Decreasing Restraint Use by Utilization of Agitation Assessment and Verbal De-escalation Strategies in an Inpatient Non-Psychiatric Hospital

Kiera Paulo
kpaulo@usfca.edu

Follow this and additional works at: https://repository.usfca.edu/dnp_qualifying

Part of the Psychiatric and Mental Health Commons, and the Psychiatric and Mental Health Nursing Commons

Recommended Citation
Paulo, Kiera, "Decreasing Restraint Use by Utilization of Agitation Assessment and Verbal De-escalation Strategies in an Inpatient Non-Psychiatric Hospital" (2023). DNP Qualifying Manuscripts. 79.
https://repository.usfca.edu/dnp_qualifying/79
Decreasing Restraint Use by Utilization of Agitation Assessment and Verbal De-escalation Strategies in an Inpatient Non-Psychiatric Hospital

Kiera Paulo

University of San Francisco, School of Nursing and Health Professions

N749A NP Qualifying Project: Manuscript Development

Dr. Trinette Radasa

September 18, 2022
Abstract

**Background:** This paper reviews the literature on ways to decrease the use of restraints in hospitals – specifically the use of agitation assessments and verbal de-escalation to be implemented in healthcare facilities to decrease the number of restraints being used to manage undesirable patient behavior and workplace violence incidents. **Problem:** Restraints have been shown to impede the nurse–patient relationship and cause emotional and physical trauma to staff and patients. They are no longer considered preferred management and in some circumstances can be considered abuse. **Intervention:** Agitation assessments and verbal de-escalation have been shown to produce less aggressive behavior and decrease the time patients spend in restraints. By having a way in which agitation levels can be measured, the provider can intervene with the least invasive methods (i.e. verbal de-escalation) before the situation devolves into one needing more invasive (i.e. restraints) interventions. **Conclusions:** By implementing the use of agitation assessments and verbal de-escalation strategies, the literature has shown that restraint use can be decreased, and time spent in restraints can be decreased.

*Keywords:* acute behavioral symptoms, de-escalation, restraints, inpatient, agitation
Contents

Problem Description........................................................................................................................................4
Available Knowledge.....................................................................................................................................5
   Review Protocol .........................................................................................................................................5
   Integrated Review of the Literature ........................................................................................................5
   Agitation Assessment ...............................................................................................................................5
   Verbal De-escalation ...............................................................................................................................8
Synthesis of Information ................................................................................................................................11
Clinical Implications for Nursing Practice ................................................................................................12
Summary .....................................................................................................................................................13
References ....................................................................................................................................................14
Journal Manuscript Guidelines ................................................................................................................17
Problem Description

The Joint Commission, in 1998, published a Sentinel Alert regarding the use of restraints in behavioral health settings (Goetz & Taylor-Trujillo, 2012). A Sentinel Alert is issued by the Joint Commission to provide to health care facilities their safety action recommendations on ways in which gaps can be addressed and identifies opportunities for improvement (Lyons, 2021). The Centers for Medicare and Medicaid Services and the Joint Commission have pushed to make the use of restraints limited to only when behavior threatens the immediate physical safety of a staff member, patient, or bystander and less restrictive measures have been unsuccessful (Gaynes et al., 2017). While the use of restraints can be viewed as a safe and quick way of managing agitated patients, there are several negative effects associated with this intervention and it can be traumatic for the staff and the patient.

Restraints can inflict feelings of hopelessness on the patient because it is an intervention done to the patient, not with them (Haefner et al., 2020). There is increased feelings of anxiety, distress, frustration, anger, and fear in both staff and patients, and restraints can result in regressive behavior and patient dependence (Perez-Toribio et al., 2021). There is also an increased quantity of injuries associated with restraints, to patients and staff (Holloman & Knox, 2012). One fourth of workplace violence (WPV) across the globe is likely to be produced by healthcare violence, making it a considerable job-related hazard in healthcare (Adams et al., 2017). Workplace violence includes any incident that causes physical or psychological harm to employees from assaults, abuse, or threats in work related conditions (Adams et al., 2017).
This paper explores solutions to decrease the number of restraints being used. This will be done by searching for information on ways the use of agitation assessments and verbal de-escalation techniques by floor staff and providers early on in the encounter with patients can decrease the use of restraints being utilized as a means of behavioral management.

**Available Knowledge**

**Review Protocol**

A literature search was undertaken to find information relevant to this paper. A systemic review of evidence was done through the Cumulative Index to Nursing and Allied Health Literature (CINAHL) Complete database. While several searches were completed, the most comprehensive one with all the articles found pertinent to this paper were as follows. Keywords input were “de-escalation” and “inpatient”. The articles needed to be written in the English language and written no earlier than 2012. This search yielded 82 articles. Modifiers to eliminate irrelevant articles were removing those not related to nursing care, those not addressing patients experiencing acute behavioral symptoms, those not addressing the use of verbal de-escalation, and articles that did not contain mechanical or chemical restraints as a means of behavioral management. These modifiers lead to a total of nine articles.

**Integrated Review of the Literature**

**Agitation Assessment**

Legambi et al. completed a quality improvement project in 2021 that implemented the use of the BARS in an emergency department (ED) to study whether early detection of
agitation could lead to a decrease in restraint use. Data was collected four months pre and four months post implementation of the Behavioral Activity Rating Scale (BARS) on restraint use, charting of BARS, and usability of the BARS by staff. Descriptive statistics were used to describe the documentation of BARS, nonrestraint interventions, restraints used for violent patients, time spent in restraints, and violent rating on the BARS. Additionally, a χ² test was used to compare the data for the different time frames of collected data. It was found that not only was the BARS usable by the staff, in combination with interventions to manage agitation, agitation could be mitigated before violence occurred. Using agitation assessments can decrease the amount of time a patient spends in restraints, not just decrease the number of patients being put into them. Holloman & Knox wrote an article releasing a consensus statement in 2012 that discusses an algorithm which was created to assist the medical professional in deciding when and if restraints or seclusion are appropriate. They spoke of how they discovered that while emergency departments (ED) and psychiatric emergency services (PES) may not be able to entirely remove the need for restraints or seclusions, strategies – specifically the use of agitation assessments – can be implemented to decrease the rate in which they are needed.

Gaynes et al. completed a systematic review of evidence in 2017 that examined 17 articles. They compared the effectiveness of various strategies used to prevent and de-escalate the aggressive behaviors of patients with a psychiatric disorder in an acute care setting. By searching databases for studies related to de-escalation strategies and violence prevention, they discovered that information regarding their topic was limited.
However, certain preventative strategies in tandem with multimodal interventions and risk assessment can lower the use of restraints and seclusion by decreasing aggressive behavior. Tucker et al. in 2020 completed a descriptive qualitative study utilizing semi-structured focus group interviews with twenty inpatient mental health nurses. They looked to examine the experiences that nurses have had regarding managing and recognizing agitation in patients and whether these experiences line up with the current best practice. They discovered that by engaging patients in decision making about their care, they individualized their approaches to combine professional judgement and clinical observations with structured agitation assessments.

These studies were evaluated using the John Hopkins Evidence-Based Model for Nursing and Healthcare Professionals (JHEBP) Synthesis and Recommendations Tool Appendix H. The JHEBP Appendix H Tool allows for the use of critical thinking to synthesize findings and find best evidence practice recommendations. Before this, they were evaluated with the JHNEBP Non-research Evidence Appraisal Tool Appendix F, or the JHEBP Research Evidence Appraisal Tool Appendix E, being guided by the JHEBP Hierarchy of Evidence Guide Appendix D. With a mixture of Level III (nonexperimental studies) and Level IV (clinical practice guidelines) evidence, these studies produced an underlying theme of ways in which to detect agitation in patients.

The key takeaways from the studies found that implementing a general application of risk assessment strategies for all individuals, not just those who are actively showing signs of aggression, can decrease restraint use by producing less aggressive behavior (Gaynes et al., 2017). Using agitation assessments is helpful but should be done in tandem
with professional judgement and clinical observations (Tucker et al., 2020). Agitation assessments can decrease the amount of time a patient spends in restraints, not just decrease the number of patients being put into them (Legambi et al., 2021). With each study giving an Overall Quality Rating of Strong from the Appendix H JHEBP Tool, the evidence is shown to be strong and compelling, having consistent results. The studies show consistency in that across the board, it was found that the use of agitation assessments can decrease the number of patients placed in restraints as well as limit the amount of time a patient is in restraints for.

**Verbal De-escalation**

Bowers in 2013 published clinical practice guidelines that provide a framework with a systemic description on the de-escalation process. These guidelines breakdown the information and make it easily presentable to staff. Perez-Toribio et al. published a retrospective study in 2022 that was meant to examine the relationship between patients who had been mechanically restrained and nurses using verbal de-escalation. Data was extracted on 493 separate episodes in which mechanical restraint was used. They looked at several variables, including sociodemographic factors, clinical factors, the diagnosis, substance use, time, date, and reason for restraint, previous use of mechanical restraints, pharmacological restraints, and if the use of verbal de-escalation was attempted. They found that in over 40% of the patients who had required mechanical restraints, no attempts at verbal de-escalation had been attempted. By analyzing the records of those who had been mechanically restrained from 2012 to 2019 at an acute mental hospital, they found that verbal de-escalation was used less in patient who had no
history of mechanical restraint or pharmacological intervention to prevent agitation and that often, these patients were restrained early on in their hospital stay. This confirmed the importance of early interventions by nurses and of establishing a trusting therapeutic relationship with patients early on in their stay.

In 2021 Haefner et al. performed a quality improvement project aimed at using verbal de-escalation to decrease patient aggression and seclusion on an inpatient psychiatric unit. The project was implemented on a 37-bed psychiatric unit and provided to nurses, psychiatric nurse practitioners, occupational therapists, psychiatric pharmacy technicians, activity therapists, and social workers. Utilizing the TeamSTEPPS educational program, staff was first provided online computer modules to complete, and then attended live de-escalation techniques demonstrations. Each individual variable data point was analyzed by using the Chi-square test for independence (with Yates Continuity Correction) with a P value of less than 0.05 showing statistical significance. They compared patient charts from two months pre- and post-training. There was found to be a decrease in the number of aggressive behaviors charted, determining that education for the nurses was beneficial in reducing a patients’ aggressive behavior.

In 2018, Hallett published an article that outlines primary, secondary, and tertiary prevention methods for decreasing challenging behaviors, including de-escalation and agitation assessments. Understanding prevention and causes of challenging behavior is important in healthcare because incidents can occur in any setting. Long et al. in 2016 completed a quality improvement study where a change in staff training on the management and prevention of violence and aggression was done and the effectiveness
of this content upgrade was assessed. The project was implemented at the Women’s Service of Saint Andrew’s Healthcare, which has 136 beds. They collected data from 12 months pre- and post-training on various factors. The factors included data on staff opinions regarding the benefits of increased focus on prevention and de-escalation which was collected using a de-escalation, restraint, and seclusion questionnaire, the association with change regarding risk behaviors which was collected using the Overt Aggression Scale, the number of restraints and time spent within them, and the impact that the changes in training on de-escalation had in terms of risk management which was collected using the Institutional Behavior Scale (IBS). By analyzing these results using the Chi-square, they found that increased training of the on-ward staff and increased time dedicated to de-escalation and prevention of aggression, lead to a decrease in risk behaviors, staff injuries, seclusions, and time spent in restraints.

These studies were evaluated using the same John Hopkins Evidence-Based Model for Nursing and Healthcare Professionals (JHEBP) tools as mentioned in the ‘Agitation Assessment’ section. With a mixture of Level IV and Level III evidence, these studies showed a common theme throughout of preventing, reducing, and de-escalating aggressive behavior by use of verbal de-escalation techniques.

The use of verbal de-escalation aims to prevent harm and avert violence without needed to use seclusion or manual restraint (Bowers, 2013). Establishing a relationship as soon as possible is important as it builds trust between patients and the staff (Perez-Toribio et al., 2022). The use of verbal de-escalation strategies can build relationships between staff and the patients, empower patients to stay in control, and encourage
patients to seek assistance early to avoid becoming agitated (Haefner et al., 2021). Emphasis was placed on the importance of continuous training on conflict management skills for staff (Long et al., 2016). The JHEBP Tool Appendix H rates the evidence found in these articles as strong and compelling, with consistent results. The evidence is consistent throughout the articles that using verbal de-escalation can limit the number of patients placed in restraints and decrease the amount of time the patient is in restraints.

**Synthesis of Information**

These studies demonstrated a consensus on the benefit to the use of agitation assessments and verbal de-escalation. There were various tools used to assess agitation, several using the Behavioral Activity Rating Scale (BARS) and some articles not stating what exactly was in place. There was also a wide variety of verbal de-escalation techniques, the common most being to stay safe by keeping a clear path to an exit, stay calm, and always appear non-judgmental - while other articles also failed to state exactly what was used or taught by the staff they were observing. Inconsistencies came out of the various limitations presented by the studies, specifically from the time frame. Results generally varied a bit when the post intervention time frames were shorter, seemingly due to not having enough time to see the changes flushed out. Other inconsistencies were in that it was unclear whether some of the sites being studied already utilized some version of agitation assessment and verbal de-escalation and just did not chart it in any noticeable way.
Most of the findings were expected. The only real surprise came from how small the pool of information was that could be found on the topic. Most of the studies were done in some type of emergency department, but the findings would be generalizable – they were not specific to the site or population studied. The findings are strong enough to support the idea of changing the way practice is currently done. Agitation assessment types and samples of verbal de-escalation are provided in the articles and could be used as references if attempting to implement the three changes discussed in the following section.

Clinical Implications for Nursing Practice

The amount of evidence found when searching for a solution to the literature review question was not as vast as would be preferred. The search had to be expanded from just the Behavioral Activity Rating Scale (BARS) to any type of agitation assessment tool because there were not enough studies to be found that addressed all that was being questioned. There were enough studies to get a basic understanding of what has been done before and what should be done in the future, but the body of evidence was minor compared to previous research inquiries done. Enough evidence was produced to promote changes that should be made in nursing practice though. Using these findings, going forward there are three recommended changes in practice that should be made. First, implement the use of an agitation assessment to be used as a general assessment on all patients. Second, implement the use of verbal de-escalation to be used by all medical staff when encountering patients exhibiting behavioral symptoms that do not pose an immediate threat to themselves or others. Third, implement some way in which
staff can document in the electronic medical chart incidents of agitation/aggression. This can be used in both an inpatient and outpatient, for floor staff – nurses and nurse aids – and providers – physicians and nurse practitioners. By having a basic understanding of agitation assessments and verbal de-escalation techniques, nursing staff and providers can feel more comfortable in their ability to interact with angry or escalating patient behavior and work with them to center themselves. This will allow for a more therapeutic and relaxed environment between the patient and their providers.

Summary

Having to come into work with the potential of experiencing workplace violence can make an already stressful environment more tense. With restraints no longer being touted as a success story for managing patient behaviors but instead potentially a form of abuse, other methods for reducing patient agitation must be attempted. Short term, integrating forms of agitation assessment and verbal de-escalation techniques has the potential to redefine the interactions that occur between staff and specific patient populations. By using the least invasive technique, patients will be more open and trusting with their nurses. This could decrease the number of restraints and the number of occurrences in which a staff member would need to attempt de-escalation on one patient.
References


https://www.scu.edu/csi/leadership/initiatives/jvia/


Journal Manuscript Guidelines

Manuscript Submission

Welcome and thank you for considering Journal of Mental Health & Clinical Psychology to submit your work.

By submitting a manuscript to the journal, authors ensure that they strictly follow the guidelines and ethics of the journal.

Manuscripts must be submitted by one of the authors of the manuscript, through online submission. If authors face any technical problem with online submission, they can send the article through an email attachment to the editorial office at editor@mentalhealthjournal.org. The submitting author takes responsibility for the article from submission until publication (during peer review and in-house process).

The documents of new manuscript submission should comprise of:

- Cover letter
- Manuscript file (including title page, full manuscript body text, conflict of interest statement, funding information and references)
- Article table of contents mentioning all levels of headings
- All tables and table legends (in order of citation within the manuscript text)
- All figures and figure legends (in order of citation within the manuscript text)
- Supplementary materials (if any)
- The name and e-mail address of the contact author who will check the proof of the paper.
A Cover Letter that explains the main purpose of the work, must accompany the manuscript. It should explain the suitability of the manuscript to this particular journal based on topic, theme, and methodological or theoretical approach. It should briefly describe the research that is being reported in the paper, why it is important, and why the readership of the journal would be interested in it.

Authors may suggest 3–6 potential peer-reviewers for the manuscript, provided, they should not be the current collaborators and should not be the members of the same research institution. The suggested peer reviewers should not have published with any of the authors of the manuscript within the past five years. Suggested reviewers may be considered along with potential reviewers recommended by Sectional Editors.

Once the manuscript is modified/corrected according to the reviewer’s suggestions and finally approved for publication, there will be no further opportunity to edit it. Any essential changes after this point will be published as corrigenda. After acceptance of the article and before its publication, corresponding author must sign a License to Publish Form. Our editorial staff will respond to any submission inquiry within two working days.

On publication of the article, all authors of the manuscript will receive a web link, which directs to the published article on the Journal website.

**Manuscript Categories**

Journal of Mental Health & Clinical Psychology requires authors to carefully choose the appropriate article type for their manuscript.

1. [Research Article](#)
2. [Case Report](#)
3. Editorial
4. Review Article
5. Mini Review Article
6. Conference Proceedings
7. Corrigenda
8. Short Communication
9. Book Review
10. Letter to the Editor
11. Commentaries and Opinions

1. Research Article: A Research article reports the new results of original scientific research within the journal’s scope. Research papers deal with its subject in depth. Generally these papers are expected to include Title, Abstract, Keywords, Background/Introduction, Materials and Methods, Results and Discussion, Conclusions, List of abbreviations used (if any), Competing interests (if any), Authors' contributions, Authors' information, Acknowledgements, Funding, Endnotes (if any), References, Illustrations and figures (if any), Tables and captions (if any), and Additional supplementary files (if any). Papers that are exclusively methodological or that the editors of the journal present models or hypothesis unsupported by original data are not acceptable. Research papers are generally expected to include 3000 – 6000 words excluding abstract and references.

2. Case report: A case report is the descriptive study of a single individual (case report) or small group (case series) that includes signs, symptoms, diagnostic studies, treatment
course and outcome. Case reports often describe unique cases that show an unexpected variation of a disease or condition and that cannot be explained by known diseases or syndromes. Journal of Mental Health & Clinical Psychology gives priority to cases with clinical significance. A case report is generally of one or two pages in length.

3. Editorial: An editorial is a brief article, written by editors, associate editors, assistant editors, or invited guests, that expresses views on the current topical issue. These are generally of one page in length.

4. Review Article: A review article accumulates and summarizes the results of many different articles on a particular topic and re-presents previously published literature, rather than reporting new facts or analysis. They generally provide a recent review of the subject matter. All review articles undergo the same peer-review and editorial process as original research reports. Review articles must include an abstract of 100-200 words and a maximum of 100 references. There is no required page limit for a review article.

5. Mini-Review Article: It is similar to that of review article except in terms of word limit & References. The word limit of mini-review article is 1500-2000 words and it can include a maximum of 50 references.

6. Conference Proceedings: Conference Proceedings are the short summaries of findings presented at many important Scientific Meetings, International Conferences, Seminars, Congresses and Scientific Events around the world. They provide an early picture of current research that is likely to appear later as a published article in any journal. Journal of Mental Health & Clinical Psychology enables fast dissemination of conference papers in dedicated online issues and offers authors, institutions and conference organizers a
fast and cost-effective way to provide maximum online exposure for their papers.

7. **Corrigendum**: Corrigenda are published to correct any significant errors within the text of an earlier published article. The title of the manuscript is read as ‘Corrigendum to "TITLE" published in JOURNAL, VOLUME, PAGES, YEAR’. Corrigenda discuss errors of only preceding papers and not the errors of the corresponding discussion paper.

8. **Short Communication**: Short Communication is a concise research article that aims to present new ideas, recent advances and key points that will have a major impact on Mental Health Disorders. It has a strong limitation on the size of the paper and are generally limited to 4,000 words, and may also include the abstract, introduction, materials and methods, results, discussion, references and figure legends. Short communications may also report the research that extends previously published research article, including the reporting of additional controls, confirmatory results etc. Authors must clearly acknowledge any published work upon which they are building.

9. **Book Review**: Book review is a critique of a book in which book is analyzed based on its content, merit and style. The title of the paper is read as “Book Review on: title”. A book review contains fewer than 1000 words.

10. **Letter to the editor**: Letter to the Editor is submitted to the Editor of Journal of Mental Health & Clinical Psychology through the online submission system. It is intended for raising or clarifying issues of specific interest to the scientific community. It is expected to provide substantive comments on papers published in the Journal of Mental Health & Clinical Psychology, in the six months prior to the submission of a letter. It also shares opinions or comments on the subjects that are of broad interest to the Mental Health
research community. If appropriate, both the letter and a reply are published together. Unpublished data is not permitted to be included in a letter to the editor. Letter to the editor will be reviewed prior to acceptance. Letters are limited to one published page and must include up to 10 references.

11. Commentaries and Opinions (1000–1500 words): Commentaries accompany the published literature. They may be written either on one's own paper or on someone's work, providing insight, interpretation and evaluation of specific issues within the scope of the journal. Commentaries explain the implications of the article and put it in context. Commentaries submitted to this journal should describe the most important conclusions of the paper they are commenting on, highlight controversial issues, if relevant mention the strengths and weaknesses of the paper, highlight the presenter's omission of key facts and mention supporting arguments that would create a stronger presentation. The title of the manuscript must read as “Commentary: Title of the original article”. Commentaries on a paper must be written only after constructively analyzing the entire piece of literature. Rebuttals may be submitted in response to commentaries. Commentaries have no set format beyond the basic building blocks of a regular article i.e., title, manuscript text, subheadings as needed, references, and author information. The journal is looking to encourage active discussion and communication among readers, authors and editorial board members with an aim to continue publishing interesting and informative Commentary articles. Opinions are also welcome as long as they are factually based.

Manuscript Submission Checklist
1. Manuscripts must be prepared in a clear font (12 pt) and the text must be double-spaced.

2. **Title Page:** The title page should contain the **title** of the paper, the **author's name**, and the **institutional affiliation**. The title should not have more than 12 words and it should not contain abbreviations or words that serve no purpose. Author's name includes first name, middle initial(s), and last name. Do not use titles (Dr.) or degrees (Ph.D.). All the authors must meet the authorship criteria. Institutional affiliation should indicate the location where the author(s) conducted the research.

3. **Abstract:** An abstract summarizes the paper describing the scope of the investigation, results obtained and major conclusions. An abstract should contain a minimum of 150 words and a maximum of 250 words.

4. **Keywords:** Keywords can be taken from the title and abstract. Keywords should not be less than six.

5. **Text:** Type the text double-spaced with all sections following each other without a break. Avoid poetic language and rhyming schemes. Use simple, descriptive adjectives and plain language that does not risk confusing your meaning. Each source you cite in the paper must appear in your reference list; likewise, each entry in the reference list must be cited in your text. In the text, reference numbers are given in superscript.

6. **Example for Reference Citations in Text:**

   The author has discussed the implications of these proposals on the National
Health Service in another paper1. Other writers have commented on related issues, notably Lane2,3 and Lewis4.

7. **Acknowledgment:** Acknowledgment, including financial supports along with the numbers of grants and funding information, should be stated after results and discussion part of the text.

8. A Conflict of Interest statement is included in the main manuscript file and appears before the reference listing.

9. **Tables:** Number all tables sequentially as you refer to them in the text (Table 1, Table 2, etc.). Label tables with an Arabic numeral and provide a title. The label and title appear on separate lines above the table. Title of the table is written in italics. Cite the source of the table in a note below the table. Include an explanation of every abbreviation and special symbol (except the standard statistical symbols and abbreviations). To indicate specific notes, use superscript lowercase letters (e.g. a, b, c), and order the superscripts from left to right, top to bottom. Each table’s first footnote must be the superscript a.

10. **Figures:** Number your figures consecutively as they are referenced in the text. If a figure has multiple panels, refer to parts of the figure as (a), (b), (c), etc. Label figures with an Arabic numeral and provides a title. The label and the title appear on the same line below the figure. The label must be in italics i.e., *Figure x*. Title of the figure must be in sentence case. If the figure has a title in the image, crop it. The text in a figure should be in a san serif font (such as Helvetica, Arial, or Futura). The font size must be between eight and fourteen points. Follow the title with a legend.
that explains the symbols in the figure and a caption that explains the figure. Cite
the source below the label and the title.

11. References: A list of references must be provided at the end of the scientific text.
This list must include the full information for all the works cited in the running text.
The entries in the reference list are placed in the same order in which they were
cited in the text. **Basic form of reference:**

a. **Standard Format for Journal Articles:**

   Author Surname Initials. Title of article. Title of journal, abbreviated. Date of
   Publication; Volume Number(Issue Number): Page Numbers.

b. **Standard Format for Books:**

   Author Surname Initials. Title: subtitle. Edition (if not the first). Place of
   publication: Publisher; Year.

c. **Standard Format for Websites:**

   Author Surname Initials (if available). Title of Website [Internet]. Place of
   publication: Publisher; Date of First Publication [Date of last update; cited
date]. Available from: URL

**Processing Time**

**Average manuscript life cycle at Journal of Mental Health & Clinical Psychology:**

- Rejection without Peer-review: less than one week
- Peer-review process: less than two weeks
- Revision of manuscript by the author: less than two weeks
- Re-review of the corrected manuscript: less than one week
The average time is taken for the manuscript to appear Online: **Four to Five Weeks**

**Publication Charges**

Journal of Mental Health & Clinical Psychology is an open access journal. In the open access publishing model, publication is considered as the last phase of the research process and the publication fee of an article is paid from the author’s research budget, or by the grants of their supporting institution. The publication fee covers the entire cost of the process of publication which includes

- Peer-review management by the editorial staff and board
- Preparation of manuscript in various formats for online publication
- Hosting, Archiving and Maintaining the manuscript
- Manuscript preparation such as copyediting, formatting, adjusting the layout
- Developing and maintaining electronic tools for peer review and publication
- Immediate, worldwide open access to the full article text

Publishing an article in the Journal of Mental Health & Clinical Psychology requires Article Processing Charges of **950 USD** that will be billed to the submitting author after the acceptance of an article for publication. Journal of Mental Health & Clinical Psychology provides a waiver to authors belonging to Low-income economies or Lower-middle-income economies (As per the classification of countries given by the World Bank as of July 2015). **Note:** These publication charges are applicable to invited authors also.

**Multimedia**

Science has always been an international pursuit. The Journal of Mental Health & Clinical Psychology is committed to using modern communication methods such as video files,
spoken audio files, audio files synchronized with a text Web page, and flash multimedia for conveying the scholarly content. Authors can create and submit review articles, research articles, experimental techniques, case reports, anatomic overviews, and more in a visual format.

All multimedia articles submitted to the Journal of Mental Health & Clinical Psychology are peer-reviewed as part of the mainstream submission process and all published multimedia articles are accessible through the journal or through YouTube. The new mechanism allows videos to be cited in the same way as a written article in a traditional open access publication. Every multimedia article published in Journal of Mental Health & Clinical Psychology will have an open discussion forum freely accessible to anyone.

Journal of Mental Health & Clinical Psychology maintains certain standards for all multimedia files it publishes. The journal accepts playable multimedia files with the following file extensions:

Audio: .aiff, .au, .midi, .mov, .mp3, .ra, .wav

Video: .asf, and .wma, avi, .gif, .mov

The author must include all the details of multimedia files such as size, type of the player etc. in a separate document. The authors must check for the following criteria before submitting their multimedia files so that they reach the widest possible audience.

- Is it compatible with commonly used browsers and mobile devices?
- Is the audio clear and easy to hear, especially the voices?
- Is the picture focused with sufficient lighting?
- Is the video clear and camera work steady?
• Are images of sufficient quality and adequately captioned?

Online publication of multimedia articles opens up a whole new form of learning and the sharing of knowledge can occur even faster

**Licensing and Copyright**

The Journal of Mental Health & Clinical Psychology publishes all its articles under the terms of Creative Commons Attribution (CC BY) License which permits use, distribution and reproduction of the information in any medium, provided the original work is properly cited. Authors retain the copyright and grant the journal an exclusive license to publish. Copyright aims to protect the specific way the article has been written to describe an experiment and the results. Journal of Mental Health & Clinical Psychology is committed to its authors to protect and defend their work and their reputation and takes allegations of infringement, plagiarism, ethic disputes and fraud very seriously. Copyright on any research article is retained by the author(s). Authors grant the journal a license to publish the article and identify itself as the original publisher. Authors also grant any third party the right to use the article freely as long as its original authors, citation details and publisher are identified.