

Handicap International

in Cooperation with

Dong Hanh Agency

and

The Centre for Care and Rehabilitation for Professional Diseases

**Evaluation to Improve
the Psychosocial Support to
Spinal Cord Injured Patients
in the First Spinal Unit
in
Ho Chi Minh City, District 8,
VIETNAM**

October-November 2003

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Psychosocial support to SCI Patients in the Spinal Unit, Dieu Duong Hospital, District 8, HCMC. October-November 2003.

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“SCI rehabilitation is to assist the individual with SCI and the family in achieving optimal physical, psychological and social functioning consistent with level of injury, personal preferences, needs and resources”

1. Introduction

People with spinal cord injuries do not only suffer physically, but also experience mental difficulties while coping with their new situation. Studies showed that *'adjustment to SCI (spinal cord injured) is accompanied by depression, anxiety and stress'*. It was also documented that *'as many as 100 % suffered from deep depression and anxiety'*. (Pisak Chinchai, Ruth Marquis, Anne Passmore, 2003: 31).

Consequently, the health workers involved in the service delivery should consider the mental state of the person as a rehabilitation outcome as important as the physical rehabilitation outcomes.

Handicap International has noticed that *'the inevitable psychological & social depressions prevent them (the SCI patient) to participate in the rehabilitation process'* (TOR, 2003: 1). Handicap International also realised that spinal cord injured patients need to be followed, encouraged and advised. As a result of this experience, Handicap International is piloting a peer counselling approach to support the SCI patients.

For this pilot project, a service contract was signed between Dong Hanh, which is a private company using a peer counselling approach, and Handicap International with the objective to *'psychologically support the new spinal cord injured, especially at the beginning of their stay in the hospital, for them and their family to better accept the disability'*. This general objective is achieved through the following 2 specific objectives.

1. Convince hospital staff of the necessity of psychological support for the patient
2. Make that psychological support is part of the holistic treatment of the patient and included in the teamwork

It is expected that Dong Hanh will select and train another peer counsellor who will be part of the Spinal Unit team. The selection and training of this peer counsellor can only commence after achieving specific objective 1, and will contribute to achieving specific objective 2.

It is important to realise that the hospital in district 8 is the first SCI Rehabilitation Centre throughout Vietnam, and is likely to be a lead example for other hospitals and INGOs.

Although the Dong Hanh Company has performed outstanding in progressing towards the above-mentioned objectives, it was felt that there might still exist some areas in which improvements could be made. Identifying these areas and formulate answers was the main purpose of the assessment study carried out in October-November 2003. This report is the result of the assessment.

2. Objectives

- General objectives:

Support the Dong Hanh peer counsellors to improve and complete the services provided to the SCI patients, in sustainable perspectives

- Specific objectives:

- 1) Precise assessment of the SCI patients' needs in terms of psychological support, socio-economic re-integration, and follow-up according to the local context specificities
- 2) Appraise the services already covered by the peer counsellors' running activities
- 3) Provide the peer counsellors with direct and concrete advice that can help them in their running activities
- 4) Identify possible complementary actions (training, additional support...) that might efficiently complete the running actions
- 5) Provide Handicap International and partners with concrete recommendations for possible, relevant and sustainable orientation of this project part (including the necessary means, calendar, objectives...)

3. Activities

In order to achieve these specific objectives, the evaluation team carried out a number of activities, including:

- Activities:

- 1) To follow the peer counsellors during their bi-weekly (Monday and Thursday afternoon) visits at the hospital
- 2) To follow the multidisciplinary team (including the peer counsellors) during a home follow-up.
- 3) To discuss and to provide the peer counsellors with direct and concrete advice concerning patient cases (weekly supervision)
- 4) To design a Peer Counsellor Job Description
- 5) To design a clinical file for SCI patients
- 6) To provide a psychological test to check depression, anxiety and stress
- 7) To list the necessary equipment required for the counselling room
- 8) To conduct an information session on "*The Role of a Clinical Psychologist and a Social Worker in a Hospital*".

- 9) To develop a mapping and a network resources centres on SCI rehabilitation in South East Asia
- 10) To collect information on Labour Law
- 11) To visit training skills centres

4. Definitions

In this section, some key concepts are defined in order to precise the aim of the evaluation.

4.1. Psychologist and Social Worker¹

*“Psychologists and social workers are core members of the interdisciplinary team. They contribute to the treatment team by providing specialized clinical skills and perspectives to help the individual achieve optimal psychological, behavioural, social, vocational, and a vocational functioning. The professional scope of practice of psychologists and social workers working with individuals with SCI is predicated upon patient needs, regardless of the clinical setting. Clinical services may be provided in the acute care setting, the rehabilitation setting, or a variety of follow-up settings, including but not limited to outpatient clinics, home health care and independent living centres. Staffing levels in all clinical settings should be commensurate with patient needs”.*²

Listed below is the kind of work undertaken by social workers in Viet Nam working in a hospital³

- Interviewing patients and their relatives
- Preparing reports, comments and assessments
- Visiting the homes of patients and their relatives while the patients are still in the hospital (if necessary)
- Home visits after the patients leave the hospital (for follow-up and further monitoring)
- Inviting the patients to join group therapy
- Providing counselling to clients and their families
- Referring patients to other agencies / services

4.2. Psychosocial Support

¹ For further information, please refer to “ The Role of a Psychologist and Social Worker in a Hospital”, annex 6.

² <http://www.aascipsw.org/StandardsPSW/ID.htm>

³ Reference Materials for the Training in Basic Social Work Skills, UNV-MOLISA-CFSI Project Phase 2 – December 2001

Psychosocial support *'is a process through which immediate measures provided by the social worker make the patient feel better, more relaxed and have more energy'* (Judith Nelson)

4.3. Counselling

*Counselling is a process of helping an individual, family or group resolve their difficulties. Counselling does not only seek to help clients to solve their problem but also enhance their capability to cope and function adequately in facing future problems.*⁴

The objectives of counselling are:

- To help the patients to reduce the negative emotional state and / or difficult situation
- To help the patients to increase understanding of themselves and their situation
- To help the patients to restore and / or to improve their functioning
- To foster new coping strategies for future reference

The basic principles in counselling are:

- Trust in the capability of the patient
- Non-judgmental attitude
- Respect for the patient as a person
- Empowerment of the patient
- Self-determination of the patient
- Confidentiality

5. Updated Facts / Figures

5.1. Some Figures

All the data on SCI that have been collected throughout Vietnam are not recently updated.

The figures come from two epidemiology surveys realized in 1990 and 1996⁵ in the **Neuro Surgery Department of Cho Ray Hospital** and in the **Traumato-Orthopedic Centre (CTO)**:

⁴ Reference Materials for the Training in Basic Social Work Skills, UNV-MOLISA-CFSI Project Phase 2 – December 2001

⁵ 356 clinical cases of cervical traumas (1996) and 504 clinical cases of dorso-lumbar traumas (1990); in *Care and rehabilitation of the SCI*, Activities report 2002, p50-55, HI VN

- Age at injury: the spinal cord injured are young adults, average 40 years old, with a peak for the range 21-30.

- Gender: Male (62%), Female (38%)

- Trauma causes and circumstances: labour (34%), Traffic (26%), Daily life activities (40%)

At the Rehabilitation Centre (ex Sanatorium)⁶:

- Age at injury: under 20 (8,7%),
 21-30 (28,7%),
 31-40 (21,3%),
 41-50 (20%),
 51-60 (12,7%),
 over 61 (8,7%)

- Gender: Male (76,6%), Female (23,4%)

- Trauma causes and circumstances: Labour (44%), Traffic (33,3%), Daily life activities (22,7%)

- Neurological level and extent lesion: cervical injuries (55,3%), dorsal injuries (20,7%), Lumbar injuries (24%)

Latest figures have been collected from 36 inpatients at the Spinal Unit (July-August 2003):

- Age at injury: average is 39,11 years old

- Gender: Male (63,8%), Female (36,11%)

- Trauma causes and circumstances: Labour (32%), Traffic (44%), Daily life activities (24%)

- Neurological level and extent lesion: cervical injuries (72,2%), dorsal injuries (13,8%), Lumbar injuries (13,8%)

%	Age at injury	Gender		Cause of injury			Extent lesion		
		Male	Female	Traffic	Labour	Daily activity	Cervical	Dorsal	Lumbar
1990/96	40	62	38	26	34	40	Unknown datas		

⁶ *Comments on SCI of 150 patients treated at department of HCMC sanatorium and department of rehabilitation, 1997.*

1997		76,6	23,4	33	44	22	55,3	20,7	24
07/08 2003	39	63,8	36,11	44	32	24	72,2	13,8	13,8

5.2. Dong Hanh Agency

Dong Hanh is a private consultancy agency created in 2000, specialized in services provided by and for disabled people.

Therefore, HI has hired Dong Hanh for a first ten days assessment of SCI patients' needs in the Spinal Unit.

Two peer counsellors went regularly to visit twice a week, ten patients with depression symptoms. By the end of the assessment, the peer counsellors had improved the mental health status of the patients, making them accept to follow their treatment plan⁷.

The results revealed a need of psychosocial and support to patients at the Spinal Unit, as these figures⁸ showed:

- Learn how to move and control the wheel chair: (100%)
- Have money to pay hospital fee: (100%)
- Making friends: (100%)
- To be known as their rest of ability: (100%)
- Having a job after recovering (100%)
- Reading Newspapers + books: (60%)
- To find out the activities of people with disabilities: (20%)
- Attend to self-help groups: (20%)

As a consequence, it has been requested for Dong Hanh to follow their peer counselling activities to reinforce and improve the psychosocial support provided for the SCI patients at the first step. Dong Hanh will be required to identify and recruit a SCI patient who could be able to be a peer counsellor after training.

Peer counsellors activities at the Spinal Unit:

Twice a week the peer counsellors visit the patients and meet them for about 15 to 30 minutes

They also collect information from the Spinal Unit team (nurses, occupational therapists, physiotherapists) and from the family on the medical and mental health status of the patient.

⁷ Introduction, in Peer counselling for patients with SCI. Evaluation report, June 2003.

⁸ Extract from Peer counselling for patients with SCI. Evaluation report, June 2003

After any visit, a report is written on the patient's status, and discussed afterwards at Dong Hanh Agency, between the two peer counsellors.

Other activity:

Dong Hanh's peer counsellors have been following training courses on Psychology for about 6 months at the University.

5.3. Spinal Unit Activities

It is the first SCI rehabilitation centre that has been implemented throughout Vietnam.

The Spinal Unit has a 30 beds capacity and the team consists of medical (2/3 doctors, 6/10 nurses) and paramedical (5/6 physiotherapists, 2/3 occupational therapists) staff.

Inpatients are referred from different establishments (Neurosurgery Department of Cho Ray Hospital, 115 Hospital, Traumatology and Orthopedics Centre) to the Spinal Unit.

The average of a length of stay for a patient is about 2 months.

6. Findings

Based on the previous experiences of the evaluation team, observations and numerous discussions with the Dong Hanh team and patients, a number of elements kept re-surfacing:

6.1. Regarding Needs of the SCI Patient in Term of Psychosocial Support, Socio-economic Reintegration, Follow-up, According to the Local Context Specificities

'Bio-psychosocial theory assumes that individuals with SCI, in addition to the physical sequelae, have experienced psychological and social changes requiring accommodation and constructive resolution. Therefore, the rehabilitation of individuals with SCI is a complex process that involves biological, psychological, and social components. (...) Services that address these issues are essential to the provision of quality rehabilitation and to the establishment of a satisfying lifestyle in the community'⁹.

SCI implies more or less a long time hospitalisation, which occurs different breaks down in the patient's life:

⁹ <http://www.aascipsw.org/StandardsPSW/IA.htm>

- Family break
- Affective and emotional breaks
- Professional break
- Social break
- Physical break

6.1.1. Psychological aspects

After injury, the SCI patient has to reconsider totally his / her way of life to cope with his / her handicap, by progressively accepting his / her new physical condition which often occur psychological consequences, such as a low self esteem, disappointment, grieves... Moreover, different studies have shown that “*adjustment to SCI is accompanied by depression, anxiety and stress*” and proved that “*there were as many as 100 per cent of people with SCI in their study, suffering from deep depression and anxiety*”¹⁰.

To help the patient dealing with depression, anxiety and stress symptoms, the Spinal Unit team (and specifically the PC) can assess his / her mental health status by using the Depression Anxiety and Stress Score (DASS) (more details further down).

One of the main concerns related to family adjustment and life perspectives that the patients have to face to - but still a culture taboo - is about sexual concerns. Sexual functioning should be mentioned and explained to patients on both physical and psychological aspects. It will be necessary to progressively explain how to sexually re-adjust after injury and searching for new sexual responses. This information should be provided for patients at the Spinal Unit and during follow-up. Some materials could be created and given to patients.

Moreover, the patient will have to be informed on the “psychological process” (denial / sadness / anger / bargaining / acceptance) he / she will have to go through in order to help him / her to overcome the traumatic event.

It will be important to focus on maximizing the patient’s capabilities. Positive reinforcement helps recovery by improving self-esteem and promoting independence.

However, counselling should not be limited to psychological support.

6.1.2. Socio-economical aspects

Patients expressed at several occasions their fear for the financial, economic and social implication of their injury. The economical aspect is one of the most inconvenient and difficult problems to solve for the patient and the family. As patients generally have to leave the Spinal Unit because they cannot afford the hospitalisation fees that have already let the family running into debts. Consequences occur on the medical treatment, as the patient doesn’t know for how long he / she can stay in the hospital.

¹⁰P. Chinchai, R. Marquis, A. Passemore: *Functional performance, depression, anxiety, and stress in people with spinal cord injuries in Thailand: a transition from hospital to home*, Vol.14, n°1, 2003

Consequently, there is need for support in these areas as well. Dong Hanh is aware of the importance of these other issues and attempts to address them. Limited resources and a lack of time make it difficult to respond properly to patients' requests.

After discharge, the labour reintegration is not facilitated for the SCI patient as labour laws for handicapped people is still not enough efficiently applied.

Though, **training skills centres** are dedicated to receive disabled people and to help them to find work.

Thus, some training skills centres have been visited in order to find valuable vocational training for the patients after injury.

- *The Charitable Centre of Training and Offering Job for the Handicapped* is a centre that provides 15 vocational trainings (electronics, silk printing, hairdressing, motorcycle repairing, etc.) to about 200 disabled people.

It seems that a low percentage of the trainees can find a sustainable and valuable employment after 6 to 12 months training.

- *CongTy Co Phan – Dich Vu Suc Song* (Go Vap District) is a private vocational centre where people with disabilities can follow computer classes, packing... The centre also provides accommodation.

- *Vietnamese Association to Handicapped People* (VNAH) has implemented 10 centres throughout Vietnam. Each centre trains 30 persons.

The organization has a valuable vocational training programme aiming to re-integrate 80% of the trainees into worklife. Therefore the pre-conditions required before introducing any patients to the vocational training, have to make sure that they will complete the entire training period. Dong Hanh will have to select candidates who they consider as the most suitable to follow and perform the vocational training.

In the future, to face the problem of social and work re-integration, the Spinal Unit could extend their activity by creating their own training skills centres. Auteuil International has been identified as the most suitable organisation to provide advices for this project.

Furthermore, some patients have planned to create their own income generation activity after reintegration in the community, but need money to achieve their goals.

Some NGO's, working on **micro-credit** projects, have been contacted in order to investigate how patients could be included as micro credit beneficiaries.

After discussion, it seems that many conditions and criterias will not permit – for the moment - patients to take part to the micro-credit programme.

Another external resource identified as a possible support is **the media**, newspaper reporting cases. Some patients in socio-economical difficulties may benefit financial helps and “social welfare” from the population, if their ‘case’ are published.

6.1.3. Home follow-up

Follow-up is essential for the long-term success of the rehabilitation and reintegration process (especially considered in terms of psychological and socio-economic rehabilitation). When possible it is preferable to go and visit the patient’s home after discharge.

The follow-up will take time to be settling down, as it requires mobilizing medical and paramedical staff regularly. The lack of time and personal staff may occur difficulties to achieve the goal. Moreover as medical staff depends on the Health Service of Ho Chi Minh City, they are able to move in restricted areas, and not allowed to go elsewhere.

To be efficient, a schedule has to be planned in order to mobilize the caregivers in charge of the patients to go and visit the patients at home. The team will arrange the frequency of visits. After discharge it could be useful to set up a regular visit in order to respond to the needs of the patient if necessary.

6.2. Regarding the (Training) Needs of Dong Hanh

- Appraise the services already covered by the PC’ running activities,
- Provide helpful and direct advices in their current activities,
- Identify potential complementary actions that might efficiently complete the running actions.

6.2.1. Weekly meetings and visits at the Spinal Unit with DH revealed some points regarding the PC’ running activities

- *No private room or space for proper counselling.*

Each room contents 3 to 4 inpatients, with their family. As it is an open space, beds are next to each other. Therefore, *privacy* and *confidentiality* required between the patient and the PC are not efficient.

The counselling session will take place in the PC room and should upgrade the counselling in terms of quality (more privacy and confidentiality).

- *Nursing and medical caretakers and / or family interrupts time counselling.*

Dong Hanh peer counsellors visit the patients twice a week in the morning, while medical and nursing staff are taking care for the patients. In addition, relatives are around to look

after and help the patient if necessary. As a consequence, the “face to face counselling process” is disturbed and interfered with the medical staff, the family and the environment (other patients and their friends / family). This situation will improve with the acquisition of a separate counselling room. However, important is that counselling will still need to be carried out in the common rooms for those patients who are unable to ‘relocate’ themselves.

- *No external resources to be helped in order to face to and to resolve psychosocial issues for patients.*

The peer counsellors mention their lack of experience and the fact that Dong Hanh agency cannot afford specialists to help, to guide or to supervise them in their work. To improve their activity, a weekly supervision lead by a social worker and / or a clinical psychologist, should help them in their work.

- *Peer counsellors and patients themselves are not well informed on the medical conditions.*

There is apparently a lack of communication and information between medical staff and patients. Probably linked to a lack of time (actually there is only one doctor) and difficulties to announce properly a diagnosis. Some cases require within a period of 3 months making a proper diagnose.

It seems that one of the difficulties peer counsellors have to face, is to be entirely integrated into the Spinal Unit team. As the Unit is about to move to another place and to be re-structured, a lack of communication and information transmitted between medical, paramedical and psychosocial staff does not facilitate a work within a multidisciplinary team.

Moreover, psychosocial field is still new and often considered as a secondary service that could be provided for the patient, as the first priority and need are the medical and nursing cares. Therefore, it should take time for the PC activity to be acknowledged as a needful and helpful service for the patients and the family.

Therefore, increasing the time of visits (3 times a week) and participating to staff meetings should able them integrating gradually the rehabilitation team.

- *How do the patients and their relatives could raise their sense of initiative to come to the peer counselors?*

Patients and family are not used yet to ask for psychosocial support, probably due to the culture when problems are solved by and into the family and not by social welfare. Furthermore, psychosocial support is a new service provided only in some health centres and still unknown by the population. Developing information and prevention materials should raise the awareness of such services.

Dong Hanh is a company that is genuinely committed to improving the lives of SCI patients. As peer counsellors, they also have gained hand-on experience regarding nearly all facets of the 'new' life of the patients. As experience is an important part of counselling, the services that they deliver are satisfactory. On the other hand, there are still a few counselling and communication skills that are missing and additional training might be called for. Important to recall in this regard is our definition of counselling. We defined counselling as 'a process of helping an *individual, family or group* resolve their difficulties. Counselling does not only seek to help clients to solve their problem but also *enhance their capability to cope and function adequately in facing future problems*'. Future trainings should also focus on the long-term consequences of the SCI and the impact on the lives (psychological and socio-economic) of the patients, their family and community. Important is that the counsellors are able to enhance the capacity of the patients and their environment to cope with the long-term impact of these physical changes. Training should also include group-counselling techniques, as the capacities of the families should be increased as well. Families should be assisted in order to deal with the physical and accompanying psychological and socio-economic changes of the patient. Additional training could increase the capacity of the Dong Hanh counsellors to provide this type of counselling as well.

6.2.2. Materials designed in order to strengthen counselling activities

- *Clinical file*

A complete questionnaire (including medical, psychological, social, financial aspects) has been designed for the PC to investigate and collect all information needed for their activities.

The lack of methodology in investigation and how to use all information collected from the patient's status could reduce the peer counselling activity. Therefore, the questionnaire should help them to upgrade their action towards the patient and the family.

A systematic use of the clinical file will:

- Facilitate the work of the peer counsellor giving him / her a number of standard areas for questions.
- Enable comparison between patients (long term) and between counsellors
- Ensure permanency in the transmission of information within the rehabilitation team
- Allow the stakeholders to monitor and evaluate the peer counsellors' activities.

- *Psychological test*

A test on mental health status for the patient, the **Depression, Anxiety, Stress Score** (DASS) will be implemented and used as a material for the follow-up of the patient. It is a self-report inventory developed in Australia.

The DASS has been translated to Vietnamese and exists in two versions 42 items or 21 items¹¹. The short version will be preferably implemented at the Spinal Unit. It is a simple material to use (easy scoring and interpretation).

The peer counsellors and the rest of the Spinal Unit team should be trained on the test passation, and may have a course on “Depression, Anxiety and Stress”.

The DASS could be given to the patient at the first day of entry and just (48h) before discharge in order to assess and compare his / her mental health status. (cf annex).

- *Equipment list*

The equipments required for the peer counsellors’ room has been listed, as a room is dedicated for counselling in the Spinal Unit. The principle equipment has been ordered (such as a table and chairs, etc.). The equipments will have to be adapted, under the technical advices of the occupational therapist(s), as the peer counsellor will be in a wheelchair and the patients who should not be able to move himself/herself easily. (cf annex). In addition, the PC will have to counsel as well in the patients’ room when the patient is not able to move for some reasons. The counselling activity should be facilitated in the room as a movable curtain separates beds.

As the counselling room will provide social services (labour reintegration) for patients, it has been recommended to facilitate their activity that a hotline service connected directly to the central standard of the hospital (to prevent and limit phone calls abuses) could be set up.

- *Peer Counsellor Job Description*

The Peer counsellor Job Description has been designed. It seems difficult to meet all the criteria that the peer counsellor’s position requires, integrating in the meantime the cultural and educational conditions the Vietnamese context implies.

As Psychology and Social Work are new fields and yet non-developed throughout the country, it would be difficult to hire a PC with all the required skills needed for such a position. Moreover, the injured patients have mainly a low educational level, as they are mostly manual workers.

Thus, the first criteria selection should be priority based on the willingness of the candidate to learn about psychology and social work, and his/her willingness to be trained by Dong Hanh in his / her future occupation. As a consequence, all these conditions should not facilitate a fast recruitment and the settlement of the peer counselling activity. (cf 7.2)

A SWOT exercise was carried out to obtain a specific overview of the strengths and weaknesses of Dong Hanh. It will give a picture of the needs of Dong Hanh, and the necessary complementary actions. More importantly, it will provide ideas on the building

¹¹ This version was translated and reviewed by the Vietnamese Committee on Anxiety / Panic Attack in Sydney, April 2003. Contact person: Tung_Pham@wsahs.nsw.gov.au

blocks for future policies (the opportunities and strengths) as well as the pitfalls that might endanger these policies (weaknesses and threats).

Table 1: SWOT analysis of Dong Hanh's work

Strengths	Weaknesses
<ul style="list-style-type: none"> • They know what they are talking about (peer counsellors) • Good relationship with the patients and staff • Commitment to counselling SCI patients • Experience 	<ul style="list-style-type: none"> • Not enough interaction between Dong Hanh and the rest of the team (ex. check-out of patient without warning Dong Hanh) Requirement: at least 2 x / week for 1 hour meeting (multidisciplinary) • No private counselling room • Lack of professionalism in certain areas (counselling and communication skills) • Lack of resources
Opportunities	Threats
<ul style="list-style-type: none"> • Good advice based on experience and further training • Commitment and enthusiasm are a good basis for long term collaboration and impact 	<ul style="list-style-type: none"> • Patients might not followed up properly • Assessments might be incomplete • Certain aspects of the reintegration might be endangered • Inadequate counselling due to lack of knowledge and / or resources

7. Recommendations

7.1. Training

Dong Hanh will greatly benefit from extra training / guidance. The new peer counsellors will also need to be trained and assisted. The training needs of the new person will have to be determined. The new counsellor can be assisted by the Dong Hanh Company through a service delivery contract, and in a later stage by more specialised personnel

Training in the following areas is advised¹²:

- Group counselling techniques

¹² Other trainings will be progressively provided in order to upgrade psychosocial support to SCI patients.

- The Spinal Unit team could be trained on the DASS test. The most ideal trainer has been identified as Mr Tung PHAM, counsellor, who was in charge to translate DASS to Vietnamese version. Five days training will include an introduction of the DASS test, how to score and interpret it.
- Mr Tung PHAM could train the Spinal Unit team on “How to deal with Depression, Anxiety and Stress” during a five-days training. This training may be held in early march 2004 (by that time, the future PC may be already identified)
- Sexual concerns and how to talk about this topic should be another training session.

7.2. Staffing

As previously mentioned, it may take time for the peer counselling activity to be improved, as the PC who would be potentially hired should probably not meet entirely all the criteria required for the position. Therefore, it may probably take within 3 to 6 months for Dong Hanh to recruit the peer counsellors, and six more months (minimum) for the PC recruited to be trained on his / her future activity. For a short term the peer counsellors will be trained by DH in order to get the basic counselling skills required. Afterwards, he / she should be operational after 6 months training (December 2004).

As a consequence, Dong Hanh should extend their services for the patients and the future PC for approximately one more year.

DH should be supported and advised in the recruitment process by a social worker and a clinical psychologist.

As the psychosocial support to SCI patients will be a long-term programme, it will be necessary to hire two peer counsellors in full-time position.

One could be specifically trained on the psychological aspect while the other will be trained on the social aspect. But both will have common training on psychosocial support.

They should be one male and one female. The difference in gender is an additional advantage. Some patients will feel more comfortable to discuss certain health / mental issues with a woman or a man.

It is almost not possible that one person can handle the load of work on the psychosocial part of the treatment plan for a long-term period. As a consequence, being two peer counsellors will be helpful as they would be able to exchange their practices, work and personal experiences together. Moreover, this measure will prevent from burn out and from a possible turn over of the PC staff.

The PC's room will have to be dedicated to counselling activities only. If not, as the room will be shared with a sport coach, a precise schedule will have to be arranged in order to not get confusion into both activities.

7.3. Procedures.

The quality of the services can be quickly improved by establishing clear and simple procedures.

To strengthen the peer counselling activities:

7.3.1. Redefine the peer counselling frame work:

- The framework will be set by:

- The peer counsellor must introduce him / herself clearly to the patients in order to be identified as a staff member (as they wear daily clothes).
- Wearing their nominative badge
- Explaining the aim of the Spinal Unit and its background (first SCI rehabilitation centre implemented throughout VN)
- Explaining the aim of their weekly visit and the framework of a peer counsellor activity.

- Important 'internal administrative' procedures are:

- Systematic use of clinical form
- A fixed weekly meeting within the counselling team to discuss about the patients
- A fixed weekly meeting with the hospital staff to discuss about the patients.
- A systematic visit of new inpatients to assess their needs and to set up the follow up during the hospitalisation.

- To be efficient, a regular counselling session should not exceed 45 minutes to 1 hour.

- The peer counsellor should increase the frequency of visit to 3 times a week (and preferably in the afternoon when nursing cares are already done) in order to be gradually integrated within the rehabilitation team, and to let the patient being familiar with the type of services they provide for.

- As an entire member of the rehabilitation team, the peer counsellor will have to be integrated in the rehabilitation programme, taking part to medical and paramedical

meetings, in order to have a detailed follow up on the patient. Last but not least, the peer counsellor will have to be able to get access to the medical and paramedical patients files.

7.3.2. Develop prevention materials, researches and surveys

- Developing prevention materials on SCI needs in terms of psychological and social issues will raise the awareness of the family, the community and the health workers.

Information session and group discussion can be held with the family and the patients in the RC, inviting ex patient to share their experience on how they got through their injury.

- Developing surveys and researches (with DASS test for example) may reveal and underline needs and concerns of the patients.

- 'Quality of life' of the patients could be upgraded. By reducing physical pain, patients can pay more attention to their psychological status and PC activities should be more efficient.

It seems that painkillers are not frequently delivered when traditional medicines could be an issue to help reducing physical pain. As a consequence, an acupuncture practitioner could be integrated as a rehabilitation team member.

8. Conclusion

This short evaluation mission has proven that Handicap International is addressing genuine needs, and is providing real solutions. Its commitment of improving the psychosocial support to SCI patients complements the merely medical approach. This holistic approach will be much better able to address all the needs of the SCI patients. The new approach revolutionises the treatment of SCI patients in Vietnam.

Handicap International is still in the process of starting up this new approach. A consultancy company, Dong Hanh, was hired to provide guidance and advice to HI, the SCI and the new peer counsellors of the hospital. The evaluation team has monitored their activities for 2 months and found that their activities have been commendable. Although there are still gaps to be filled in terms of training, procedures, methodology and communication, they have provided excellent services to the SCI patients and to HI. The evaluation team has solved certain more urgent needs of the peer counsellors by developing a client file and providing the DASS test. However, further training is necessary and should be an integral and important part in the project budget.

Some needs of the SCI patient remain insufficiently addressed. The socio-economic integration is an important but undervalued aspect in the project and rehabilitation process. Vocational training centres are still important actors that are absent in the project. Furthermore, the evaluation team found that there is also little attention paid to support groups within the community (social integration).

The hospital is the most important player to make to the project successful. Without its support, Dong Hanh and other peer counsellors will be unable to satisfactorily carry out their tasks. The evaluation team has found a bottleneck in the communication flow, which should urgently be addressed. Increasing the knowledge about the work of the peer counsellor (and its importance for the SCI patients) of the medical staff in the hospital might achieve this. The evaluation team has started with the awareness raising with conducting an information session in the hospital about the importance of psychological and socio-economic support through a presentation on the roles of social workers / psychologists. This process should be continued.

There are also a number of less controllable factors affecting the success of this project. The evaluation team found that there exists no legal backing for the SCI patients in cases of refusal / abuse in the work environment.

Finally, there are the 'social' factors that complicate counselling. In this light one should consider the suggestion of the evaluation team to hire 2 part-time counsellors of different gender and schooling. It was argued that that would be more adequate, considering the cultural context in Vietnam and the wide variety of tasks to be carried out.

9. Calendar

Activities	Dong Hanh	Spinal Unit	Handicap International	Calendar
Dong Hanh's activities and services	To keep providing peer counselling / support to SCI patients at the Spinal Unit	To accept Dong Hanh' running activities at the Spinal Unit	To pay for Dong Hanh's services	Year 2004
Recruitment of two new peer counsellors	To identify and recruit the peer counsellors	To hire the peer counsellors in full time position	To provide external resources (psychologist and / or Social worker) to help DH in the recruitment process.	January to April 2004
Training of the peer counsellors	To train the peer counsellors	To integrate the peer counsellors within the Spinal Unit	To provide sustainable trainings to the peer counsellors (if necessary)	From the day the peer counsellors are recruited (January –

				April 2004) until December 2004
Training	Receive training + train the peer counsellors	To select medical and paramedical staff to be trained	To provide trainers	Year 2004
- Group discussion techniques				
- DASS				
- Sexual concerns				
Surveys and prevention materials	To start researches and assessments based on the DASS test	To allow Dong Hanh to get access to patients files	To provide necessary trainings or external resources (psychologist and / or social worker) to help Dong Hanh achieving their activities	Year 2004 (Starting as soon as possible)

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11. Annexes

Annex 1: Terms of Reference (TOR)

Annex 2: Equipment List Counselling Room

Annex 3: Clinical File

Annex 4: Peer Counsellor Job Description

Annex 5: Role of a Psychologist and Social Worker in a Hospital

Annex 6: Depression, Anxiety and Stress Score (English / Vietnamese)

Annex 1: Terms of Reference (TOR)

Annex 2: Equipment List Counselling Room

Equipment list for the peer counselling room

- 1/ 1 table and 1 desk (adapted to the peer counsellors)
- 2/ 2 chairs (considering that the peer counsellors may not use it as he / she will be in a wheelchair and the patient might be in a wheelchair too)
- 3/ 4 folding chairs
- 4/ 1 bookshelf with key locker (for books, documents and confidential patients files)
- 5/ 1 board
- 6/ 1 mailbox
- 7/ 1 telephone
- 8/ Files folders
- 9/ Tissues
- 10/ 1 clock
- 11/ 1 lavabo (if possible)
- 12/ 1 bed (?)

Budget given by Handicap International approx. 500 USD

Budget estimated: between 150 to 200 USD

Annex 3: Clinical File

Patient's Psychosocial File

Name:

Age:

Sex:

Marital status:

Place in the family:

Religion:

Profession:

Address:

Type of lesion:

Degree of lesion:

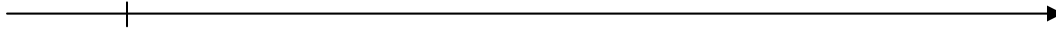
Cause of lesion:

(Intended) length of stay:

Counsellor:

Sessions in hospital

(1)



Home follow-up sessions

Medical information

- **Medical background** (file medical staff)
- **Diagnoses** (file medical staff / PT)
- **Physical appearance** (observation height, weight, face, external wounds...)

Psychosocial information

- **Patient**
 - **Background on the accident** (causes, consequences...)
 - **Comparison of the psycho-social situation before / after the accident** (changes caused by the accident in his social, psychological and physical well-being)
 - **'Assessment' by the patient of his psycho-social responses** (his coping mechanism, defence mechanism etc) to the physical change
 - **Changes in his environment and his reaction**
 - **Risk behaviour** (alcohol, drugs...)
 - **Sexual problems / concerns**
 - **Financial situation** (before and after the accident)
 - **Social security / insurance**
 - **Vocational training / employment**

- **Comparison of the relations between the patient and the environment** (family and community)
- **Suitable home environment** (adjusted to the new physical abilities and needs of the patient, to create a conducive environment for the rehabilitation and re-integration) → in close collaboration with the occupational therapist

- Environment / external support

1. Family

- **Key family figures**
- **Comparison of the relations between the patient and his family**
- **Changes in his environment**
- **Financial situation** (before and after the accident)

2. Community (friends, neighbours...)

- **Key community figures**
- **Comparison of the relations between the patient and his environment**
- **Changes in his environment**

3. Medical and paramedical staff

Doctors:

Nurses:

Physiotherapists:

Occupational therapists:

Annex 4: Peer Counsellor Job Description

Job description for a Peer Counsellor

Under the responsibility of the Rehabilitation Centre and in cooperation with Handicap International Belgium and Dong Hanh, the national peer counsellor (registered in Ho Chi Minh City) will have to develop and strengthen the psychosocial part of the SCI patients' treatment plan in charge and at discharge.

Main tasks:

- Monitoring and evaluating the psychosocial needs of patients in charge at the Rehabilitation Centre and at discharge.
- Setting up a follow-up including orientation, assessment, treatment plans, for the SCI patients in charge and after discharge.
- Providing individual and group counselling and/or family (and environment) counselling for SCI patients
- Providing counselling (including socio economic aspects of the patients life) to SCI patients as to facilitate his/her socio-professional integration.
- Helping the SCI rehabilitation team and the family (and environment) to understand the individual's psychosocial status and its influence upon accommodation to SCI
- Weekly report to the Rehabilitation Centre and to Dong Hanh (and other stakeholders required) his/her activities
- Mapping all the resource centres that could be useful for the psychosocial treatment plan of the SCI patients in charge and at discharge.

Physical abilities required:

Daily life autonomy:

- Ability to dress him or herself in bed and wheelchair.

- Ability to be self-contained (washing, feeding, defecation, self-catheterisation, etc.)
- Ability to move inside and outside (from wheelchair to bed, WC, floor....)
- Ability to wheel and to go up and down from a ramp.

Level of injury: Paraplegia

Required qualifications:

- Age: preferably between 25 and 35 years old
- Received a formal training to improve listening and counselling skills or have the willingness to be trained on Human Sciences (Psychology, Social work, Education), socio-economic aspects and labour laws for disabled people.
- Good report writing skills
- Ability to work in a multicultural environment and in a multidisciplinary teamwork.
- Demonstrated effective communication, analytical and problem solving skills
- Ability to relate to one's peer group (be approachable, shows empathy)
- Comprehensive approach of the SCI in term of psychosocial consequences
- Ability to propose workable solutions and identify their implications (positive and negative) adapted to the psychosocial needs of patients.
- Demonstrate good understanding of SCI and psychosocial issues in Vietnam
- Ability to work with and find psychological and social issues for patients in crisis
- Ability to work under pressure and to meet deadlines
- Ability to search and find out information needed
- Ability to be supervised and guided
- Willingness to be trained on SCI care, rehabilitation and health psychology

Preferred qualifications

- Formal degree in Counselling, Psychology or Social work
- Have a previous experience in counselling
- Spoken and written English or French

Transportation: The peer counsellor must have his/her personal wheelchair in order to come from his house to the Rehabilitation Centre by his/her own.

Two full-time positions based in Ho Chi Minh City (District 8)

Annex 5: Role of a Psychologist and Social Worker in a Hospital

LE PSYCHOLOGUE A L'HOPITAL

Introduction

Science récente datant du 20^{ème} siècle, comparée à la médecine qui est plus ancienne. C'est une science à part entière, différente encore de la psychiatrie et de la psychanalyse.

A/ Définitions

La psychologie est la science des conduites humaines. C'est-à-dire l'étude des comportements que l'être humain adopte en fonction des situations de vie auxquelles il fait face et ce, en fonction de son expérience individuelle et collective.

Face à une situation identique, deux êtres humains ne vont pas réagir de la même façon.

Le psychologue analyse les rapports entre la vie psychique du sujet et les comportements individuels et collectifs afin de favoriser l'autonomie et le développement de la personne. Il met en place des moyens pour répondre aux besoins particuliers des contextes sociaux et humains, en vue de contribuer à la modification des comportements individuels et collectifs, si nécessaire.

B/ Où ? Quand ? Comment ?

Le psychologue peut travailler dans plusieurs institutions différentes :

- en entreprise pour le recrutement,
- à l'école pour aider les enfants en difficulté scolaire,

- dans les différents centres de soin comme l'hôpital.

On fait appel au psychologue pour demander des conseils, il peut aider à orienter et déterminer certains choix dans des situations complexes.

C/ Le psychologue à l'hôpital

Il peut intervenir dans tous les services hospitaliers. Il a un rôle d'écoute et de soutien, aussi bien auprès du patient, de sa famille que de l'équipe soignante.

□ Auprès du Patient

∞ La relation d'aide : un lien particulier

Le psychologue se détache du personnel soignant dans le sens où il ne procure pas de soins physiques directs comme peuvent le faire les infirmières ou alors donner des directives comme le font les médecins. Par conséquent, le psychologue a une place assez particulière et son rôle n'est pas forcément évident à cerner tant par les autres membres du personnel soignant que par le patient lui-même.

Le psychologue à l'hôpital a pour rôle de venir en aide et soutenir une personne en souffrance psychique. Le lien crée avec le patient ne sera pas de nature « médicale ».

∞ Mode et rôle d'intervention

Tenu par le secret professionnel au même titre que le corps médical, il est préférable qu'il puisse intervenir et échanger avec le patient dans un cadre confidentiel, c'est-à-dire dans un espace privé. Toutefois, il adapte sa pratique clinique¹³ en fonction des circonstances. Il n'est pas rare qu'il consulte dans les chambres avec plusieurs patients, mais cela peut limiter la qualité des échanges.

Il n'a pas pour responsabilité comme le médecin ou le psychiatre d'annoncer des diagnostics, ou bien encore de prescrire des ordonnances.

Il a un rôle d'*accompagnateur* en offrant un soutien, un support quand la personne se sent vulnérable. Tout comme le médecin apporte un soutien physique par des soins médicaux, le psychologue procure un *soutien* psychique par son *écoute* et sa *présence bienveillante*. Il offre un espace d'échange où le sujet est libre de s'exprimer ET de ne pas s'exprimer.

La présence et le travail d'un psychologue au sein d'un service hospitalier contribuent à l'amélioration des conditions d'hospitalisation du patient.

∞ Ses outils et techniques

¹³ Clinique = « au chevet du malade »

Son outil principal sera l'**entretien** :

- individuel :

Le temps d'échange individuel a son importance car cela permet au patient de se confier et de livrer certaines choses qu'il n'oserait probablement pas dire en situation collective. C'est après plusieurs rencontres, dans un suivi des entretiens qu'une relation de confiance s'établit.

- collectif :

Dans le cas où il reçoit le patient et sa famille ou lorsqu'il anime des groupes de paroles pour les patients par exemple.

Mais il peut aussi se servir de **tests** (personnalité, intelligence) quand il doit mesurer certains paramètres nécessaires pour mieux identifier l'état mental, moral, neuropsychologique du sujet.

□ **Auprès du personnel soignant**

∞ Travail de liaison et de médiation

Il peut être un *médiateur* entre l'équipe et le malade et la famille. Il est présent pour supporter et aider à résoudre les situations conflictuelles dans l'institution, interpersonnelles, relationnelles etc.

Il trouve des outils et des moyens à mettre en place pour améliorer la communication entre le personnel soignant, le patient et son entourage.

Il est **MEDIATEUR** mais en aucun cas il peut remplacer un membre du personnel soignant.

Dans le cas d'une annonce de diagnostic difficile, il peut aider le médecin à préparer l'annonce, à trouver le meilleur moyen et le moment adéquat pour faire l'annonce. Mais il ne pourra pas faire l'annonce du diagnostic¹⁴ à la place du médecin, pour des raisons de responsabilité, mais aussi de crédibilité.

Il a un rôle de soutien et d'écoute auprès du personnel dans les cas cliniques difficiles, il peut aussi supporter l'équipe après une lourde prise en charge ou après le décès d'un patient par exemple.

D/ Le patient et le personnel soignant à l'hôpital

Dans une approche **biopsychosociale**, on envisage la prise en charge du patient sous plusieurs points de vue :

- d'un point de vue biologique, l'individu doit se remettre de ses séquelles physiques et apprendre à s'en ajuster ;

¹⁴ Dans le cas d'accident médullaire le diagnostic/pronostic est prononcé et peut être fiable après un délai de +/- 3 mois. Cela entraîne des conséquences sur l'état psychologique du patient et sur ses possibilités de projets de vie.

- d'un point de vue psychologique et social, il doit aussi s'accommoder à certains changements et bouleversements.

Il s'opère donc un changement complexe biopsychosocial.

Ce sont le psychologue et l'assistant social à l'hôpital qui vont aider le patient et sa famille du point de vue psychosocial.

Ils sont là aussi pour aider les membres de l'équipe soignante à comprendre les implications psychosociales individuelles du patient.

Ils sont responsables d'aider et d'accompagner le patient au cours de son hospitalisation (dans le programme d'admission) et dans le suivi jusqu'à la réintégration du patient dans la communauté.

□ **Côté Patient**

★ Phase de non acceptation de la réalité des faits

Le psychologue a pour rôle d'aider le patient à accepter son nouvel état physique. Son état mental doit se réajuster à son « nouveau » corps. Le patient est tout d'abord dans une phase de **déni** de la situation, niant totalement de manière générale ce qui vient de se produire. Par exemple, il va penser qu'il va remarcher, car c'est trop difficile pour sa conscience d'accepter la réalité des faits.

★ Phase de colère, révolte

Le patient se révolte, éprouvant souvent un fort sentiment d'injustice envers la vie et ce qui lui arrive. Il ne comprend pas pourquoi il se retrouve dans cet état.

★ Phase de tristesse

Période nécessaire pour faire le deuil de son état antérieur. Il renonce à ce qu'il a été. C'est une phase très délicate pendant laquelle le sujet est très fragilisé. Il a besoin de son entourage à ce moment là car il traverse de manière générale des états dépressifs, qui peuvent s'installer durablement s'il n'est pas soutenu extérieurement.

★ Phase de reconstruction

Après plusieurs mois, le patient parvient progressivement à surmonter toutes ces phases et à s'adapter à son handicap. C'est grâce aux soutiens médical, psychosocial et de son entourage que le patient se réintègre dans sa communauté.

Au cours de toutes ces phases, il arrive que la situation (physique, mentale) soit trop conflictuelle et trop dure à gérer par le patient. Il se sent dépasser par les événements et peut vouloir mettre fin à sa vie par des passages à l'acte tel que le suicide. Il est donc important d'être vigilant pour prévenir ce type de passage à l'acte.

Ainsi, à travers toutes ces étapes et avec l'aide du personnel médical, le psychologue comme l'assistant social vont intervenir auprès du patient et mettre en place des prises en charge adaptées dans la mesure du possible pour permettre au patient de se rétablir le mieux possible. Il est donc important de pouvoir anticiper et **envisager un projet de vie, en adéquation maximale avec les ressources physiques, psychiques et économiques du patient.**

Le fait de pouvoir réintégrer la société et de se sentir accepté en tant que membre à part entière favorisera dans une certaine mesure l'amélioration de l'état physique et psychique du sujet.

Toute l'équipe soignante, médicale (médecins, infirmiers) et paramédicales (kinésithérapeutes, ergothérapeutes, psychologues, assistants sociaux, pairs) travaillent tous ensemble pour former une équipe pluridisciplinaire et ce dans le but d'améliorer les conditions de vie physique et psychique du sujet, pour favoriser le Bien Etre de celui-ci.

□ **Côté Soignant**

Face à des prises en charge lourdes, le personnel soignant peut vivre des conditions difficiles, engendrant du stress et de l'anxiété. Dans le cas où les situations s'accumulent, le personnel soignant peut se sentir débordés, dépassés par les événements et connaître le *syndrome du Burn Out* ou syndrome de l'épuisement professionnel. Le soignant peut se sentir découragés et ressentir le découragement même du patient. En cas d'épuisement professionnel, le soignant adopte souvent des attitudes négatives voire dépressives, malgré lui, mais cela produit des effets peu bénéfiques pour le patient.

Il est nécessaire que l'équipe puisse avoir un temps de parole pour échanger entre elle sur les patients, sous l'aide et la supervision d'un psychologue. Bien souvent, par manque de temps, ce temps de parole n'est pas pris alors qu'il est tout à fait indispensable.

Conclusion

La psychologie est une discipline encore neuve et peu développée au sein des hôpitaux. Mais c'est un complément indispensable pour une prise en charge intégrale du patient mais aussi un soutien pour l'équipe soignante dans certains cas de figure. C'est dans un travail d'équipe pluridisciplinaire et de liaison que le personnel soignant améliore la qualité des soins pour le Bien Etre du patient.

A Social Worker in the Hospital

1. General information about the 'social worker'

Social workers have the strong desire to help improving the quality of lives of people (clients) who face a wide variety of problems, including:

- mental disorders
- substance abuse
- serious illness or disability
- financial distress, unemployment and / or lack of job skills
- anti-social behaviour ...
- inadequate housing

Social workers practice in a wide variety of settings:

- In hospitals and psychiatric hospitals: to provide or arrange for a range of support services
- In mental health and community centres: to provide counselling services (therapy for addictive or physical disorders)
- In schools: to help children, parents and teachers cope with problems
- In social service agencies: to help people locate basic benefits (income assistance, housing, job training...)
- In employment settings: to counsel people with personal, family, professional or financial problems affecting their work performance
- In courts and correction facilities
- In private practice: to provide clinical and diagnostic testing services covering a wide range of personal disorders; to counsel clients with mental and emotional problems.

The variety of the tasks social workers can and actually perform, means that it is nearly impossible to come up with the typical job description of the social worker. The tasks depend on the work environment, the specialization of the social worker, the tasks at hand... One can say that social workers generally help clients through direct counselling and / or through referring them to more specialized institutions / health workers. Social workers generally follow through with the client to assure that their services (e.g. counselling) are helpful and that the clients make proper use of the services offered.

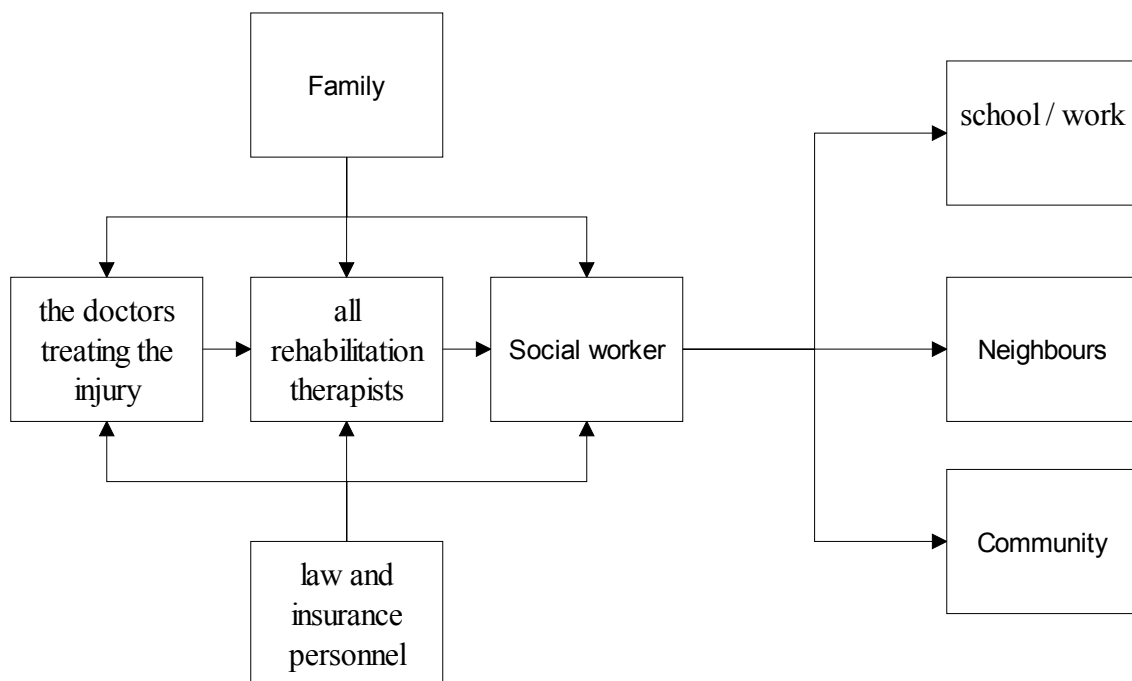
2. Social worker for people with disabilities

Social workers are also involved in all the different facets regarding the treatment, recovery, rehabilitation and re-entry into society of the disabled patient. Often, the social worker is the crucial link between these different services, some of which can be delivered by the social workers themselves (e.g. counselling, social / professional re-entry in society...). The points the social worker are connected with might be:

- The doctors treating the injury
- All rehabilitation therapists
- Family
- School / work
- Law and insurance personnel

Graphically this can be represented as follows:

Figure 1: The social worker in the ‘web’ that helps the spinal cord patient



Social workers will provide a background study of the injured person before the accident took place, the patient’s personality, lifestyle, emotional behaviour, past relationships, education and work history, special interests, financial background, ...

In other words, they will gather information which is necessary to understand the patients needs and concerns, and to facilitate his / her rehabilitation and integration in the community.

In most instances, the relationship between the social worker, the patient and his / her family is extremely important. This relation is characterized by confidentiality of information. The client should be able to tell the social worker everything in full confidence if the client does not want to have this information in public.

Specific issues the social workers is expected to deal with are: depression, anxiety, substance abuse, disturbed social relations, dealing with other people given a new physical condition, sexuality, interaction, motivation, panic, pain, ...

Goal: To make the transition between hospital and home an easy one.
To work with the patient and the family to decrease the anxiety that comes along with this devastating injury.

Annex 6: Depression, Anxiety and Stress Score (English / Vietnamese) + information

DASS21	Name:	Date:
Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you <i>over the past week</i> . There are no right or wrong answers. Do not spend too much time on any statement.		
<i>The rating scale is as follows:</i>		
0 Did not apply to me at all		
1 Applied to me to some degree, or some of the time		
2 Applied to me to a considerable degree, or a good part of time		
3 Applied to me very much, or most of the time		
1	I found it hard to wind down	0 1 2 3
2	I was aware of dryness of my mouth	0 1 2 3
3	I couldn't seem to experience any positive feeling at all	0 1 2 3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0 1 2 3
5	I found it difficult to work up the initiative to do things	0 1 2 3
6	I tended to over-react to situations	0 1 2 3
7	I experienced trembling (eg, in the hands)	0 1 2 3
8	I felt that I was using a lot of nervous energy	0 1 2 3
9	I was worried about situations in which I might panic and make a fool of myself	0 1 2 3
10	I felt that I had nothing to look forward to	0 1 2 3
11	I found myself getting agitated	0 1 2 3
12	I found it difficult to relax	0 1 2 3
13	I felt down-hearted and blue	0 1 2 3

14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

Overview of the DASS and its uses

1. General description of the scales

The DASS is a set of three self-report scales designed to measure the negative emotional states of depression, anxiety and stress. The DASS was constructed not merely as another set of scales to measure conventionally defined emotional states, but to further the process of defining, understanding, and measuring the ubiquitous and clinically significant emotional states usually described as depression, anxiety and stress. The DASS should thus meet the requirements of both researchers and scientist-professional clinicians.

Each of the three DASS scales contains 14 items, divided into subscales of 2-5 items with similar content. The Depression scale assesses dysphoria, hopelessness, devaluation of life, self-deprecation, lack of interest/involvement, anhedonia, and inertia. The Anxiety scale assesses autonomic arousal, skeletal muscle effects, situational anxiety, and subjective experience of anxious affect. The Stress scale is sensitive to levels of chronic non-specific arousal. It assesses difficulty relaxing, nervous arousal, and being easily upset/agitated, irritable/over-reactive and impatient. Subjects are asked to use 4-point severity/frequency scales to rate the extent to which they have experienced each state *over the past week*. Scores for Depression, Anxiety and Stress are calculated by summing the scores for the relevant items.

In addition to the basic 42-item questionnaire, a short version, the DASS21, is available with 7 items per scale. Note also that an earlier version of the DASS scales was referred to as the Self-Analysis Questionnaire (SAQ).

As the scales of the DASS have been shown to have high internal consistency and to yield meaningful discriminations in a variety of settings, the scales should meet the needs of both researchers and clinicians who wish to measure current state or change in state

over time (e.g., in the course of treatment) on the three dimensions of depression, anxiety and stress.

2. Characteristics of high scorers on each DASS scale

Depression scale

self-disparaging
dispirited, gloomy, blue
convinced that life has no meaning or value
pessimistic about the future
unable to experience enjoyment or satisfaction
unable to become interested or involved
slow, lacking in initiative

Anxiety scale

apprehensive, panicky
trembly, shaky
aware of dryness of the mouth, breathing difficulties, pounding of the heart, sweatiness of the palms
worried about performance and possible loss of control

Stress scale

over-aroused, tense
unable to relax
touchy, easily upset
irritable
easily startled
nervy, jumpy, fidgety
intolerant of interruption or delay

3. The DASS in research

The DASS may be administered either in groups or individually for research purposes. The capacity to discriminate between the three related states of depression, anxiety and stress should be useful to researchers concerned with the nature, aetiology and mechanisms of emotional disturbance.

As the essential development of the DASS was carried out with non-clinical samples, it is suitable for screening normal adolescents and adults. Given the necessary language proficiency, there seems no compelling case against use of the scales for comparative purposes with children as young as 12 years. It must be borne in mind, however, that the lower age limit of the development samples was 17 years.

4. Clinical use of the DASS

The principal value of the DASS in a clinical setting is to clarify the locus of emotional disturbance, as part of the broader task of clinical assessment. The essential function of the DASS is to assess the severity of the *core* symptoms of depression, anxiety and stress. It must be recognised that clinically depressed, anxious or stressed persons may well manifest additional symptoms that tend to be common to two or all three of the conditions, such as sleep, appetite, and sexual disturbances. These disturbances will be elicited by clinical examination, or by the use of general symptom check lists as required. The DASS may be administered and scored by non-psychologists, but decisions based on particular score profiles should be made only by experienced clinicians who have carried out an appropriate clinical examination. It should be noted also that none of the DASS items refers to suicidal tendencies because items relating to such tendencies were found not to load on any scale. The experienced clinician will recognise the need to determine the risk of suicide in seriously disturbed persons.

5. The DASS and diagnosis

The DASS is based on a *dimensional* rather than a *categorical* conception of psychological disorder. The assumption on which the DASS development was based (and which was confirmed by the research data) is that the differences between the depression, the anxiety, and the stress experienced by normal subjects and the clinically disturbed, are essentially differences of degree. The DASS therefore has no direct implications for the allocation of patients to discrete diagnostic categories postulated in classificatory systems such as the DSM and ICD. However, recommended cutoffs for conventional severity labels (normal, moderate, severe) are given in the DASS Manual.

DASS 21			
(BẢNG ĐO LƯỜNG MỨC ĐỘ ƯU SẦU, LO SỢ, CĂNG THẲNG TINH THẦN)			
Tên:.....		Ngày:...../...../.....	
Xin vui lòng đọc từng câu và khoanh tròn số 0, 1, 2, hay 3 để chỉ định xem câu nào thích hợp với những gì đã xảy ra cho mình trong tuần lễ vừa qua. Không có câu trả lời nào đúng hay sai. Không nên mất quá nhiều giờ để lựa chọn.			
<u>Cách phân loại như sau :</u>			
0 Điều này hoàn toàn không xảy ra cho Tôi			
1 Xảy ra cho tôi một phần nào, hay thỉnh thoảng			
2 Thường xảy ra cho Tôi, hay nhiều lần			
3 Rất thường xảy ra, hay hầu hết lúc nào cũng có			
D	A	S	

1. Tôi nhận thấy khó mà nghỉ ngơi	0 1 2 3			.....
2. Tôi thấy mình bị khô miệng	0 1 2 3		.....
3. Tôi không thấy có một cảm giác lạc quan nào cả	0 1 2 3	.....	
4. Tôi bị khó thở (thở nhanh, khó thở mà không do làm việc mệt)	0 1 2 3		.....
5. Tôi thấy khó mà bắt tay vào làm công việc	0 1 2 3	.....	
6. Tôi đã phản ứng cách quá lớn khi có những sự việc xảy ra	0 1 2 3			.....
7. Tay tôi bị run	0 1 2 3		.....
8. Tôi thấy mình đã dùng quá nhiều năng lực vào việc lo lắng	0 1 2 3			.....
9. Tôi lo mình đến những nơi mà tôi có thể bị hốt hoảng và tự làm mất mặt ..	0 1 2 3		.....
10. Tôi thấy tương lai mình chả có gì để mong chờ cả	0 1 2 3	.....	
11. Tôi thấy bồn chồn	0 1 2 3			.....
12. Tôi thấy khó mà thư giãn	0 1 2 3			.....
13. Tôi thấy mình xuống tinh thần và buồn rầu	0 1 2 3	.....	
14. Tôi thấy thiếu kiên nhẫn với những điều cản trở việc tôi đang làm	0 1 2 3			.....
15. Tôi thấy mình gần như bị hốt hoảng	0 1 2 3		.....
16. Tôi không thấy háng hái để làm bất cứ chuyện gì	0 1 2 3	.....	
17. Tôi thấy mình là người kém giá trị	0 1 2 3	.....	
18. Tôi thấy mình rất dễ nhạy cảm	0 1 2 3			.....
19. Tôi thấy tim mình đập nhanh, đập hụt nhịp mà không do làm việc mệt....	0 1 2 3		.....
20. Tôi cảm thấy sợ vô cớ	0 1 2 3		.....
21. Tôi cảm thấy cuộc sống mình không có ý nghĩa	0 1 2 3	.....	
Tổng cộng số điểm				
Tổng cộng số điểm sau khi nhân cho 2				

Psychosocial support to SCI Patients in the Spinal Unit, Dieu Duong Hopsital, District 8, HCMC. October-November 2003.