A GUIDE

TO

MENTAL HEALTH

FOR

SOCIAL WORKERS

राष्ट्रीय
मानसिक स्वास्थ्य
कार्यक्रम

First Published: 2016

BRAIN AND BEHAVIOUR

The human brain is a complex organ of the body. It weighs about 1.5 kg and consists of billions of tiny cells. It enables us to sense the world around us, to think and to talk. The brain consists of the stem and cerebral hemispheres. The human brain and nervous system begin to develop at about three weeks' gestation. The largest part of the brain, in volume, is the *cerebral cortex*, which is divided into two *hemispheres*. Each half divided into four *lobes*, the occipital lobe, the temporal lobe, the parietal lobe, and the frontal lobe. Functions, such as vision, hearing, and speech, are distributed in selected regions. Some regions are associated with more than one function.

The nervous system is divided into the central nervous system and the peripheral nervous system. The central nervous system consists of the brain and the spinal cord. The peripheral nervous system connects the brain and the spinal cord to the other parts of the body. The peripheral nervous system is divided into the somatic nervous system, which contains sensory and motor nerves, and the autonomic nervous system, which monitors the body's internal organs. Neurons send information in the form of waves of electricity through substances called as neurotransmitters. Disorganized signaling of neurons, in some instances, result in various disorders such as Epilepsy, Schizophrenia, Depressive Disorder and Dementia.

Most mental disorders are caused by a combination of factors including: Stressful life events, Biological factors, Individual psychological factors e.g. poor self-esteem, negative thinking, adverse life experiences during childhood e.g. abuse, neglect, death of parents or other traumatic experiences.

STRESS & COPING:

Stress can be a result of both positive and negative experiences, and it is a necessary part of our daily lives. We all feel the pressure of our environment during times of transition (i.e., at the time of high school graduation) and in preparation for significant life events (i.e., in anticipation of a job interview). Although response to stress is often adaptive (i.e., feeling stress before an exam may be a critical motivator in studying for it), too much stress or an inability to cope with it can cause negative emotional and physical symptoms. The sources of stress include hassles such as not being able to hand in an essay, concerns about weight, etc. Finally another source of stress that is worthy to mention is 'work-related stressors.' This source of stress encompasses all the social and environmental conditions at the work place, such as noise, co-worker relationships, but they depend on the nature of the job. The responses to stressors are multidimensional that includes behavioural, sensations, emotional, cognitive, biological and interpersonal responses.

Folkman and Lazarus (1980) define coping as `the cognitive and behavioural efforts made to master, tolerate, or reduce external and internal demands and conflicts among them'. These efforts can attempt to change the person–environment realities behind negative emotions or stress (problem-focused coping). These can also relate to internal elements and try to reduce a

negative emotional state, or change the appraisal of the demanding situation (emotion-focused coping). The coping also can be classified as positive and negative coping where the negative coping leads to disorders and positive coping leads to wellness. Below flowcharts show the response of negative and positive coping cycle.

VULNERABILITY AND RESILIENCE:

Disruption in development can create vulnerability in an individual's mental health. Development crisis, problematic attachments and environmental risks (Eg: poor parenting, poverty, violence) may result in a person being less able to manage and mediate distress. An individual is said to be resilient when they have had good outcomes in spite of the serious threats to adaptation or development. Resilience and risk go hand in hand. Several additional factors have been associated with resilience: a positive sense of self, self efficacy, self-regulation of mood, cognitive abilities, perseverance and relationships or contact with significant nurturing adult or supporting community.

Persons with mental and psychosocial disabilities comprise a vulnerable group as they are subjected to high levels of stigma and discrimination, due to widely held misconceptions about the causes and nature of mental health conditions. Due to these factors, people with mental and psychosocial disabilities are much more likely to experience disability and die prematurely, compared with the general population.

Resilience and wellbeing are dependent upon both internal and external factors. A person's innate way of looking at the world and solving problems can influence their resilience and wellbeing – but people can learn new skills to help them respond more positively to life's challenges. The environment is also important, as people develop working models about social interaction and come to an understanding of what other people expect of them. In a school setting, creating a supportive and caring environment is important. As health, mental health also lies in a continuum from mental health to mental illness. Various mental disorders occur for individuals due to various stressful events, coping mechanisms, vulnerability and resilience factors.

ASSESSMENT AND DIAGNOSIS OF MENTAL DISORDERS

PSYCHIATRIC HISTORY TAKING

COMPONENTS	DETAILS
Basic information	Information about client, informants, other medical records.
Chief complaints	What brought the client to the hospital? Client's problems should be recorded as his own /her own words.
History of present illness	Symptoms, onset, course, severity, triggering events.
Past psychiatric history	Previous evaluations, therapies, medications, hospitalizations, history of violent behavior, suicide attempt
Family history	History of psychiatric illness, suicide, substance abuse.
Personal history	Birth and childhood development, education, occupation, sexual and substance use history.
Pre-morbid history	Behaviour, attitudes, hobbies etc. of the client before the onset of the illness

Mental Status Examination:

COMPONENTS	DETAILS
General appearance and behavior	Careful examination of client's cleanliness, verbal and non-verbal communication.
Speech and motor activity	Volume, rate, spontaneous, coherence, relevance, tone and tempo of the speech. Psycho motor activity: (increased/decreased)
Mood	Changes in the mood: depressed, elated, anxious, or irritable.
Thought	Examine the abnormalities in the thought process Content: Delusions, depressive thoughts, Obsessions, and anxious thoughts. Form: relevance, flight of ideas, loosening of connections.
Perception	Hallucinations, illusions
Cognitive functions	Attention, concentration, orientation, memory, intelligence, general knowledge, arithmetic skills
Judgment and insight	Personal and social judgment: (Client's capacity to make sound and reasonable decisions. Person's awareness about his/her disorder and the willingness to accept it and readiness to take treatment.

COMMON PSYCHIATRIC DISORDERS AND DIAGNOSIS:

The most common psychiatric disorders presenting in general health care are delirium, dementia, depression, anxiety, psychoses, substance dependence and unexplained physical symptoms. This disorders can be classified into, organic mental disorders, common mental disorders, and severe mental disorders.

Severe mental disorders cause marked disruption in bio-psycho-socio-occupational functioning. These disorders are serious mental illness may affect a person's ability to recognize and react rationally to the reality and also associated with odd thinking, perception and behavior. Schizophrenia, bipolar affective disorder and delusional disorders come under this category.

Schizophrenia: It is a major psychiatric disorder. Onset of this disorder can be sudden or insidious and sometimes gradual. In most of the cases it is observed that this disorder has a long and continuous course. It is considered as a severe mental illness, because it affects all the domains of functioning of a person. Paranoid schizophrenia, catatonic schizophrenia, hebephrenic schizophrenia, simple schizophrenia and residual schizophrenia are the subtypes of schizophrenia.

Delusional disorders: Delusional disorders are characterized by a single or a group of related delusions which are persistent and last for long without any other psychotic symptoms. People with delusional disorder often do not have any significant problems on their socio - occupational functioning apart from the subject of their delusions. Common types of delusions can be persecutory (suspicious that somebody may harm), somatic (false belief of having some illness), or grandiose (false belief of having extraordinary power).

Mood (affective) disorders: It is the most common, severe and persistent psychiatric disorder. Depression, mania, and bipolar are major categories come under mood disorders. Depression and mania can be graded into mild, moderate and severe based on the severity of symptoms.

Symptoms and diagnosis

Depression	Mania	Bipolar affective disorder
Core symptoms • Depressed mood • Loss of interest • Reduced energy or increased fatigue Other symptoms • Reduced attention and concentration • Reduced self-esteem • Ideas of guilt and worthlessness • Ideas or acts of suicide	Elevated mood Increase speech activity sexual energy Over familiarity Irritability Feeling of well-being Decreased need for sleep	Bipolar affective disorder: It is characterized by periods of prolonged depression alternate with elevated, irritable mood or mania. • Manic episode usually begin abruptly last for between two weeks to five months. • Depressive episode lasts for six months. • Inter-episodic remissions between episodes

Depression	Mania	Bipolar affective disorder
• Disturbed sleep • Decreased appetite		
Mild :Any two core symptoms + any two of other symptoms Duration: two weeks	Hypomania: mild elevation of mood + other symptoms Without severe disruption of daily functioning	Bipolar I: Characterized with one or more episodes of mania and severity and duration of episodes often lead to hospitalization.
Moderate:at least two of core symptoms + three of other symptoms. Duration: 2weeks	Mania:Elevated mood with uncontrollable excitement + other symptoms with severe destruction of functioning Duration: one week	Bipolar II:Characterized by at least one episode of hypomania and at least one episode of severe depression. Hypomanic episode does not lead to hospitalization.
Severe :All three of core symptoms + four of other symptoms Duration:two weeks	Mania with psychotic symptoms : all symptoms of mania + delusions and hallucinations	Bipolar affective disorder with psychotic symptoms: Bipolar I or Bipolar II + psychotic symptoms (Delusions, hallucinations etc.)

Anxiety disorders: Anxiety disorders are a category of mental disorders characterized by persistent and irrational fear of certain events, objects, or situations. Social phobia, specific phobia, panic disorder, generalized anxiety disorder, obsessive compulsive disorders, dissociative disorder and somatoform disorders are most common anxiety disorders.

Anxiety disorders	Symptoms
Social phobia	• Constant and irrational fear of being criticized or evaluated by others. • Avoidance of social situations (e.g. eating in public, public speaking, interacting with opposite sex etc.) • Associated physical symptoms such as blushing, sweating, tremors
Specific phobia	• Persistent irrational fear of specific situation or object • Avoidance of specific situations or objects • Physiological signs of fear or anxiety associated with specific phobic situations or objects • Example fear of closed paces, fear of insects etc.
Panic disorder	• Recurrent attacks of severe anxiety • Anxiety attacks are unpredictable and not restricted to any specific situations, events or objects. • Sudden onset of physiological symptoms such as palpitations, choking sensation, dizziness and chest pain • Secondary fear of dying, losing control, going mad. • Each episode usually lasts for some minutes

Generalized anxiety disorder	• Persistent and excessive tension and anxiety about everyday problems • Physical symptoms such as nervousness, palpitations, sweating, lightheadedness, dizziness, muscular tension and trembling. • Sleep disturbances • Reduced concentration, irritability • Course: Fluctuating and chronic
Obsessive compulsive disorder	• Obsessions (intrusive, unwanted, recurrent thoughts, ideas, or impulses) • Patient's own thoughts and ideas • Unsuccessful in resisting these thoughts • Thoughts produce distress and anxiety • Compulsions (repeated which may be observable or mental activity intended to reduce the distress or anxiety of obsessions.) • Repeated thoughts or acts are not pleasurable e.g. Repeated thoughts of contamination or pathological doubts (obsessions). Repeated washing and cleaning or checking (compulsions)

Dissociative disorders	• Partial or complete loss of memory (certain events, time periods.) • Partial or complete loss of immediate sensations or control of bodily movements. • Sense of being detached from self • A perception of people and things around are unreal or distorted • Considerable degree of conscious control over above symptoms • Fluctuations in the above symptoms to seek attention • Sudden onset and termination of symptoms • No medical evidences to prove the physical symptoms shown by the patient • Above symptoms are in response to a significant stress in relationship, work or any other areas of life
Somatoform disorders	• Repeated complaints about physical symptoms • Persistent requests for laboratory tests in spite of repeated negative findings. • Repeated reassurance seeking from the medical professionals

	• Consultation with multiple medical professionals • Distress and preoccupation about the physical symptoms • Strong link between the onset and continuation of these symptoms with psychological stress or an unpleasant life event.

Substance use disorders or substance dependence: According to World Health Organization (WHO) drug is any substance that, when taken into the living organism, may modify one or more its functions. Substance dependence or addiction is a chronic relapsing disorder which not only affects individual but also the family and society. Alcohol, nicotine, cannabis, opioids, inhalants (glue, petrol, etc.) and other prescription drugs are the commonly seen substances of abuse. Identification of substance abuse or addiction can be made on the basis of self-report data from the patient, clinical symptoms and signs and also by laboratory reports of blood and urine. There is a set of diagnostic criteria given by WHO (ICD-10) to diagnose addiction which is given below,

1. Strong desire or sense of compulsion to take the substance.
2. Loss of control – difficulty in controlling taking substances in terms of onset, quantity of use and termination
3. Physiological withdrawal state – when substance use has stopped or been reduced lead to withdrawal symptoms (e.g. tremors, vomiting, sleep disturbances, restlessness, body pains and aches, sweating etc.)
4. Tolerance – In order to get the effects of the substances obtained with lower doses, person has to take higher doses.
5. Progressive neglect of alternative pleasures or interests – because individual tends to spend more time on procuring and using the substances.
6. Continue to use substances despite of harmful effects caused by the substances.

Duration: Three or more of the above symptoms present together in the previous year.

Organic mental disorders: Organic mental disorders or organic brain syndrome describes decreased mental functions due to a medical condition other than a psychiatric disorder. Dementia and delirium are the major forms of organic brain syndromes seen in general health care practice. Memory loss and cognitive decline are the common symptoms presents by elderly in primary health care system. Symptoms and diagnostic criteria for dementia and delirium are given below:

Dementia	Delirium
• Progressive decline in memory and thinking • Impairment in the activities of daily living (e.g. dressing, personal hygiene, eating, washing etc.)	• Impairment in consciousness and attention • Disorientation and cognitive disturbances (disorientation for time/place/person, Hallucinations and

• Impairment in memory majorly affects registration, storage, and recollection. • Impairment in thinking and reasoning (difficulty to take part in a conversation, difficulty to shift from one topic to another) • The above symptoms are present when patient is in clear consciousness. • Duration: above symptoms are present in last 6 months.	illusion usually visual, Impairment in thinking and comprehension, impairment in recent and immediate memory but relatively less problem in remote memory) • Psychomotor disturbances (increased or decreased level of activity, increased or decreased flow of speech) • Disturbances in sleep (decreased or no sleep at night, reversal of sleep cycle, disturbing dreams or nightmares) • Emotional disturbances (depression, anxiety, fear, elevated mood) • Sudden onset with fluctuating course

COMMON MENTAL HEALTH PROBLEMS IN CHILDREN:

Attention deficit hyperactivity disorder, learning disability and mental retardation are the common mental health problems seen in children though children also are vulnerable to develop other mental disorders like anxiety disorders, mood disorders etc. It is essential to understand the symptoms of above disorders such as mental retardation, attention deficit hyper activity disorder (ADHD) and learning disability.

Mental retardation (MR)	**ADHD**	**Learning disability**
• Impairment in skills • Developmental delay in all the areas such as cognitive, motor, language and social. • Difficulties with functioning in everyday activities of life • Poor academic performance • Difficulty in comprehension especially complex instructions • Developmental	• Impaired attention and over activity • Frequent change from one activity to another activity • Accident prone • Difficulty to discipline • Frequently makes careless mistakes • Frequently lose thing • Easily get distracted or get bored • Often interrupts others or other children in the class. • Earlyonset (within 5years of age)	• Difficulty in reading/writing/calculations • Difficulty in remembering • Trouble in following directions • Problems in staying organized • Inconsistent school performance • Problems in understanding words and concepts • Problems in eye-hand coordination • Difficulty in placing letters in correct sequence/sounding out words • Delayed speech development • Normal IQ

delay can occur with or without any other physical or mental problems		

DETECTION OF MENTAL ILLNESS IN THE COMMUNITY

Mental disorders are highly prevalent and cause considerable suffering and disease burden. Moreover, many individuals with psychiatric disorders remain untreated in the community although effective treatments exist. Untreated mental illness increases the disability associated with it. Therefore, it is very important to detect them early in the community and refer them to a nearest mental health centre. If the detection and treatment are initiated at the early stages of the illness, the recovery will be better and the disability can be prevented to a large extent.

Methods to detect mental illness in the community:

- Mental health awareness to the community
- Capacity building
- Community mental health camp (Camp approach)
- Focusing on risk population
- Use of screening tools

PSYCHOSOCIAL ASSESSMENT

Concept of Psychosocial assessment and Social diagnosis

The word ***psychosocial*** indicates that psychic (mental) needs have a social dimension. This social dimension includes the environment which provides resources for fulfilling various needs. Personality development is also determined and influenced by the social dimensions. *Social diagnosis* is a psychosocial process. It is a process of discovering patterns of significance in the information directly obtained or inferred. It can be arrived through qualitative and quantitative measures, which include clinical interviews, social enquiries (work spot enquiries, school and college enquiries), interviews with significant persons, home and neighborhood visits, assessment of individual, family and social context of the person. These are commonly called as psychosocial assessments.

Psychosocial assessment for severe and common mental disorder

A psychosocial assessment is an evaluation of an individual mental health and social well-being. It assesses the perception of self and the individuals' ability to function in the community.

Severe mental illnesses usually refer to illnesses where psychosis occurs. Psychosis like schizophrenia and bipolar disorders causes loss of reality a person experiences so that they stop seeing and responding appropriately to the world they are used to. A *psychotic episode* commonly isolates the person from others and disturbs peer relationships. Impairment of functioning like in school and work performance is common with the potential for profound damage to future vocational prospects and consequent financial insecurity. It can cause strained relationship in the family and increased psychological morbidity amongst family members. **Common mental disorders** are a group of distress states manifesting with anxiety, depressive and unexplained somatic symptoms typically encountered in community and primary care settings.

Social work assessment in mental health refers to the process of developing with the client a shared understanding of their situation and related problems and strengths. Comprehensive assessment is bio-psycho-social, addressing the physical, psychological and social aspects of the client and their situation. It includes problems and strengths in social role functioning, in meeting financial and other basic needs, in family interactions, significant relationships and other social supports, and cultural factors.

Psychosocial history

The psychosocial history helps us to understand the facts and evidences of the current events and feelings developed as a result of one's life experiences. The information gathered will help to identify the risk and protective factors as well the strengths and resources available for the client.

The psychosocial history can be assessed in the following dimensions : developmental and early childhood history, current living situation, socio economic wellbeing, socio economic status , educational history, occupational history, coping skills, support system, strength assessment, alcohol and drug use history, risk and suicide assessment, legal history, spiritual assessment, cultural assessment, life events ,marital history, family assessment and community assessment .

Psychosocial assessment at individual level:

- **Personal disability**: Self care, activities of daily living, levels of activity
- **Social functioning**: participation in social gatherings, functions, communication and interaction with others

- **Occupational functioning**: income generating activity, responsibilities for domestic and household activities, financial hardships, regularity at work
- **Social roles**: ability to perform different family roles as a spouse, parent
- **Self concept**: Self confidence, any perceived stigma,
- **Motivational level:** Motivation to recover from one's illness, adherence to treatment
- **Accommodation and housing:** living with whom, facilities available
- **Burden:** Impact of illness on the patient, emotional state, expressed fears and anxiety
- **Social support:** Social contacts availability, information and physical support, emotional support
- **Social relationships:** Interpersonal relationships with others, any current conflicts
- **Strengths and resources:** Any vocational skills present, spirituality beliefs, resources available

At family level:

- **Roles of family members**: ability to carry out expected roles, who plays which role, felt difficulties in carrying out roles,
- **Communication patterns of the family**: who speaks to whom, communicating positive and negative feelings, kind of communication
- **Problem solving abilities and coping:** types of problems faced,collective problem solving, ways in which is problems are solved, strategies employed to overcome problems
- **Family risk factors for relapse**: any expressed emotion, diagnosis of mental illness in other members, violence in family, lack of awareness of mental illness, attitude towards medication and treatment
- **Violence**: Any violence experienced as a result of illness or otherwise, family violence, who is involved in violence, kind of violence, extent of violence and any legal issues
- **Burden:** caregivers burden, family's routine activities, minimizing families recreational activities and interests
- **Stigma:** Any negative attitude or discrimination felt by the family from other relatives and neighbours, withholding services because of mental illness, response of relatives, neighbours, school, work place and peers

Psychosocial assessment for survivors of disaster

The following aspects need to be assessed in persons who are affected by disasters : Socio demographic profile and Psychological responses to disaster. Psychosocial assessment of survivors is carried out with the help of both quantitative and qualitative measures. Some of the common assessment tool/scales are: Socio demographic profile, Impact Event Scale, Self Reporting Questionnaire (SRQ).

Psychosocial assessment for children and adolescent problems

Children need to be evaluated in the context of the family, the school, the community and the culture, which means that no child can be assessed in isolation. Simultaneous examination of parental and family functioning is crucial, as is the need for multiple informants. The following aspects are relevant towards understanding child mental health needs:

Pre- and Peri-natal development history like basic functions, psychomotor milestones, cognitive development and school functioning, interpersonal development, emotional development and temperament, trauma history, harmful behaviour , family history of family functioning and about neuro-psychiatric disorders in other members of the family.

Psycho-social assessment of mental health among women

The topic of 'women's health' includes health issues and diseases that are unique to women, such as gynecological conditions; disease that are more prevalent in women and disease that are expressed differently in women and men, meaning that women may present with different symptoms, have more serious form or a different course of illness, or respond differently to interventions. In this, information on menarche, pregnancy, sexual abuse and domestic violence are most pertinent.

Psychosocial assessment of elderly

Many older adults are at risk of developing mental disorders, neurological disorders or substance use problems as well as other health conditions such as diabetes, hearing loss and osteoarthritis. Assessment related to physical functioning, nutrition, vision and hearing and cognitive capabilities is important. In psychosocial status, enquiry should be made on support system,caregiver burden,economic well-being, elder mistreatment, advance directives

Psychosocial assessment of disabled

The term disability refers to any restriction or lack of ability to perform an activity in the manner or within the range considered normal for human being. Psycho-social assessment would further cater to the needs of the individual in making them more self reliant in spite of their disability. Quantification of Disability is done through two major instruments; one is the Indian Disability Evaluation and Assessment Scale (IDEAS) and Assessment of disability in persons with Mental Retardation (ADPMR).

Social diagnosis:

Social diagnosis is a psychosocial process. It is a process of discovering patterns of significance in the information directly obtained or inferred. It is tentatively constructed and refined throughout the whole period of contact with the client. To understand the social

dimension of an individual's psychological construct calls for the expertise of the social worker.

Social Diagnosis can be arrived through qualitative and quantitative measures which include clinical interviews, social enquiries (work spot enquiries, school and college enquiries), interviews with significant persons, home and neighborhood visits, assessment of individual, family and social context of the person. These are commonly called as psychosocial assessments.

PHARMACOLOGICAL MANAGEMENT AND DRUG ADHERENCE

Psychopharmacotherapy should always be a part of a comprehensive treatment plan arrived at after a thorough psychiatric evaluation that result in a diagnosis or a working diagnosis. Some of the common drugs prescribed are:

Schizophrenia: Chlorpromazine, Trifluoperazine, Fluphenazine, Haloperidol and Risperidone

Depression: Imipramine, Amitryptyline, Fluoxetine, Sertraline, Escitalopram, Venlafaxine

Mania: Mood stabilizers like Lithium, Valproate and Carbamezapine or with antipsychotics.

Anxiety disorders: Alprazolam, Bupropion, Acetaminophen, Butalbital and Caffeine, Amitriptyline, Chlordiazepoxide,Clonazepam, Escitalopram, Fluoxetine etc.

Attention Deficit Hyperactivity Disorder: Dextroamphetamine and Methylphenidate
Epilepsy: Carbamazepine, Phenobarbitone, Phenytoin, Valproate etc.

Drug Adherence:

Assessment of Barriers to drug adherence:	**Strategies to improve adherence:**
• Lack of Awareness about illness. • Medication Side-Effects. • Patients' Lack of Belief in Benefit of Treatment. • Barriers to care or medications • Complexity of Treatments. • The perceived costs of Treatment. • Poor relationship with one's health care provider. • Core Psychiatric symptoms. • Missed Appointments. • Inadequate Follow-up or discharge planning etc.	• Define illness from patient perspective/patient point of view • Define Target Symptoms and severity • Empathy & support • Provide Rationale for use of medication. • Elicit Patients Resistance • Disclose the need of medicine and prescribe dose • Convey hope & optimism, • Develop therapeutic alliance • Discuss alternative treatments

PSYCHOSOCIAL INTERVENTIONS

Despite the fact that the main treatment for people with severe mental illnesses has been pharmacological interventions, the partial and limited control of the symptomatology, the short and long-term side effects, and the poor treatment adherence of quite a considerable percentage of people affected, pose the need to use a broader approach, where pharmacological treatment is complemented with other psychotherapeutic and psychosocial interventions, which must be efficiently coordinated and applied to help them recover from acute episodes and from the functional deficit during the episodes and between them.

Caring for mental illnesses no longer just means relieving symptoms but it also means having to cope with the different resulting needs. All in all, caring for these people requires integrating psychopharmacological interventions and psychosocial interventions into a mental health network comprised of interdisciplinary teams.

Psycho-social interventions can be broadly grouped into:

- Individual patient interventions
- Family interventions
- Community based interventions
- Programmes aimed at leisure and spare time
- Programmes aimed at vocational skills training, sheltered employment etc.
- Day centres and/or psychosocial rehabilitation centres
- Community Mental Health Centres
- Intensive Case Management Approach and Assertive Community Treatment etc.

Psychosocial intervention at Individual Level:

- To improve the individual functionality.
- To help with relationships and communication.
- Supportive Psychotherapy
- Social Skills Training
- Vocational Skills
- Training
- Placement- Place & Train or Train & Place
- Cognitive Retraining
- Psycho education
- Attitudinal change
- Job placement
- Follow-up services
- Case management
- Encourages to participate in social roles

Psychosocial Intervention at family Level

- Build a relationship with care givers based on empathetic understanding
- Focusing on the strengths of caregivers and assisting them to identify community resources.
- Promote Medication compliance.
- Promote early identification of relapse and swift resolution of crises.
- Reduce personal and social disability.
- Reframe expectations and moderate the affect in the home environment.
- Emotional support to caregivers.
- Develop self-help groups for mutual support and networking among families
- Provide information about services, welfare benefits.
- Address family burden
- Strengthen the coping strategies of family
- Provide crisis management
- Respite care
- Deal with expressed emotions in the family
- Provide family support services

Psychosocial Intervention at Community Level

- Community Based Rehabilitation
- Self Help Groups
- Awareness of Welfare measures
- Critical Evaluation/Review of Existing MH Policies
- Address myths and misconceptions about mental illness and mental retardation in the community
- Work with faith healers, youth leaders and village leaders to create awareness
- Promote community care of mentally ill
- Make home visits in the community
- Eradicate Stigma and Discrimination
- Educate the community through campaigns
- Identify resources available in the community
- Enhance the social and community network and support system

PSYCHOEDUCATION

Psycho-Education is an educative method based on clinical findings for providing information and training to families with psychiatrically ill persons to work together with mental health professionals as part of an overall clinical treatment plan for their ill family members.

Basic Components of Psycho-education

- Basic facts about disorder
- Stress-Vulnerability model of psychiatric disorders
- Medication
- Early warning signs of relapse

Focus of Psycho-education is on:

- Relapse Reduction/Prevention
- Increase medication Adherence
- Increase satisfaction with Mental Health service delivery System
- Improve Quality of life
- Overall well being of client & Caregivers

PSYCHOSOCIAL REHABILITATION

The main focus of rehabilitation is the functioning of people in their normal environments, improving their personal and social skills, giving support for them to undertake the different roles of social and community life. The aim of psychosocial rehabilitation is to help people with severe and persistent mental illnesses develop intellectual, social and emotional skills that they need to live, learn and work in the community with the least possible professional support.

Psychosocial rehabilitation, also called psychiatric rehabilitation consists in "a series of psychosocial and social intervention strategies that complement the pharmacological interventions and management of the symptoms, and whose aim is to improve personal and social functioning, quality of life, and support to the community integration of people affected by severe and chronic mental illnesses".

Goals of psychiatric Rehabilitation:	**Strategies**
• Activities of daily living • Behaviour of daily living • Opportunities • Identification of community resources • Independent • Empowerment of the client • Recovery • Quality of life • Community advocacy • Increase Coping skills • Increase social support • Satisfaction of basic needs • To increase Interpersonal skills • Improvement of his social network • Diminishing the impact of psychiatric symptoms	• Psycho education • Independent living skill training • Basic living skills training • Communication Skills Training • Social skills training • Vocational training • Activity scheduling • Supportive counseling • Horticulture Therapy • Recreational Therapy • Behavioral intervention

The rehabilitation of persons with severe mental disorders can be practiced both in the residential and non residential set up. The various kinds of facilities available in these settings are provided below:

Residential Facilities	***Non-residential Facilities***
• Psychiatric hospitals • Halfway Home • Foster homes • Hostels • Long-term facilities	• Day hospitals • Day care center • Sheltered workshop • Vocational rehabilitation

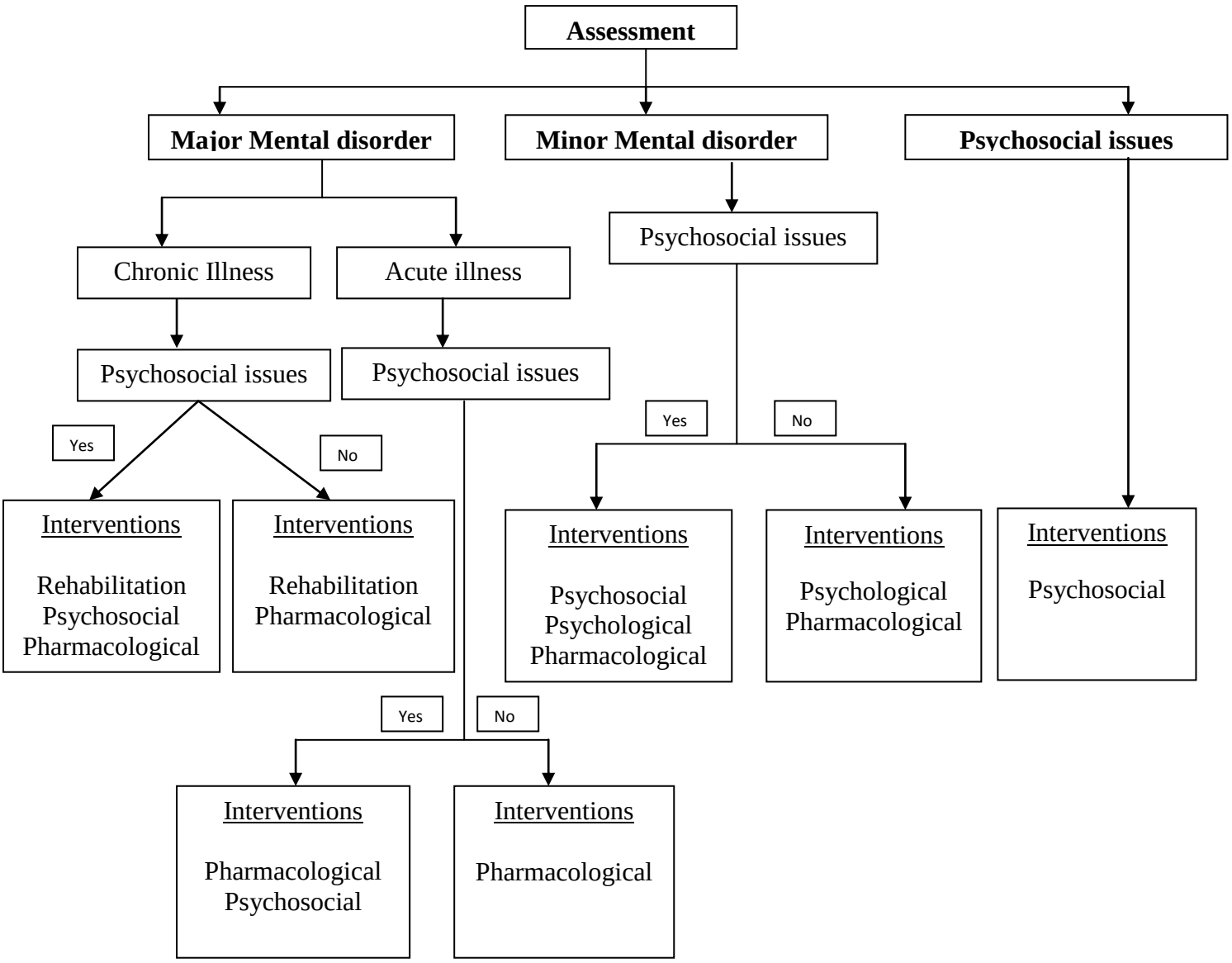
The Social Workers need to also facilitate the vocational rehabilitation programmes available in the community to persons recovering from mental disorders. The Social worker working in this set up has multiple roles to play.

• Working with family • Working with groups • Working with individual • Community Organization • Home/ office/ school visits • Family Guidance and counseling services • Training volunteers, various Professionals • Referrals • Advocacy	• Teamwork • Networking • Supervision • Coordinator • Consultation • Skills training • Correspondence • Resource mobilizing • Interagency collaboration • Community liaison and consultation • Researches in Psychiatric Rehabilitation

Social workers need to work for comprehensive recovery of individuals with mental disorders. For this, they need to work with the individual client, the family and the community.

A comprehensive rehabilitation planning that is well coordinated, multidisciplinary in nature, involves working with the client, his family and the community, and makes the optimum use of community resources helps in the comprehensive recovery of those recovering from severe mental disorders.

FLOW CHART FOR ASSESSMENT AND INTERVENTIONS



Directorate Geneal of Health Services
Ministry of Health and Family Welfare
Government of India

National Institute of Health and
Family Welfare