage." Importantly, all reflective statements are intended to convey a sense of having heard what the consumer has said, and may also be useful when clarification is necessary. In particular, there are three types of reflections commonly used in MI. They include Simple reflections, Amplified reflections, and Double-sided reflections. Each of these reflections can be useful in encouraging the consumer to continue an internal exploration of their experience. Simple reflections serve to acknowledge the consumer's thoughts, feelings and positions in a neutral manner such that further exploration is facilitated. Amplified reflections serve to reduce the intensity of a consumer's stance on a given position so that the individual is more inclined to argue for the other side of his or her ambivalence. Double-sided 14

reflections capture both sides of a consumer's ambivalence and are particularly useful with respect to the process of developing discrepancy.

Let's take a moment to consider a hypothetical case example of a consumer named Joe P. Joe is a 34-year-old husband and father of two young boys. He has been referred to treatment by the legal system after having been cited for driving under the influence of alcohol. He's a salesman, and spends a considerable amount of time on the road.

Currently, he is facing a suspension of his driving privileges unless he completes a treatment program for first-time offenders. How might a treatment provider using MI respond to Joe's ambivalence about being in treatment? Using examples of responses from each of the 3 reflective styles, we'll illustrate some possible choices. As you read the examples, think of other responses that you might use in each of these categories.

Joe: I can't believe I've been ordered to treatment for a single DWI. This is a long way to go to keep from having my license suspended. You'd think the legal system had bigger fish to fry.

Provider (Simple reflection): You're having a hard time making sense of why you're here.

Joe: Exactly. I mean, don't get me wrong, I know driving under the influence is a big problem, but this seems a little unnecessary to me.

By rolling with resistance and offering a simple reflection to let the consumer know that his frustration has been heard, the provider has successfully opened the

door to more exploration. Let's take a look next at an Amplified reflection to the same statement:

Joe: I can't believe I've been ordered to treatment for a single DWI. This is a long way to go to keep from having my license suspended. You'd think the legal system had bigger fish to fry.

Provider (Amplified reflection): You don't think the legal system has any business dealing with these issues.

Joe: Well, not exactly. I just think that being mandated to treatment is a little extreme for a first offense. 15

By having his objection to the legal system overstated, Joe backs-off a bit and is now in a position where is able to acknowledge the other side of his ambivalence. Last, we have an example of what a Double-sided reflection might look like:

Joe: I can't believe I've been ordered to treatment for a single DWI. This is a long way to go to keep from having my license suspended. You'd think the legal system had bigger fish to fry.

Provider (Double-sided reflection): On the one hand, you're not too happy to be here, but on the other, there might be a substantial benefit to keeping your license from being suspended.

Joe: I guess that's true. It is a huge pain to have to work this into my schedule, but it would be worse to have a suspended license. Maybe this is simply the lesser of evils.

By offering an acknowledgement of the fact that Joe is not happy about being mandated to treatment, but following with what he stands to gain by participating, the provider has illustrated both sides of Joe's ambivalence. As a result, Joe is in a position to examine the issue from a wider perspective. These examples illustrate the way in which reflections might be used to offset resistance and initiate the exploration of relevant areas. It is important to note that all reflections require a sense of straightforward support and should convey both effective listening and accurate empathy. A sarcastic or disingenuous tone will ruin the reflection and is not in the spirit of motivational interviewing.

Affirmations

Affirmations of consumers' strengths make good clinical sense in general, and should occur frequently within the context of treatment. The process of affirming consumers is a fairly straightforward one. In addition to sound reflective skills, affirmations offer the consumer praise in the form of compliments and/or statements of appreciation that help to build and maintain therapeutic rapport. Rather than being superfluous to the already affirming nature of MI, direct affirmations offer a unique form of support and can play a key role in the process of exploring past successes as discussed with respect to issues of self 16 efficacy. Affirming statements can take on a variety of forms. Here are a couple of examples: "It sounds like you've really overcome a lot, you must be a very resourceful person," or, something even as simple as, "With all that you have going on, I really appreciate that you made it in for our session today. Ultimately, genuine affirmations represent sound clinical practice--especially when they relate to characteristics that are likely to aid in recovery process.

Summarizing

Summaries within the context of MI serve to pull together multiple points of information for three specific purposes including the collection of information, linking material presented at different times in an effort to have the consumer reflect upon it, and transitional summaries that mark shifts in focus (Miller & Rollnick, 1991; in press).

Importantly, summaries convey to the consumer that you have not only been listening to what they have said, but also promote further exploration of the topic being discussed or summarized. To that end, summaries are often concluded with open questions or reflections that encourage consumers to elaborate further. An example of a linking summary might go as follows:

It strikes me as I've been listening to what you've said that you're torn between two different directions. On the one hand, your drinking is beginning to concern you.

After having wound up in the emergency room and receiving a DWI, you've really become aware that you could have been killed and, in fact, have already injured someone else. Additionally, you've mentioned that your productivity at work has suffered and you're concerned about possibly losing your job. At the same time, however, drinking has played an important role for you both socially and in terms of coping with day-to-day stress. You're clearly concerned, but feel as though you're between a rock and a hard place.

In this example, the summary links together information from various points that may have occurred over the course of more than one session. Additionally, the summary utilizes both a double-sided reflection and ends with a complex reflection that goes beyond the 17

scope of a simple reflection by inferring a deeper, unspoken state that the consumer can then address in response. Summaries also offer the consumer a chance to correct information that the provider may have wrong. Once treatment providers become proficient in the use of Open questions, Affirming, Reflective listening, and Summarizing (also known by the acronym OARS; Miller & Rollnick, in press), the stage is set for eliciting self-motivational statements.

Self-Motivational Statements

Providers usually think it's their job to talk people into changing. The purpose of self-motivational statements is to have *consumers* become advocates for such change. After all, people are most likely to make changes when they argue for it themselves. Therefore, the practice of eliciting self-motivational statements is key to the successful practice of MI.

A decisional balance exercise is a generic procedure often used as a way to acknowledge ambivalence when change is being considered, setting the stage for change talk to occur.

The decisional balance exercise compares the “good things and the not-so-good things” (Miller & Rollnick, 1991) of drinking. Acknowledging that there are things about drinking that the individual likes (the “good things”) makes it easier for them to consider and explore the consequences of their drinking (the “not so good things”). The purpose of a decisional balance is to have the consumer openly compare the costs versus benefits of use. It is important that the treatment provider

begin the decisional balance exercise by focusing on the benefits of the status quo first. By discussing the benefits of drinking, the provider is more likely to elicit costs *from the client*. As a result, it is now the client who is in the position of arguing against use instead of the other way around. During the exercise, the provider can write down items from both categories in a side-by-side fashion, offering a visual comparison for the consumer when it is completed. Often, consumers will generate 18

a list containing more cons than pros and this is a useful time to elicit self-motivational statements from the consumer in favor of change. If it's the case that the list favors the pros of use, and/or the consumer seems unable to come up with their own discrepancies about using and how it may be interfering with other important goals, this is a good time for the interviewer to use what they have learned about the consumer's values in an attempt to develop discrepancies.

The Role of Personalized Feedback

In addition to the clarification of values and decisional balance exercises, another useful tool is personalized feedback resulting from the use of objective tests and measures related to drinking or drug using. However, it is essential that providers do *not* use this information to verbally confront consumers. Instead, let the data itself do the confronting.

Feedback forms an integral part of Motivational Enhancement Therapy (MET) (Miller et al., 1995), which is a brief (3-5 sessions) structured clinical intervention focused specifically on the on the second principle of MI-the development of discrepancy. Helping the consumer to develop discrepancy between the perceived (if any) and actual costs associated with substance abuse is a powerful tool in the process of eliciting self-motivational statements for change. Comprised of three components including, feedback, decisional balance exercises, and the creation of a change plan, MET serves to facilitate and support the consumer's evaluation of two essential areas (Miller et al., 1995). First, by using feedback procedures based on data obtained during an intake assessment, the degree to which substance abuse is affecting the consumer's life, both positively and negatively, and with regard to established normative data is examined. Second, by attending to the costs and 19 benefits associated with change and how that change will impact daily life, the consumer is able to make decisions about their continued use of alcohol or drugs.

While the scope of assessment may vary widely, there are several categories commonly targeted for the feedback session. These may include: 1) Information about the consumer's substance use including amount typically consumed in a given week, and the consumer's level of use relative to all same sex American adults, 2) Level of intoxication including peak blood alcohol concentrations (BACs) (for alcohol) for a typical week and heavier drinking or drug use, 3) A variety of risk factors including level of tolerance, other drug use, familial risk (based on heritability), and age of onset, 4) Negative consequences, and 5) Physiological measures such as SGOT, GGTP, SGPT, Uric Acid, and Billirubin. References for a number of assessment options related to these categories and more detailed information on the structured practice of MET can be found in the resource section.

Considerations and Limitations

While the effectiveness of Motivational Interviewing has been studied widely in a number of different populations and been found to be one of the most promising approaches to treating addictions, there are applicable limitations that must be considered (Burke, Arkowitz, & Dunn, in press; Noonan & Moyers, 1997). First, MI should not be thought of as a panacea for the comprehensive treatment of addiction. Instead, MI represents a focused response to ambivalence, and may be an appropriate initial strategy that is of relatively low cost. Because MI is primarily intended to aid consumers in working through aspects of ambivalence, the use of many of its techniques may serve to impede or frustrate the already motivated consumer who is ready to actively engage in the change process. In such cases, the role of MI is simply to address issues of ambivalence should they occur.

Alternatively, while Motivational Interviewing is certainly a learnable skill, not all who attempt to acquire it are successful. Like many clinical interventions, there may be differential personal congruence with the approach (Moyers & Yahne, 1998). Some providers may feel that MI reinforces consumer denial, that it may take too much time to achieve results, or that it supports the status quo. Providers who are dedicated to the confrontation of denial and resistance in substance abusing consumers may find that motivational interviewing is not a good "fit" for their clinical style.

Finally, this guideline has been created in the interest of introducing treatment providers to a general overview of the use of Motivational Interviewing. As such, it provides a very basic introduction to an area of much greater complexity. The acquisition of adequate Motivational Interviewing skills will likely require most healthcare professionals to conduct a more effortful review of the literature and we would highly recommend formal training via sources such as videotaped training sessions, live training seminars, and/or supervision from a qualified source. References for some of these resources are provided in the resource section.

Summary

Motivational Interviewing is a focused approach that originated for the treatment of addictive behaviors and has since been expanded to address issues of the general process of change. Research suggests that MI may serve to enhance client outcomes when it precedes other forms of treatment (Brown & Miller, 1993), and it has also proven to be a cost-effective stand-alone brief intervention (Project MATCH Research Group, 1997). 21

Many providers view themselves as helping by being action-oriented, yet consumers are frequently contemplative about such change. Therefore, MI represents an added dimension of competence, allowing therapists to be effective with a broader range of consumers. By enhancing the continuum of care for substance abuse problems, MI provides an important option for those consumers who are not yet committed to the process of change by employing an empathic, egalitarian style that promotes self-efficacy.

However, while MI may provide an essential framework by which to address motivation for changing alcohol and/or drug use, it may also be necessary to help

consumers, once motivated to change, develop specific skills by which to alter their use of substances. 22

11. Social Work Practice Departmental Manual

Introduction

Since the early 20th century, social workers have been involved in health care fields. Originally, the social work focus was to ensure equal health services to the poor people and to improve their social conditions in order to prevent any possible infectious disease. But nowadays, social workers are joining other fields of health profession and have expanded their fields of work to all health settings such as clinics, hospitals, etc. It is worth mentioning that at some point in the history of the social work profession, it was eliminated from most of the health facilities due to the lack of funding and more importantly lack of understanding regarding the vital role of this profession in provision of health services. But through provision of specialized services in several health care fields such as rehabilitation, end of life care, crisis intervention, ethics and several other fields, social work gained recognition and prospered to an extent that today social work is an inseparable component of health services.

Research, development of guidelines and standards in social work not only benefits the families and individuals but the very existence, effectiveness, and validation of the profession. Standards and guidelines offer guides to social workers who practice in health care settings. For this reason, standards and guidelines have been produced, developed and implemented in order to standardize and increase the quality of their services.

The principles of social work:

The foundation and basic values of social work are respecting individual's right to self-determination and having an attitude of empathy toward them. When clients or their families face dilemmas or needs in health care, social workers use such values in order to help them in their course of decision making.

Additionally, cultural awareness and competence is another principle to the work of social workers. They are respectful, responding and affirmative of the worth and dignity of people of all cultures, language, class, ethnicities, religions, sects, and gender. When responding to the health needs of an individual, social workers always take into consideration all the factors existing in an individual's environment which influences their total health care experiences.

Generally, the principles of social work profession is to provide timely, comprehensive and equitable health care for individuals who have less access to health serviced due to various reasons. Development in medical technology and increased quality of life has been effective in providing health services but at the same time leads to increased costs of such services. It's a major reason for increased importance of Social workers roles in today's health system. Social workers are involved in a variety of health care settings such as public health, addiction and rehabilitation, acute and chronic care settings and etc. and provide services such as health education, crisis intervention, supportive and motivational counseling, etc.

Purpose of the guideline:

The purpose of this guideline is to establish a standard of practice for the social workers of Kabul Mental Health Hospital and Jangalak Substance Abuse Treatment Center. Also, this guideline will help enabling them to provide standard and high quality social work services to the clients of the In-patient and Out-patient departments.

This guideline is open to any suggestions and recommendations from any mental health specialist regardless of their specialty e. g. Psychologists, Counselors, Psychiatrists, Occupational Therapists and any other individual expert working in the field of mental health in Afghanistan. This guideline could also serve as a basis for further standards of practice and guidelines which the Mental Health Department of the Ministry of Public Health might develop for use at a national level.

Target audience:

The primary user group of this guideline is Social workers at Kabul Mental Health Hospital Jangalak Substance Abuse Treatment Center. The primary beneficiaries of this guideline are clients visiting these two centers.

Definitions:

Biopsychosocial–spiritual Perspective:

Social workers use a system of health care in which several aspects of one person comes into the equation of health services. These aspects are physical and medical aspect (bio), psychological and emotional aspects (psycho), the socio-cultural, socio-political and socio-economic aspects (social) and the ways people find meaning in their lives (spiritual).

Case Management:

Case management is a collaborative process in which social workers assess, plan, and facilitate options and health services in order to be efficiently responsive to the needs of an individual. Sometimes it might also include arranging, coordinating, monitoring, evaluating and advocating on behalf of the client when they need several health services.

Client/Patient:

Both of these two terms refer to any individual who receives care and treatment healthcare providers. They can be used interchangeably based on the environment in which social workers are involved. In Kabul Mental Health Hospital and Jangalak Substance Abuse Treatment Center, the term “Patient” is mostly used to refer to the individuals who receive therapeutic intervention to deal with their mental health disorders and substance abuse problems.

Continuity of Care:

Social workers ensure that health care for individuals are coordinated within the organization (KMHH, and JangalaKk) to maximize benefit to the patient and reduce duplication of services.

Health Care Settings:

Health care settings are usually referred to the places in which treatment addresses physical, mental, emotional and social well being of the person. In this document, health care setting is referred to Kabul Mental Health Hospital and Jangalak Substance Abuse Treatment Center.

Guidelines for Social Work Practice:

1- Ethics and Values

Social workers shall have knowledge of the practice of social work and should practice in the realm of the specialty and their terms of reference developed by Ministry of Public Health and according to the rules and regulations of the Mental Health Hospital and Jangalak Substance Abuse Treatment Center. Additionally, they should have full awareness of the mental health act of the Islamic Republic of Afghanistan and abide by its guidelines.

The primary mission of the social work is to enhance human well-being. So, the following universal core values are the foundation of the social work practice:

- Service
- Social justice
- Dignity and worth of the person
- Importance of human relationships
- Integrity
- Competence

2- Cultural Competence

Social workers shall be aware of the history, traditions, values and systems of different groups of the society. They shall develop and maintain such understanding in their practice of social work. They should be aware of the sensitivity of different cultures and increase their awareness of the diversity in cultural norms and standards. They shall approach their patients in a manner which is respectful to their cultures and norms. They should avoid stereotyping beliefs regarding each individual patient and should take appropriate steps toward a deeper understanding of their patients. It is especially important in establishing a proper therapeutic relationship with their patients.

3- Confidentiality

According to article 33 of Afghanistan mental health act, all information of the patients should be kept confidential. Social workers should communicate this clearly to their patients and clearly explain the exceptions that would lead to breach of this confidentiality.

These exceptions include but are not limited to:

- Court order
- Harm to self and others
- Abuse of a child or elderly

4- Knowledge

Social workers in health care settings shall demonstrate a working knowledge of current theory and practice and integrate such information into practice. This knowledge includes but is not limited to the following:

- Roles and functions of social worker
- Biopsychosocial needs of the patients
- Physiological elements of patients' illness
- Psychosocial implication of the patients' condition

- Communication skills and expertise so they could clearly communicate treatment plans to the clients and their families
- Resources available in the community
- Cultural awareness and competence
- Ethical knowledge
- Proper knowledge of the laws and regulation which could affect their patients

5- Assessment

Social workers should be able to provide ongoing assessment including gathering comprehensive information to use in developing interventions and treatment strategies. Assessment is a fundamental process of social work practice. A comprehensive, culturally competent assessment includes:

- Past and current health status
- The impact of health conditions or treatments on cognitive, emotional, social, sexual, psychological, or physical functioning
- Social history, including current living arrangement and household environment
- Work, school, or vocational history
- Cultural values and beliefs, including views on illness, disability, and death
- Family structure and the client's role within the family
- Social supports, including formal and informal support systems
- Behavioral and mental health status and current level of functioning, including history, suicide risk, and coping styles
- Financial resources

6- Intervention and Treatment Planning

The interventions that social workers make to promote patients' well-being should be based on a comprehensive, culturally competent assessment with interdisciplinary input.

Intervention or treatment plans may include:

- Strategies to address needs identified in the assessment
- Information, referral, and education
- Individual, family, or group counseling
- Vocational, educational, and supportive counseling
- Psychoeducational support groups
- Discharge planning
- Interdisciplinary care planning and collaboration
- Goals and objectives

7- Case Management

Case management in social work is designed to optimize patient functioning and to facilitate collaboration among health providers to address patients' needs.

Social work case management shall optimize

In managing each case, social workers should abide by the following scope of services:

- Case facilitation
- Patient and family counseling

- Crisis intervention
- Quality improvement
- Resource brokering/referral/development
- Continuity of care planning
- System integration
- Outcome evaluation
- Teamwork/collaboration
- Patient/family education
- Patient/family advocacy

8- Client and Community Education

Social workers should act as educators for clients, families, communities and other professionals regarding prevention, impact of illnesses and diseases, advocate for health maintenance and treatment modules.

9- Teamwork and Collaboration

Social workers should always practice their interventions along with a team of other professionals. Such teams often provide comprehensive care and information regarding clients in outpatient and inpatient departments of the mental health hospital.

10- Workload

Social workers should maintain a workload and manage their patients in a manner that allows them to be more efficient in providing quality social work services delivery. They should manage their time in order to allow them to have enough time to research and read information that helps them to work with their clients better. Also, they should manage their work time in a manner that allows them to increase their knowledge and capacity.

11- Documentation

Social workers are required to keep adequate records of their social work practice with their clients whether it is provide in an individual or group setting. They are responsible for the safeguarding and confidentiality of these records and their safe delivery to the medical record section of the hospital.

Comprehensive documentation includes the following:

- Comprehensive assessment and services delivered to the client and client systems, including the development of a plan of care
- Ongoing assessments, interventions, and treatment planning
- Goals and planning that reflect an explicit statement of agreement with client, client systems, and team input
- Referral sources and collaborations
- Dates, times, and descriptions of client and client system contacts
- Documentation of outcomes
- Reason for case closure or transfer
- Written permission to release and obtain information, where appropriate
- Documentation of compliance with confidentiality rights and responsibilities

12- Performance Improvement

Social workers shall always evaluate their practice to assess the quality and appropriateness of the services they provide. This will allow them to maintain a level of competence which helps them to be more effective and successful in their practice of social work.

Evaluation practices may include the following:

- Using appropriate tools such as clinical indicators, practice guidelines, etc.
- Assessing both outcome and process objectives
- Involving the client and client system and colleagues in the evaluation process
- Protecting the privacy of the client and client system and other professionals
- Disseminating evaluative data to clients, and other professionals on request and adhering to privacy rights

13- Qualifications

In every health care setting including this hospital there should be highly qualified personnel to plan, provide and evaluate social work practices and ensure that social workers are meeting standards in their social work practice.

14- Supervision

In every health care setting including this hospital, a social work leader or supervisor shall be available to supervise health care social work staff on their responsibilities in practice, orientation, and education. The purpose of supervision is to enhance the social worker's professional skills and knowledge, to enhance competence in providing quality patient care.

12. Occupational Therapy Departmental Guide Line

1. Preface

People have an intrinsic drive to be active that is expressed through activities that form the fabric of their everyday lives. Occupations include everything that people do in everyday life and are central to the existence of individuals, groups and communities. Occupation is the means by which people maintain themselves in the world and realise their potentials (COT 2006a, Wilcox 1998). In the eyes of the world, people are largely what they do through the roles that they adopt in life.

Maintaining an acceptable and personally satisfying routine of activities that have meaning and value for the individual creates a sense of purpose and direction to life. Conversely, any disruption to the individual's daily routines caused by illness or disability can lead to dissatisfaction, disorientation and distress. Occupation is therefore essential for good mental health and well-being.

'Adults with long-term mental health problems are one of the most excluded groups in society. Although many want to work, fewer than a quarter actually do – they form the lowest employment rate for any of the main groups of disabled people.' (ODPM 2004, p3)

The international scene

The United Nations has developed an overview of international legal frameworks for mental health & disability legislation as well as vocational rehabilitation guidelines for this client group (resolution 48/96 of 20 December 1993). It is the role of the Occupational Therapy department to ensure the implementation of such.

2. Occupational therapy: Definition

Occupation:

Occupation, as used here, refers to the actions of seizing, taking possession of, and occupying time, and the spaces, and roles in one's life (The Oxford English dictionary, 1989).

In this sense, occupations include actions that people perform to occupy their homes, workplaces, and the places where they participate in education, and recreation or leisure, which allow meaningful use of time and assumption of life roles (Fisher, 1998).

The occupational dimension of people's lives contributes a vital perspective to the existing biological, psychological, cultural and social models of health and well-being that many disciplines and practitioners utilise in their work. This occupational perspective recognises that human beings are essentially occupational beings, who use occupations as the means for interacting with their worlds, creating and maintaining their sense of self, for survival and maintaining health.

1. What is the occupational therapy role?

The domain of occupational therapy is concerned with the occupational dimension of people's lives.

According to the World Health Organisation's (WHO, 1998) Occupational therapists are health and community service providers whose main contribution is concerned with enabling occupation

Occupational therapy services are provided for the purpose of promoting health and wellbeing. The domain aims to address physical, cognitive, psychosocial, sensory, communication, and other areas of performance in various contexts and environments in everyday life activities that affect health, well-being, and quality of life (American Occupational Therapy Association [AOTA], 2004).

The overarching goal of occupational therapy is "to support people's health and participation in life through engagement in occupations" (AOTAA, 2008, p. 626). The key aim is to get patients back to their community where they can function socially and economically regardless of their conditions.

Occupational therapists in mental health work with people with all types of mental distress including depression, anxiety, psychosis, bipolar disorder, personality disorders and substance misuse.

2. Occupational therapy in Mental Health

Occupational therapists in mental health emphasise the relationship between occupation, mental health and wellbeing

The domain of occupational therapy in the mental health field is concerned with understanding and addressing:

- The occupational consequences of mental health problems and mental illness;
- The occupational needs of people, who are at risk, and have mental health problems and mental illness.
- The ways in which people's environments support and restrict their functioning, recovery, and occupational development.

3.Occupational Therapy Philosophies and skills in OT:

Mental Health Occupational Therapy Practice: Key Purpose Statement

Occupational therapists in mental health work collaboratively with patients/ service users, carers, and carers. They support and enable patients/ service users and families to create and maintain ways of living, learning, playing, working, and relating that enhance their abilities to respond to the challenges, opportunities, and demands of their worlds; minimise the impact of mental health problems or mental illness; and contribute to their wellness.

Occupational Therapy Underpinning Attitudes

The underpinning attitudes of occupational therapists are seen as central to achieving positive outcomes for patients/ service users and carers. Of primary importance, occupational therapists' practice is expected to reflect the principles of valuing the lived experience of patients/ service users and carers, valuing working in partnerships with patients/ service users and carers, and valuing the healing potential in these relationships in all aspects of their work.

They emphasise respect for, acknowledgement and genuine valuing of another person's knowledge and lived experience, acceptance of a range of ways of viewing, or framing issues, and the quality of relationships as important for achieving positive outcomes for patients/ service users and carers. Therefore, occupational therapists will:

- Treat patients/ service users and carers with respect and dignity,
 - Demonstrated by seeking ways to genuinely value and acknowledge the knowledge and lived experiences of patients/ service users, of carers about lives.
- Recognising the rights of patients/ service users and carers
 - Demonstrated by complying with regulations and legislation protecting their rights, recognising and treating patients/ service users and carers as fellow human beings, and maintaining optimism in their work to foster hope;
- Share power in relationships with patients/ service users and carers
 - Demonstrated by informing patients/ service users and carers about their rights, service choices, and options
 - Sharing occupational therapy resources in a mutual educational process with patients/ service users and carers
 - Collaborating with patients/ service users and carers to facilitate their decision making.

Occupational Therapy Underpinning Knowledge

Occupational therapists should have an occupational perspective on health, which is of holistic approach since occupation influences mind and body in an integrative way (Wilcock, 1998).

Throughout peoples' occupational development there is recognition of their intrinsic need to live lives that are healthy, meaningful, satisfying, productive and contributing, creative, communal, ecologically sustaining, playful and enjoyable (do Rozario, 1994a; 1994c).

To facilitate occupational development, occupational therapists should use knowledge of occupation, the capacities, skills, and habits required for effective performance, as well as the intrapersonal, interpersonal and environmental dimensions that influence participation in occupations. For occupational therapists, knowledge of people's lived experience is as necessary as knowledge of their illness, disability, or developmental delay, for understanding their occupational difficulties, and finding ways to enable them in their occupations.

Specific knowledge underpinning occupational therapy practice within mental health contexts includes knowledge of:

- Medical diagnostic systems (such as DSM, the Diagnostic & Statistical Manual), psychiatric diagnoses, and medical treatments
- Models that contribute to an understanding of functioning, such as the bio-psychosocial model,
- ICIDH-2 (WHO, 1997), cultural and political perspectives
- Case management, psychosocial rehabilitation, and recovery/empowerment-oriented models and practices
- Assessment and outcome measurement methods and practices, including mental health status, risk, functional, and patient/ service user-focused assessment and outcome measurement
- Stress management and relaxation approaches and practices

Occupational Therapy Underpinning Skills

All occupational therapists in mental health practice should have the basic/ general occupational therapy skills with additional specific skills. Specific skills underpinning occupational therapy practice in mental health practice include the following areas:

- Mental health status, psychiatric assessment and evaluation
- Dealing with psychiatric emergencies, psychopathological, and problem behaviours
- Interpersonal communication, counselling, and conflict resolution
- Case management practice, including engagement, intervention/care planning, and implementation in a collaborative manner
- Working with families and social systems
- Individual and group counselling and psychotherapeutic strategies
- Psycho-educational, and skills training strategies
- Health promotion and health education
- Culturally sensitive practice
- Use of occupation-focused and functional assessments
- Occupational analysis, and use of lifestyle redesign strategies involving play, education, work, recreation and retirement
- Creative, recreational, and play therapies
- Community living and vocational skills training and integration

4. Departmental guide

Awareness-raising

Occupational Therapy Department should take action to raise awareness in society about people with mental health and substance misuse problems, their rights, needs, potential and contribution.

- Occupational Therapy Department should initiate and support information campaigns concerning people with mental health and substance misuse problems, conveying the message that people with mental health and substance misuse problems are citizens with the same rights and obligations as others, thus justifying measures to remove all obstacles to full participation.
- Occupational Therapy Department should invite people with mental health and substance misuse problems and their families to participate in public education programmes concerning mental health matters.
- Occupational Therapy Department should initiate and promote programmes aimed at raising the level of awareness of people with mental health and substance misuse problems concerning their rights and potential.
- Awareness-raising should be an important part of the education for mental health and substance misuse clients/ patients

Rehabilitation

The term "rehabilitation" refers to a process aimed at enabling people with mental health and substance misuse problems to reach and maintain their optimal physical, sensory, intellectual, psychiatric and/or social functional levels, thus providing them with the tools to change their lives towards a higher level of independence. Rehabilitation may include measures to provide and/or restore functions, or compensate for the loss or absence of a function or for a functional limitation. The rehabilitation process does not involve initial medical care. It includes a wide range of measures and activities from more basic and general rehabilitation to goal-oriented activities, for instance vocational rehabilitation.

Occupational therapy Department should ensure the provision of rehabilitation services to people with mental health and substance misuse problems, in order for them to reach and sustain their optimum level of independence and functioning.

- Occupational therapy departments should develop rehabilitation programmes for all groups of people with mental health and substance misuse problems. Such programmes should be based on the actual individual needs and on the principles of full participation and equality.
- Such programmes should include a wide range of activities, such as basic skills training to improve or compensate for an affected function, counselling of people with mental health and substance misuse problems and their families, developing self-reliance, and occasional services such as assessment and guidance.
- All people with mental health and substance misuse problems, including people with severe and/or multiple disabilities, who require rehabilitation should have access to occupational therapy at the hospital.

- People with mental health and substance misuse problems and their families should be able to participate in the design and organization of rehabilitation services concerning themselves.
- At the start of every functional group work, the occupational therapist should facilitate group members to develop their goals as well as planning the way forward.
- Special time-limited rehabilitation courses may be organized, for specific groups to enable them to develop life skills so as to combat relapse.
- The Occupational therapy and social work department should draw upon the expertise of organizations of people with mental health and substance misuse problems when formulating or evaluating rehabilitation programmes.

5. Department and Practitioner's Assessment, treatment and education guide.

Occupational Therapy assessment in mental health

Person-centred assessment of a client's occupations is a key part of understanding what activities may have contributed the service user's mental health problems.

Person-centred assessment also helps identify what activities will enable the person to gain empowerment in their lives, feel socially included and promote recovery. For example, having a highly stressful job may be detrimental to a person's mental health while engaging in enjoyable leisure activities with good friends will ensure mental resilience. The assessment aims to gather information about a client's level of function in their everyday lives. This will include consideration of three main areas (Creek 2003):

- Self maintenance activities which include the ways that a person attends to their immediate health needs and those of their environment including washing, dressing, cooking, cleaning, eating, managing money and paying bills, looking after the home, dealing with mail, using public transport and sleep
- Productivity activities which include the main way that a person feels they contribute to society including voluntary work, child rearing, caring for relatives, paid employment and attending college
- Leisure activities which include everything a person does for enjoyment and relaxation including exercise, hobbies and socialising

Impact of the assessment

The assessment will also consider the client's physical, cultural and social environment and how this impacts on a person's occupations. For example if a client lives in an isolated, deprived area with poor public transport and low levels of income, this will probably restrict their range of options to engage in social and leisure occupations. In addition, the stigmatising socio-cultural environment reduces a client's chances to gain work or meet friends (Hean Lim 2005).

Assessment of client's values and interests can lead to an understanding of their motivation for occupation, their everyday habits and patterns of occupation (Kielhofner 2002)

The assessment will also need to include present levels of functioning related to past patterns of occupation and the expectation of future patterns of occupation (Creek 2003). Information about a service user's occupations may also be discussed with the consent of the individual, with significant others and carers/chaperon to gain additional insight into the presenting situation.

Occupational therapists use a range of evidence-based, standardised assessment tools which produce data to assist the service user and team members to understand how a person is managing their occupations and how this changes through occupational therapy interventions. Three commonly used assessment tools which can be used singularly or in combination:

- The Model of Human Occupation (MOHO) assessment tools e.g. Model of Human
- Occupation Screening Tool (MOHOST)The Canadian Occupational Performance Measure (COPM)
- The Assessment of Motor and Process Skills (AMPS)

Following the assessment, formulation requires that the therapist, client, and where appropriate or family mutually explore and interpret what the challenges are, where they are located and what might be achieved (Creek 2003).

Occupational Therapy interventions in mental health

A thorough assessment will have led to a rounded picture of the individual service user, their hopes, motivators and aspirations. Nevertheless, the main intervention modality offered by occupational therapists are therapeutic activities which are selected because they are meaningful to the service user and can be used to develop or maintain skills and contribute to the person's health and wellbeing (Creek 2003). The occupational therapist can directly provide the activity and carry it out with the service user (Creek 2003). Occupational therapists will also carry out interventions which target the person's social environment which can be changed to facilitate activity and occupational engagement. Examples of types on interventions are as follows:

- Direct provision of, or facilitating access to activity such as art and craft activities, creative activities, self-care activities, work activities, leisure activities, life-style activities, community outings or social activities
- Environmental adaptation e.g. changing or influencing the physical, cultural, institutional or social environments in order to facilitate occupational performance by, for example, providing education in community facilities about mental health

- Group or individual psycho-educational work e.g. anxiety management, anger management, assertion skills, dealing with hearing voices, recovery groups, lifestyle management
- Working with the service user to maintain their life role, main vocation and social relations e.g. homemaker, mother, carer, employee, friend
- Facilitating community integration in order to enable the service user to maintain their desired lifestyle
- Preventative interventions aimed at maintaining communities general mental health

6. Step by step practitioner's guide

Assessment

- Assessment of physical, emotional, behaviour (habits) and cognitive functioning with environmental considerations
- Evaluation of the home, work or school environment to assess the need for specialized equipment modifications and/or supports

Treatment/Management

- Individualized treatment plans to develop, maintain, or augment function using evidence based treatment modalities
- Teaching daily living and community life skills
- Prescribing specialized adaptive equipment and teaching proper usage
- Modification of the physical and social home, work or school environments

Education/Advocacy

- Educating and counselling family members and caregivers regarding the impact of disability, injury or disease on the individual and their potential role within the recovery process
- Educating and counselling to promote function and independence including health promotion, drug and harm reduction

Referrals/Collaboration

- Based on assessment the occupational therapist refers the individual to additional health care services as needed
- Collaborates with other health care professionals and service providers to promote comprehensive and coordinated care.

<http://www.coto.org>

Engage clients carers and others in identifying occupational strengths, competence, needs, resources, and opportunities.

- Relevant people and system are identified and engaged in collaborative, respectful partnerships to explore strengths, needs, resources and opportunities.
- The lived experience of those involved, and the dynamic interrelationships and interconnections between people, systems, and environments are explored in the assessment of strengths, needs, resources and opportunities.

- Interpersonal and counselling processes are used to establish and facilitate ongoing communication and partnerships with patients/ service users, carers and other involved people and systems.
- Information is gathered about past, present, desired and relevant living, learning, working, relating, and leisure occupations in collaboration with the people and system(s) involved.
- Occupational strengths and competence (eg attributes, knowledge, attitudes, aspirations, functional abilities and skills) and occupational resources (eg personal resources, social supports, community and environmental resources) are identified.
- Occupational needs and difficulties (eg occupational deprivation, performance difficulties and challenges) and occupational opportunities (eg possibilities for change, enrichment, future development and growth) are assessed/ analysed.
- Mental and physical health status, bio-psychosocial functioning and cultural factors are explored and taken into account.
- Applicable occupational therapy and service models are used to guide the occupational analysis/assessment.

Review & interpret the occupational analysis, and then develop occupational strategies for change.

- An occupational profile that synthesises the occupational life history, directions, aspirations, and issues identified, is developed in collaboration with the respective people and system(s).
- Occupational strategies for change, resolution of issues, or for healthy living are developed and planned in collaboration with the respective people and systems.
- Dynamic interrelationships and interconnections between people, systems, and environments are taken into account in plans for facilitating occupational development and lifestyle redesign.
- Consideration of mental and physical health status, the bio-psychosocial functioning, culture, rights and the service context are integrated in the development of occupational change strategies.
- Time frames, access to support, closure, and discharge planning, as applicable in the service context, are considered in making plans with the respective people

Enable occupational engagement for learning, occupational development and bio-psychosocial wellbeing:

- Occupational engagement experiences are developed in collaboration with the respective people or systems.
- Occupational engagement and enrichment opportunities are created that are congruent with enhancing overall health and wellness, and with the people mental and physical health status, bio-psychosocial functioning, culture, and the service context.
- Occupational engagement experiences and environments are organised and structured to facilitate occupational enrichment, learning of skills, enhance

occupational performance and provide sufficient challenges to sustain occupational development and healthy living.

- Individual, group, and community learning opportunities for exploring occupations, choice making, risk taking, experimenting, and rediscovering through occupational engagement are created, and supported.
- Group processes and dynamic interrelationships and interconnections between people, system(s), and environments are utilised to support occupational engagement.
- Creative problem solving, change management and lifestyle redesign, knowledge and skills are utilised in collaboration with people and system(s) involved, to support learning, effective response to life circumstances, and sustained participation in occupations of personal, social and cultural relevance.
- Individuals and/or systems are facilitated to develop their own frames of reference, repertoire of strategies and supports to sustain occupational engagement, learning, and development for healthy living and lifestyle redesign.
- Individuals' and systems' skills and resources to access, and successfully utilise mental health services, other relevant sources of support and community services are supported and developed.

Evaluate occupational change strategies.

- Regular and ongoing reviews are undertaken in collaboration with the people and system(s) involved.
- Ongoing feedback about progress and outcomes in relation to the previously identified occupational profile and planned occupational strategies is sought from the respective people and systems.
- Feedback is reviewed, and issues enhancing and impeding progress identified, in collaboration with the respective people and/or systems involved.
- Alternative occupational change strategies are explored in collaboration with the respective people and/or systems as part of the renegotiating of plans, and reviewing ongoing progress.

Select and use suitable methods, tools and processes for information gathering, assessment, and evaluation to facilitate occupational development.

- Methods and processes for learning about the lived experience of patients/service users, families, other carers are utilised.
- Relevant and acceptable tools, methods and processes are chosen in collaboration with people and systems involved.
- Selection of tools, methods, and implementation processes take account of mental and physical health status, bio-psychosocial functioning, culture and rights of those involved.
- Recognised and relevant methods and tools for occupational and other assessment and evaluation that are congruent with the service context and guidelines for best practice are selected.

- Occupational and other information gathering, assessment and evaluation tools and methods are clearly explained to those participating in these processes.

Undertake timely recording & reporting of the occupational development process.

- Patient/ service user and carer respectful language is used in all communications and records.
- Occupational profiles, plans, progress and outcomes are clearly documented and shared in a respectful, ethical manner with those involved, in particular the patient/ service user (s), carer(s) and other involved service providers.
- Documentation is congruent with the requirements of the service context, guidelines and standards for best practice.

Facilitate Occupational Development with Individuals and Groups

Elements:

- Engage patients/ service users, carers and others in identifying occupational strengths, competence, needs, resources and opportunities
- Review and interpret the occupational analysis, and then develop occupational strategies for change
- Enable occupational engagement for learning, occupational development and wellness
- Evaluate occupational change strategies
- Select and use suitable methods, tools and processes for information gathering, assessment and evaluation to facilitate occupational development
- Undertake timely recording and reporting of the occupational development process

Develop and Maintain Collaborative Partnerships with Patients/ service users and Carers:

Elements:

- Actively seeks to understand the lived experience of patients/ service users and carers
- Appreciate the contribution of relationship and partnership
- Support and implement patient/ service user and carer participation policies, guidelines and initiatives

Undertake and Support Systems Advocacy to Support Patients and Carer Self Advocacy

Elements:

- Promote and support patients and carer self advocacy, and carer support on behalf of patients
- Work with patients/ service users, carers, and other stakeholders to develop strategies that support advocacy related to identified areas of concern
- Promote community awareness and understanding of mental health issues and the needs of people affected by mental health problems

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3. For Motivational Interviewing

Recommended Reading

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Recommended Assessment and Treatment Manuals for MI or MET

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Demonstration Videotapes

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Motivation and Change. Set of two training videotapes available from the Addiction Research Foundation, 33 Russell Street, Toronto M5S 2S1, Ontario, Canada. 23

Rollnick, S. *I Want It But I Don't Want It: An Introduction to Motivational Interviewing*. Mind's Eye Video, 1989. European format only. Available from the Department of Psychology, Whitchurch Hospital, Cardiff, Wales, United Kingdom, CF4 7XB.

Internet-Based Resources

The two websites listed below offer a rich source of information regarding the assessment and treatment of addictive behaviors. Many assessment instruments can be downloaded free of charge from the UNM CASAA website, and you can also order training materials and view the locations for upcoming training sessions.

If you are looking for assessment instruments, or information on a variety of other related topics, you can find them on the University of New Mexico Center on

Alcoholism, Substance Abuse, and Addictions (CASAA) website at <http://casaa.unm.edu>.

For information about motivational interviewing, please consult the official MI website at www.motivationalinterview.org. 24

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