MENTAL HEALTH SERVICES

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This block focuses on the mental health services that are available for the people with mental illness with special focus on the present scenario in India. It will cover aspects of community mental health care in Indian setting, rehabilitation of people with mental illness and procedure for certification. Thus, the course will help in focusing on the management of the people with mental illness beyond hospitalisation and medications.

**Unit 1** will deal with the mental health services available especially in India. This unit focuses on the term community mental health. It further deals with the history of community mental health in Indian context. Research in community mental health will also be covered in this unit.

**Unit 2** deals with the rehabilitation of the mentally ill persons. Various topics related to psycho-social rehabilitation, social skills training, vocational rehabilitation will be covered in this unit. The unit will also discuss the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), Persons with Disability Act (PWD Act), 1995 and the Rehabilitation Council Act of India (RCI Act). It will also focus on the National Trust for the Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities, the role of Government in rehabilitation and recent initiatives and the role of the NGOs towards psychosocial rehabilitation in India.

**Unit 3** covers certification for different issues related to mental illness (including disbursement of pension etc. It deals with medical certificate for involuntary hospitalisation (Indian Mental Health Act, (IMHA) 1987), certificates in services/jobs and related issues, benefits of certification, assessment of disability in mental retardation and certification, Indian Disability Evaluation and Assessment Scale (IDEAS), Indian Scale for Autism Assessment and assessment of multiple disabilities.
1.0 INTRODUCTION
The World Health Organization (1948) defines health as “a state of complete physical, mental and social well being and not merely an absence of disease or infirmity”. And recently ‘the ability to lead a socially and economically productive life’ has also been included in the above statement. Thus, in addition to being physically and mentally healthy, a person also has to be ‘socially’ healthy. He/she has to be productive in the society. Hence, the role of a person in the community is very much important for his/her overall health status.

From the perspective of mental illness, in the past, asylums were the place where the mentally ill people were kept and treated. Later on, these gave away to mental hospitals. However due to various reasons, it was seen that while a large number of people suffering from mental illness was increasing, the treatment facilities and the availability of specialists in the field of mental health were very less. Even less developed was the availability of treatment for the people with mental illness at the community level. Thus, a branch of Psychiatry relating to the treatment and care of the patient in the community level was the need of the hour. Needless to say, the era of “community mental health” had begun, albeit a bit tediously.
Community mental health, in very broad and simple terms, refers to the care and services provided to persons with mental health problems and their families in community settings. In developing countries such as India, community settings would include a person’s home, large joint family setting, a general practitioner’s clinic, a government run Primary Health Centre, Community Health Centre or a District Hospital, a non-hospital residential facility such as a Half-Way Home or hostel run by NGO, a private Psychiatrist’s office/clinic, a counselling centre or a rehabilitation centre in a community location running day programs and providing a range of other community based services.

1.1 OBJECTIVES

After studying this unit, you will be able to:

- explain the history of community mental health in India;
- describe the different community mental health models that are in use in India;
- discuss why there is a need to treat some mental illnesses in the community;
- be able to identify the common mental illness and treat them in a community setting; and
- explain the present scenario in the field of community mental health in India including the District Mental Health Programme.

1.2 HISTORY OF COMMUNITY MENTAL HEALTH IN INDIA

Mental illnesses have been documented since earlier times. In India, ‘Ayurveda’ did deal with mental illness and the practice of Psychiatry was known as ‘Bhoot Vidya’. Later on during the era of British colonization, mental asylums came into being which eventually gave away to the mental hospitals of the present time.

After India gained its independence, the entire health system underwent a massive revamp following the suggestions of the ‘Bhore Committee (1946)’. However in the field of mental health, little progress was made. There was hardly any community based intervention for people with mental illness. Initially family involvement was the only aspect of treatment and care, so far as community involvement was concerned. Such involvement of family members can be traced back to 1920 when cottages were constructed in the Central Institute of Psychiatry, Ranchi (presently) wherein patients would be admitted along with family members. Post-independence, family involvement started in 1950s (Carstairs, 1974; Srinivasa Murthy, 2007; Vidya Sagar, 1973). Mention must be made about Dr. Vidya Sagar who started his innovative ‘camp approach’ wherein families were also involved in the treatment and care of the mentally ill. He put up tents within the hospital premises and requested the relatives of the patient to stay there and take care of the patient there. This also led to the setting up of general hospital psychiatric beds. 1975 saw the integration of mental health with general health services, which was called as community psychiatry initiative, and was employed to enhance and develop mental health services.
Self Assessment Questions 1

1) Describe the contributions of Dr. Vidya Sagar.

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1.3 COMMUNITY MENTAL HEALTH

In certain acute cases of mental illness or its aggravation, hospitalisation is often the rule. Apart from these circumstances, in a number of situation, treatment is possible in the community settings too. This section explores some of the models of community mental health care in our country.

1.3.1 Community Mental Health Models

Integration of mental health into primary health care: Two landmark studies conducted at two different places in India demonstrated that mental health can be integrated with primary health care (Murthy and Wig, 1983; Wig et al, 1981). This in a way led to the development of the National Mental Health Program (NMHP) in 1982. The goal of NMHP was to integrate mental health services into primary care. As a result of initiation of NMHP, the District Mental Health Program (DMHP) was started following the success of Bellary district (in Karnataka). The DMHP is currently implemented in 123 districts and there is a plan to extend it to all the districts in the 12th Five Year Plan. In addition to convenience and feasibility, another guiding principle for integration of mental health into primary care is the fact that 10 to 25% of those attending primary care have some form of psychiatric disorder (Cohen, 2001; Patel et al, 1998).

Initially it was decided that after brief training of primary health care staff, the mental health cases would be taken up by the staff of Primary Health Centers (PHC). However due to several reasons, like heavy work load of medical and surgical cases, implementation of other mental health programs etc, the government decided to support manpower through the DMHP. Presently, the DMHP has a multi-disciplinary team comprising of Psychiatrist, Clinical Psychologist, social-worker, a nurse and a clerk.

Advantages of integration of mental health into primary health care are:

a) An alternate treatment facility for people with mental illness that is accessible.

b) Increase in the number of trained manpower in the field of mental health.

c) Reduction in stigma as a result of shifting mental health care to the primary care.

d) Leads to improvement in early detection and treatment.

e) Results in cost efficiency and savings.

f) In a way it counterbalances the limitations of mental health resources through the use of community resources.
Mental Health Services

Treatment through the DMHP was provided for a number of disorders like psychosis, affective disorders, anxiety spectrum disorders, epilepsy, and child mental health problems and so on. Some of the medicines were also provided free of cost to the patients.

Progress and short-comings: During the mid-course evaluation of the DMHPs in 27 districts in 2003 by a team of experts from NIMHANS, it was reported that the program was functioning at different levels of efficiency contributing to different levels of outcome. Many of the DMHP in most states had shown satisfactory progress at various stages of implementation. On the flip side, though there is a provision for the training of community leaders under DMHP, community participation is minimal. There is a need for linkages with the community through the training of ANMs(Auxiliary Nurse Midwifery), ASHA (Accredited Social Health Activist) and PHC (Primary Health centre) level paramedical staff and ensuring involvement of the family members and the community. The services at sub-center, PHC, CHC (Community Health Centre) level also need to be strengthened and made more accessible to the patients.

Satellite Clinics (or Out-reach Clinics): Some teaching hospitals in India have established out-patient treatment services to reach out to patients who cannot reach hospital based facilities. Often such services are provided by professionals (Psychiatrist, Clinical Psychologist, Social Worker, Nurse) from the teaching hospitals, who have additional responsibility of teaching, clinical care of the patients in the hospitals and research. Most such satellite clinic functions once a week. Some Institute also provides once a month treatment.

Ideally, for a satellite clinic to be successful:

a) It must be located in a health set up like Dispensary, PHCs etc.
b) It must have referral arrangements to tertiary centers for emergencies.
c) The community has to be informed regarding whom and where to seek help after clinic hours.
d) Linkages must be developed with other mental health care facilities in the community.

The advantages of satellite clinics are as follows:

a) Early diagnosis and treatment of common mental illness in community settings.
b) Easy accessibility and reduces stigma on the part of the patient.
c) Patient discharged from tertiary hospital care can be followed up in the satellite clinic, thus reducing the work load of the tertiary care hospital and at the same time benefitting the service users in terms of reduced travel expenses and reduced waiting period for consultation.

Self Help Group (SHG) and Support Groups: Self Help Groups are voluntary, small groups of persons facing similar problems and they come together for a special purpose. They are usually formed by care givers who come together for mutual assistance in handling a common handicap or life-disrupting problem. The indicators and members of such group perceive that that their needs are not addressed by existing government programs and social institutions. Self Help Groups emphasise face-to-face social interactions and the assumption of personal
responsibility by members. They often provide material assistance as well as emotional support; they are frequently cause oriented, and promulgate an ideology or values through which members may attain an enhanced sense of personal identity.” This definition provided by Katz and Blender (1976) is possibly the most comprehensive definition of Self Help Groups.

From the perspective of Clinical Psychiatry, perhaps one of the well known SHG is the Alcoholic Anonymous (AA). It is a group formed by people who have alcohol related problems and who want to quit alcohol. SHGs are involved in solving the practical problems and psychological sorrows of sufferers (Lock, 1986) and are involved in curative, preventive, promotive, palliative and rehabilitative services (Nayar et al, 2004). SHGs are complementary to medical services and not substitutes to medical treatment (Moeller, 1983). A characteristic of SHG is that their members are simultaneous givers and receivers of help.

**Therapeutic Community (TC):** The concept of therapeutic community was initiated by Tom Main in 1946 and popularised by Maxwell Jones. It is a residential facility for a variety of disorders like mental illness, substance abuse and even for prisoners. Based on the principles of social learning theory, TC is a tertiary preventive measure to reduce the impact of maladaptive behaviour and enhancing the rehabilitation efforts through the environmental approach (Carson and Butler, 1992).

The TC believes that people can change and that learning occurs through challenge and action, understanding and showing common human experience. The TC model incorporates elements like active participation, membership feedback, role modeling, collective formats for guiding individual change, open communication, individual and group relationships and a unique technology.

In TC working for those with mental illness, involves continuous risk assessment and management, helping client identify unhealthy aspects of their personality and instilling a sense of responsibility in the client (that the harmony of the community depends on him/her). Some TCs like ‘Aatma Shakti Vidyalaya’, Bengaluru, have additionally incorporated methods of transactional analysis (re-parenting) as part of therapy (Kumar and Srinath, 2009).

**Crisis Intervention Team (CIT) and Helpline Services:** In a community many a times, a person may have acute psychological distress, for example, a depressed person having repeated thought of suicide or an intoxicated person may have acute psychosis. In such emergency cases certain groups of trained persons are available, especially in the developed nations, who provide immediate care and that too at the affected person’s door step. These people form what is known as ‘Crisis Intervention Team’. In developed nations they are a part of the case management approach wherein any required service including non-pharmacological service is provided at all hours of the day. Such CIT may include Psychiatrist / Psychologist, Paramedics and Psychiatric Nurses.

Helpline services are basically the provision of telephone services to assist and guide people regarding health related issues. Helpline programs related to Psychiatry include Suicide Prevention Helpline, Smoking Cessation Helpline, and Child Helpline etc.
Mental Health Services

Calls to the help lines are initiated by the client and are available round the clock. Helpline services usually offer counseling (psychological first aid) provided either by trained volunteers or by trained psychotherapists in crisis situation. Some helpline centers also follow-up with clients that have called (call-back) to know if further help is required or direct them to appropriate services. Some of the suicide helpline available in India are: Sneha (Chennai), Aasra (Navi Mumbai), Samaritans Sahara (Kolkata), Aasha (Chandigarh).

Out-patient camps: This unique approach was initiated by teams of Psychiatrists from Pune and Miraj in Maharashtra (Deb Sikdar et al., 1976 and Luketuke et al., 1978). These early camp involved case identification and treatment initiation as out patient service.

The Department of Psychiatry, Government Medical College and Hospital, Chandigarh, have been conducting one day camps within Chandigarh for the past 15 years. The approach was basically used for identification of patients and to encourage them to seek treatment at feasible locations. Basically these camps were ‘awareness-cum-motivation’ camps and intervention was limited to the initiation of treatment.

Some of the limitations of out-patient camps are:

- Post-camp patients frequently needed expert advice and consequently had to travel to the base hospital.
- Arranging free medications was not always possible.
- Prescription would not be renewed due to unavailability of the specialist after the camp.
- Significant man hours were lost in seeing non-psychiatric cases who reported to the camp.

Para-institutional Care (Half Way Home and Day Care Centre): A Half Way Home (HWH) is a rehabilitation facility for individuals such as patient with mental illness or substance abusers, who no longer require the complete facilities of a hospital or other institution, but who are not yet prepared to return to their communities. HWH assist persons who have left highly structured institutions to adjust to society in order to re-enter it and live within its own accepted norms. The intervention provided are those that improve skills, improve interpersonal communication and provide vocational training.

School Mental Health: In India, child and adolescent Psychiatry is not very well developed. With 47% of the population of the country below 19 years of age and an estimated prevalence of 15% of psychiatric issues in their population, the treatment gap is huge for Psychiatric services (Malhotra, 2004).

NIMHANS, Bengaluru developed the School Mental Health Program to overcome these service provision deficits. Their model is an integrated one, using resources already available in the schools. Teachers are trained as ‘master trainers’ who further conduct training for other teachers to be ‘life skill teachers’. It is a participative program focusing on experimental and peer learning. The activities are based on various developmental themes of nutrition, hygiene, academics, inter-personal relationships, substance abuse, gender issues, career and social responsibility (Bharath et al., 2008).
Home Based Community Programs (Domiciliary Care): Mental Health programs that deliver mental health services by case management approach at client’s door-step may not be envisioned at least for the next few years. However, many institutions in India have attempted this, albeit on an experimental basis, primarily in limited localities and by providing pharmacological treatment only (Chavan et al., 2010; Pai et al., 1985)

While planning for home based treatment options, it is necessary to adequately train the staff involved. Training should include identification of symptoms, ability to judge worsening/improvement of symptoms, identify treatment related side-effects, motivating patients for compliance and addressing family concerns including stigma associated with mental illness. Patients must be provided with contact number so that there is no delay in treatment seeking, if required.

Telepsychiatry: Telepsychiatry, subsumed under telemedicine, has been in existence for over 50 years. Telepsychiatry involves a host site (where the clinician works) and a remote site (where the patients are seen)

The advantages of telepsychiatry are as follows:
- Improves accessibility of services in rural areas and areas that are far from tertiary care.
- By providing a suitable alternative, and cutting down on travel time, the psychiatrist is able to serve in a more time-efficient way.
- By coordinating with the primary health professional, it provides continuing education to the primary doctor, thus reducing provider isolation

In India, use of telepsychiatry has been reported by some institutions. Schizophrenia Research Foundation (SCARF), Chennai, has reported successful use of this method in collaboration with Indian Space Research Organization (Thara et al., 2008). In recent times, the department of Psychiatry, PGIMER, Chandigarh is also in the process of developing telepsychiatry services.

Faith Healers: Services provided by faith healing groups are neither standardised nor scientific, and vary considerably in the intervention provided. The interventions include blood letting, exorcism, removal of insects from the head, prescribing amulets (tabiz), extortion, oblation (bali) and many other such procedures.

Though not exactly a model in community Psychiatry, still they may have an important role to play. This group possibly attracts less stigma compared to mental health services and may be regarded as easily accessible.

The World Health Organisation (WHO) has long advocated local level policy of close collaboration between the conventional health system and traditional medicine, particularly between individual health professionals and traditional practitioners.

1.3.2 Need for Treatment of the Mentally Ill in the Community

Though, the acute cases and those patients who have relapsed need treatment in a hospital setting, a large number of patients can be treated in the community.
During the period beginning from 1980s, efforts have been directed to develop and evaluate the community based mental health programs. One of the first such studies was from Chandigarh which examined the utility of a team consisting of a Psychiatric Nurse and Psychiatric Social Worker in providing care in the community for persons suffering from chronic schizophrenia (Suman et al., 1980). This was soon followed by a major research effort which compared home-based care with hospital care (Pai and Kapur, 1982, 1983; Pai et al., 1983, 1985). Recent research studies have addressed the situation of persons suffering from schizophrenia and the effectiveness of community level interventions (Chatterji et al., 2003, 2009; Srinivasa Murthy et al., 2004; Thara et al., 2004; Thirthahalli et al., 2009, 2010).

The process of deinstitutionalisation led to increased focus on community based care. Studies started to report on the effectiveness of community psychiatric interventions in both the developed as well as developing nations (Araya et al., 2003; Patel et al., 2003).

The need for treatment in the community was further reinforced by studies which have shown that the cost of providing care in the community is considerably lesser compared to hospital based care (Dauwalder and Ciompi, 1995; Hafner and Heiden, 1989; Mitchel et al., 1990; Goldberg, 1995). Most cost advantages are obtained by shortening or even eliminating the initial period of in-patient care (Goldberg, 1995). The lower daily cost of living accommodation for deinstutionalised patients easily offsets the cost of services required for treatment in the community.

Thus, in short we cannot undermine the fact that there is indeed a need for community based treatment of the mentally ill.

1.3.3 Institutional Care versus Community Care

It seems treatment in the community settings have numerous advantages. Studies have reported the cost effectiveness of treatment in community settings (Dauwalder and Ciompi, 1995; Hafner and Heiden, 1989; Mitchel et al., 1990; Goldberg, 1995). Further it has been suggested that a closure of mental hospitals lead to savings which can be infused into developing community care services. These savings more than offset the funds used to expand community services (Kaumis-Gould et al., 1999).

Studies have shown that maintenance costs may also be less in the community care settings. For example, a study by Dawlder and Ciompi (1995) over a ten year period has shown that direct daily costs for community based social psychiatric care were about half that of in-patient treatment over the whole period. The WHO-Choice program found that treatment of severe mental disorders in the community care settings costs 35 to 50 per cent less than hospital based care in developing countries (Chisholm D, 2005, Chisolm D et al., 2008).

Recent studies have tried to integrate cost of care with out-come, in either monetary or non-monetary terms. Cost-benefit analysis (using monetary terms in outcome) has shown that added benefits are clearly more than added costs (Weisbroad et al., 1980). Studies measuring outcomes on other domains have also shown that care in the community is more cost effective than hospital based care (Dickey et al., 1997; Weisbroad et al., 1980). Also most of the studies have
expressed improved outcomes in terms of improved satisfaction with services as perceived by patients and their care-givers (Hoult and Reynolds, 1994).

Some recent studies have also evaluated other outcomes like symptoms and social adjustment and have found positive outcomes (Knapp et al., 1998; Reinharz et al., 2000). WHO-Choice program also replicated the findings that community based treatment for severe mental disorders is more cost-effective compared to hospital based care, with cost-effectiveness ratios estimated to be 25-40 per cent lower (Chisholm et al., 2000). Even in acutely ill people (where hospital based care is considered to be more effective), residential crisis program have been tried and found to be cost-effective compared to hospital based care (Fenton et al., 2002). The residential crisis programs had near-equivalent effectiveness and reduced cost of services.

Though it seems that community care has several advantages, even then, all is not so straight forward. The Health Evidence Network (HEN) synthesis report on community mental health mentions: There is no compelling argument or scientific evidence that favours a mental health care model focused on hospital care alone. On the other hand, there is also no specific evidence that community services alone can provide satisfactory comprehensive care. Available evidence and accumulated clinical experience in many countries support a balanced care model that includes elements of both hospital and community care. Nevertheless, local communities may have strong views on developing such mental health services in their midst.

**Self Assessment Questions 2**

1) Who initiated the concept of “Therapeutic Community”? Describe the Concept

2) Name the district whose success in integration of mental health with primary care led to the commencement of the District Mental Health Programme in India?
3) Name a self-help group formed by people who have alcohol related problems and who want to quit alcohol.

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4) What do you understand by “helpline” services in Psychiatry?

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1.4 COMMUNITY MENTAL HEALTH IN INDIA

The story of community mental health in India is very different from the West. In India persons with mental disorders traditionally have always been treated in the community. Such persons were generally taken care of by the family, the larger community and traditional healers. Asylums, which later became mental hospitals, were opened in India, initially by the British East India Company and later by the country’s colonial rulers, primarily for British soldiers and British nationals who suffered from mental disorders. More mental hospitals were also built after India’s independence. Bold reforms involving the family members of those admitted to the hospital were initiated as early as the mid 1950s and 1960s in mental hospitals at Amritsar and Agra and certain centers, as Vellore. During the late 1970s and 80s, the Community Mental Health Unit at NIMHANS developed an approach and strategy for integrating basic mental health care with the existing general health care services in India. Initially it was tried in various PHCs in Karnataka state and later it was expanded to the whole district, in Bellary district of Karnataka. The overall strategy which evolved after 5 years of trial in Bellary came to be known as the ‘Bellary Model’ of District Mental Health Program (DMHP) and was adopted by the Ministry of Health and Family Welfare, Government of India for staggered country wide implementation as a fully centrally funded program (Issac, 2011; Srinivasa Murthy, 2011). Thus the era of community mental health had slowly begun in India.

1.4.1 Present Scenario

In 1982, India was one of the first countries in the developing world to formulate a National Mental Health Programme (NMHP). But budgetary allocation for the NMHP was made only since 1996-97, during the ninth (1997-02), tenth (2002-07) and the eleventh (2007-12) Five Year Plan by the Government of India.

The NMHP is now accepted as a relative low-cost, high yield public health intervention which is a doable as shown in states such as Kerala and Gujarat...
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(Goel, 2011). The country is also on the threshold of seeing a new National Mental Health Care Plan with specific reference to NMHP and DMHP, with specific strategies and activities to implement the priority areas of action identified in the National Mental Health care policy and an estimate of financial resources required to implement the plan by April, 2002 according to the ‘Terms of Reference’ of the Policy Group (Government of India-MOHFW, 2011).

In addition on 30th August, 2011, a Memorandum of Understanding (MoU) was signed between the Ministry of Health and Family Welfare, Government of India and the University of Melbourne, to effectively develop Community Mental Health in India. Four centers were selected to develop a tribal model, model for rural area, urban model and an extended outreach model. The selected institutes for these four models are Central Institute of Psychiatry and Ranchi Institute of Neuro-Psychiatry & Allied Sciences(RINPAS) (Jharkhand; Eastern region; tribal model), Ahmedabad Mental Hospital (Gujarat; Western region; model for rural area), Department of Psychiatry, Government Medical College and Hospital (Chandigarh; Northern region; urban model) and Madurai Medical College (Tamil Nadu; Southern region; extended outreach model). The project is likely to start in the first quarter of the year 2013.

1.4.2 DMHP and its Role in Community Mental Health

The DMHP was conceptualised to understand the feasibility of providing basic mental health care for the entire district. The experience with respect to integration of mental health care in primary health care before this was largely confined to the population reached through primary health centres. The DMHP was pilot-tested to understand the feasibility of Mental Health care programme on a public health platform in the district of Bellary, Karnataka, covering a population of 1.5 million people. The effectiveness of the DMHP in Bellary resulted in the implementation of this model in several states in the country.

Currently, over 125 districts implement the DMHP with financial assistance from the Ministry of Health, Government of India.

Aims and objectives of DMHP: The aim of the DMHP is to extend mental health services to persons suffering from mental disorders in the district through the existing health care personnel and institutions. The mental health services should cater to the need of persons with psychosis, depression, neurosis, mental retardation and childhood mental health problems, substance use disorders and epilepsy. The trained PHC personnel are to be provided support and supervision on a regular basis to empower them to provide holistic care to the population. The progress of DMHP is to be monitored by developing systemic mechanisms like review meetings, on-the-job training to refine skills, and improved coordination between the agencies to facilitate implementation of the DMHP.

The specific objectives of DMHP are as follows:

a) To develop and implement a decentralised training program in mental health for all categories of health personnel appropriate to their levels of functioning with the least disruption to the ongoing general health care activities.

b) To provide a range of essential drugs (anti-psychotics, both oral and parenteral; anti-depressant; anti-convulsants; minor tranquilizers) for the management of persons with mental disorders.
c) To develop a system of simple recording and reporting of case by health care personnel.

d) To monitor the effect of service programs in terms of treatment utilisation and outcomes with treatment.

It was envisioned that the DMHP would be launched in all the states of the country after training the Psychiatrist/Program Officer and other members of the team in the philosophy of decentralised care within the district as in any other National programme. The district mental health team consisting of the psychiatrist will conduct training programs for the primary health care personnel to provide essential mental health care for the entire population of the district through primary health care services in an integrated manner.

However DMHP probably didn’t progress as smoothly as it was supposed to. Several authors have looked into the lacunae of the DMHP and have offered corrective suggestions (Goel, 2011; Isaac, 2011; Jacob, 2011; Patel, 2011, Srinivasa Murthy, 2011). Most experts believe that the DMHP has failed to “integrate mental health care delivery into primary care due to a wide variety of administrative, managerial and technical reasons”. However, experts observe “……the programme has ensured wider availability of essential psychotropic medication…” (Jacob, 2010), the DMHP is “essentially a psychiatrist led outpatient clinic in district hospitals” (Patel, 2011) and “major gains have been made…..”. The country can soon expect a “radical revision and re-hand of the dysfunctional NMHP” and a “re-written” DMHP for the 12th Five Year Plan (2012-2017) in independent India’s first mental health policy as in early 2011, the Ministry of Health and Family Welfare, Government of India, constituted a mental health policy group comprising diverse stakeholders (Patel, 2011).

Role of DMHP in Community Mental Health: Though the DMHP had several hurdles on its way, it did contribute to community mental health.

a) Manpower development: The DMHP helped in increasing manpower pertaining to mental health. Overall 55% of health personnel confirmed that they had received training and more than half of the health personnel (54.7%) were satisfied with the training programme.

b) Availability of drugs: 25% of the districts reported a regular inflow of drugs. The rest of the districts faced difficulties in maintaining regular availability. However 80% of the beneficiaries across districts also indicated that they received at least some medicines from the health centers.

c) Access to treatment facilities: About 61% of the beneficiaries accessed the district hospital as their first point of contact. The percentage of patients accessing CHCs (12.7%) and PHCs (11.5%) were found to be low. Again 18% of the total respondents confirmed that they were referred to the district level for treatment.

d) Awareness about mental illness and its treatment: In the DMHP districts, 86.9% of the community members contacted knew about mental illness which is higher than in non-DMHP districts (74.7%). Awareness about the type of mental illness namely psychosis, neurosis, epilepsy etc were found to be significantly higher in the DMHP districts compared to non-DMHP districts. More than half of the respondents from the DMHP districts agreed that proper
medication and counseling could help in the treatment of mentally ill people, against only 30% in non-DMHP districts. 70% of the respondents in the DMHP districts also recommend treatment at a hospital.

Thus, it can be seen that right from promoting awareness about mental illness to its treatment, the DMHP had played a wide role in the community.

### 1.4.3 Role of Village Panchayat, “Sarpanch”, Municipal Councillors etc. towards Promotion of Positive Mental Health

The Public Health Agency of Canada (PHAC) definition looks at five potential components of positive mental health. These are:

a) Ability to enjoy life.

b) Dealing with life’s challenges.

c) Emotional well being.

d) Spiritual well being.

e) Social connections and respect for culture, equity, social justice and personal dignity.

In a community its leaders and representatives like the ‘Village Panchayat’, ‘Sarpanch’ (in rural area) Municipal Councilors (urban area) etc. have a wider role in promotion of positive mental health, so that all these five components are well received by the community. These leaders often have a larger say in the key decisions related to the development of the community as a unit. The people also look up to them for various purposes, both personal as well as non-personal. These leaders have often contributed in promotion and coordination of various health related activities. These representatives are a part of community resources, which are helpful not only in sensitizing the community about psychiatric illness, but also encourage community participation in therapeutic process.

In Indian context mention may be made here about the formation of the Mental Health Association at Raipur Rani (in 1978). This was formed by the community members of the villages in Raipur Rani Block in Ambala district of Haryana. The aim of this association was to support the service activity, educate the public to accept the modern treatment, rehabilitation of those recovering from illness and impress the state machinery for the needed service. This association has been functioning in a limited way during last two to three years. The village leaders have been meeting periodically and sharing their experience as well as supporting certain activities.

In the camp method of treatment carried out by the Department of Psychiatry, Government Medical College, Chandigarh, often the leaders like ‘Sarpanch’ and Municipal Councilors not only extend their cooperation in organization of these camps, but they were also instrumental in motivating the local people to attend these camps for treatment of mental illness. In fact the first camp by the Department was conducted by invitation from community leaders of village Palsora in Chandigarh (Chavan and Arun, 1999). This was soon to be followed by many such camps in a number of places in Chandigarh.
1.5 RESEARCH IN COMMUNITY MENTAL HEALTH

Academic research that takes place outside the laboratory is becoming an increasingly important force in addressing and helping communities resolve local programmes. Academic researchers use different terms to describe this kind of inquiry, including applied research partnership. In community research some of the principal methods used are:

a) A case-by-case phase (Natural observation method): Here the researcher collects detailed information from case to case to provide basic facts in many areas.

b) The Experimental Design: The experimental design uses appropriate control and statistical tests of significance to provide results with a greater degree of certainty.

c) The Survey Method: It is a systematic investigation, whether by questionnaire, interview or reading of the records and analysis of the characteristics of large group of individuals or agencies or institutions who have been randomly selected from a larger population with given characteristics so that they are representative of this population.

d) The Epidemiological Method: Epidemiological inquiry is designed to measure the risk of attack by specific disorders within communities and to uncover clues about their origin and mode of spread. These clues are gleaned from the distribution of diseases in relation to time space or the distinguishing characteristics of the individuals or social groupings which are affected. In the study of mental disorders, the epidemiological approach has been used to investigate genetic, physical, psychological and social factors in the etiology and evaluation of mental illness.
e) **Community Based Participatory Research (CBPR):** CBPR (Wallerstein and Duran, 2003) is a collaborative approach to research that equitably involves all partners in the research group and recognizes the unique strengths that each brings. CBPR begins with a research topic of importance to the community and has the aim of combining knowledge with action and achieving social change to improve health outcomes and eliminate health disparities. CBPR differs from more traditional forms of research by involving community members at the levels of input (communities initiate research ideas and projects), process (communities remain intimately engaged throughout data collection and interpretation phases) and outcome (communities play significant roles in mobilizing the knowledge attained in CBPR projects for social change).

f) **Practice-Based Research Networks (PBRN):** PBRN were developed in North America (AAFP, 1998) more than twenty years ago to study the health and health care events that are common in everyday primary care practice. During the past two decades, the number of PBRNs has increased and they have made major contributions to the science base of health and health care.

g) **Participant Observation:** It is a type of research strategy which is widely used methodology in many disciplines, particularly anthropology, and also in sociology, communication studies and social psychology. Its main focus is to gain a close and intimate familiarity with a given group of individuals and their practices through an intensive involvement with people in their natural environment. It is a qualitative method with roots in traditional ethnographic research, whose objective is to help researchers learn the perspectives held by study population (De Walt et al, 1998).

1.5.1 **Importance of Community Based Research (CBR)**

CBR is important for the following reasons:

a) Understanding of risk and protective factors in the causation of common mental disorders from a variety of social circumstances.

b) To reduce the risks through targeted intervention.

c) Building of partnership/alliance where in the teams from academic institutes and community (Panchayat members, religious leaders, NGOs, teachers, youth and self help group, health providers, caregivers) come together to address issues of mutual concern to decide that relevant questions are posed and the research findings are rapidly disseminated.

d) CBR has an advantage because it can reach out to the marginalized population who may not come in contact with health care facilities, eg marginalized children, women, persons with different sexual orientation, HIV infected and victims of stigmatizing illness.

e) For regular funding and survival of these community based interventions there is a need of accountability and efficiency and it can be possible through regular flow of information between researchers, treatment providers, policy makers and the service users.
1.6 LET US SUM UP

The era of community mental health has slowly progressed in India. Right from the ‘camp approach’ by Dr. Vidya Sagar to the development of community mental health model under Indo-Australian collaboration we have come a long way. In the community, different types of community mental health models are being used, each with its distinct style of operation and suitability as and when the situation demands. Treatment of the mentally ill in the community does have its advantages and many common mental illnesses like anxiety; depression etc can also be treated in the community, thus saving both time and money for the service users. The Government of India has taken a very bold and healthy step by initiating the National Mental Health Programme which does have a greater role to play in the field of community mental health. For bringing the treatment facility at the door step of the people and for the community mental service to be more effective the District Mental Health Programme is being revamped and its progress is to be monitored by developing effective systematic mechanisms. Thus in a nutshell, India seems to be moving in the right direction so far as rendering community based mental health services is concerned.

1.7 ANSWERS TO SELF ASSESSMENT QUESTIONS

Self Assessment Questions 1

1) Vidya Sagar started his innovative ‘camp approach’ wherein families were also involved in the treatment and care of the mentally ill. He put up tents within the hospital premises and requested the relatives of the patient to stay there and take care of the patient there.

Self Assessment Questions 2

1) The concept of therapeutic community was initiated by Tom Main in 1946 and popularised by Maxwell Jones. It is a residential facility for a variety of disorders like mental illness, substance abuse and even for prisoners.

2) The District Mental Health Program (DMHP) was started following the success of Bellary district (in Karnataka).

3) Alcohol Anonymous

4) Helpline services are basically the provision of telephone services to assist and guide people regarding health related issues. Helpline programs related to Psychiatry include Suicide Prevention Helpline, Smoking Cessation Helpline, and Child Helpline etc.
Mental Health Services in the Community, with Special Reference to India

Self Assessment Questions 3

1) During the late 1970s and 80s, the Community Mental Health Unit at NIMHANS developed an approach and strategy for integrating basic mental health care with the existing general health care services in India. Initially it was tried in various PHCs in Karnataka state and later it was expanded to the whole district, in Bellary district of Karnataka. The overall strategy which evolved after 5 years of trial in Bellary came to be known as the ‘Bellary Model’ of District Mental Health Program (DMHP) and was adopted by the Ministry of Health and Family Welfare, Government of India for staggered country wide implementation as a fully centrally funded program (Issac, 2011; Srinivasa Murthy, 2011).

2) The aim of the DMHP is to extend mental health services to persons suffering from mental disorders in the district through the existing health care personnel and institutions.

Self Assessment Questions 4

1) The importance of Community Based Research is as follows:
   a) They help in understanding of risk and protective factors in the causation of common mental disorders from a variety of social circumstances.
   b) It can be used to reduce the risks through targeted intervention.
   c) It helps in building of partnership/alliance where in the teams from academic institutes and community (Panchayat members, religious leaders, NGOs, teachers, youth and self help group, health providers, caregivers) come together to address issues of mutual concern to decide that relevant questions are posed and the research findings are rapidly disseminated.
   d) CBR has an advantage because it can reach out to the marginalized population who may not come in contact with health care facilities, eg, marginalized children, women, persons with different sexual orientation, HIV infected and victims of stigmatizing illness.
   e) For regular funding and survival of these community based interventions there is a need of accountability and efficiency and it can be possible through regular flow of information between researchers, treatment providers, policy makers and the service users.

1.8 UNIT END QUESTIONS

1) Write Short Notes on:
   a) Half-Way Home
   b) Community Based Participatory Research
   c) Self-Help group in mental health
   d) School mental health
   e) Depressive disorder
   f) Indo-Australian collaboration on development of community mental health in India.
2) Long essay type questions:
   a) Critically evaluate the District Mental Health Programme
   b) Describe briefly the features of “common mental disorders”. How will you manage the “common mental disorders” in the community?
   c) Is treatment in the community setting a viable alternative to hospitalisation for treatment of mental illness? Justify.

1.9 REFERENCES


1.10 SUGGESTED READINGS


UNIT 2  REHABILITATION OF THE MENTALLY ILL PERSONS

Structure

2.0  Introduction
2.1  Objectives
2.2  Psycho-Social Rehabilitation
  2.2.1  The Role of Psychiatrist in Rehabilitation
2.3  Challenges in Psychosocial/Psychiatric Rehabilitation
2.4  Social Skill Training
2.5  Vocational Rehabilitation
2.6  United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)
2.7  Persons with Disability Act (PWD Act), 1995
  2.7.1  The Main Provisions of PWD Act
2.8  The Rehabilitation Council Act of India (RCI Act)
2.9  National Trust for the Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities
  2.9.1  Services Provided by the National Trust
2.10  Role of the NGOs Towards Psychosocial Rehabilitation in India
  2.10.1  Mental Health Non Governmental Organisations (MHNGOs)
  2.10.2  Rehabilitation Centres
2.11  Let Us Sum Up
2.12  Answers to Self Assessment Questions
2.13  Unit End Questions
2.14  References
2.15  Suggested Readings

2.0  INTRODUCTION

Mental illness can have a wide ranging impact on the individual and can be broadly grouped as:

a)  Difficulty in learning new skills and employment.
b)  Participating in social and recreational activities.
c)  Establishing and maintaining relationships.
d)  Maintaining housing.

Not surprisingly, those with Severe Mental Illness (SMI) typified by persistent psychopathology, marked instability characterised by frequent periods of illness or hospitalisation and social maladaptation (The Royal College of Psychiatrists, 1996) are more likely to have problems in all of these domains. Thus, the goal of psychiatric rehabilitation is to develop the emotional, social and intellectual skills needed to learn, live and work in community with the least amount of support (Rossler, 2006).
The essential elements of all rehabilitation programs are similar (Bachrach). These are:

a) Enable a person with mental illness to develop to the fullest extent of their capacities despite the existence of mental illness.

b) Rehabilitation has to happen in the context of the individual’s environment.

c) Rehabilitation is directed towards utilising the individual’s strength.

d) Restoration of ‘hope’ for those with mental illness – a distinctive feature of rehabilitation.

e) Optimism about vocational potential of people with mental illness.

f) Reaching beyond work activities to cover other concerns of individuals.

g) Active involvement of individuals and primary caregivers.

h) Maintaining continued care.

i) Establishing strong relationship between patient and care-giver.

### 2.1 OBJECTIVES

After studying this unit, you will be able to:

- describe psychosocial rehabilitation and its challenges;
- explain social skill training and its role in psychosocial rehabilitation;
- get an overview of vocational rehabilitation in mental illness;
- acquire knowledge on some landmark development related to rehabilitation of people with mental illness: UNCRPD, PWD Act, RCI Act, National Trust; and
- discuss the role played by the government and NGOs towards rehabilitation of people with mental illness.

### 2.2 PSYCHO-SOCIAL REHABILITATION

Psychiatric rehabilitation or ‘psycho-social rehabilitation as it is now frequently termed as, has been variously defined by authorities. Some of these are:

WHO (1980) defines it as an application of measures aimed at reducing the impact of disability and handicapping conditions and enabling disabled people to achieve social integration.

Anthony (1984) defines it as improving the psychiatrically disturbed persons’ capabilities and competence by bringing about behavioural improvement in their environment of need.

Benett (1978) described psychiatric rehabilitation as helping the individual adapt to their deficits in personal skills by making best use of his residual abilities in order to function in as normal environment as possible.

Bachrach (1992) defined it as a therapeutic approach that encourages a mentally ill person to develop to his or her fullest capacity through learning and environmental support.
The overall philosophy of psychiatric rehabilitation in mental disorders comprises of two intervention strategies.

**Individual-centered strategies:** Aimed at developing patient skills in interacting with stressful environment.

**Ecological strategies:** Directed towards developing environmental resources to reduce potential stressors. Most disabled persons need a combination of both approaches.

The starting point for an adequate understanding of rehabilitation is that it is concerned with the individual person in the context of his or her specific environment. Psychiatric rehabilitation is regularly carried out under real life conditions. Thus, rehabilitation practitioners have to take into consideration the realistic life circumstances that the affected person is likely to encounter in his or her day to day living (Bachrach, 2000).

A necessary second step is helping disabled persons to identify their personal goals. This is not a process where that person simply lists his/ her needs. Motivational interviews provide a more sophisticated approach to identify the individual’s personal costs and benefits associated with the needs listed (Corrigan et al, 2001). This makes it also necessary to assess the individual’s readiness for change (Rogers et al., 2001; Liberman et al., 2004).

Subsequently the rehabilitation planning process focuses on the patient’s strengths (Bachrach, 2000). Irrespective of the degree of psychopathology of a given patient, the practitioner must work with the “well part of the ego” as “there is always an intact portion of the ego to which treatment and rehabilitation efforts can be directed” (Lamb, 1982). This leads to a closely related concept: the aim of restoring hope to people who have suffered major setbacks in self esteem because of their illness. According to Bachrach (2000), “it is the kind of hope that comes with learning to accept the fact of one’s illness and one’s limitations and proceeding from there”.

Psychiatric rehabilitation cannot be imposed. Quite the contrary, psychiatric rehabilitation concentrates on the individual’s rights as a respected partner and endorses his or her involvement and self determination concerning all aspects of the treatment and rehabilitation process. The rehabilitation values are also incorporated in the concept of recovery (Farkas et al., 2005). Within the concept of the recovery, the therapeutic alliance plays a crucial role in engaging the patient in his or her own care planning (Priebe et al., 2002). It is essential that the patient can rely on his or her therapist’s understanding and trust (Tuttmann, 1997), as most of the chronically mentally ill and disabled persons lose intimate and stable relationship in the course of the disease (Barbato et al., 2004). Recent research has suggested that social support is associated with recovery from chronic diseases, greater life satisfaction and enhanced ability to cope with life stressors (Rogers et al., 2004). Corrigan et al (2005) have found that the most important factor facilitating recovery is the support of peers. Therefore, psychiatric rehabilitation is also an exercise in network building (Cutler, 1985).

Finally, people with mental disorders and their care givers prefer to see themselves as consumers of mental health services with active interest in learning about mental disorders and in selecting the treatment approaches. Consumerism allows
the taking of the affected persons’ perspective and seriously considering courses of action relevant for them (Kopelwicz et al., 1995). In this context, physicians should also acknowledge that disagreement about the illness between themselves and the patient is not always the result of the illness process (Bebbington, 1995).

As a general rule, people with psychiatric disabilities tend to have the same life aspirations as people without disabilities in their society or culture (Onken et al.). They want to be respected as individuals and lead a life as normal as possible. As such they mostly desire: (a) their own housing, (b) an adequate education and a meaningful work career, (c) satisfying social and intimate relationships and (d) participation in community life with full rights.

2.2.1 The Role of Psychiatrist in Rehabilitation

Cancro (2000) described the role of Psychiatrist in Rehabilitation as follows:

“A properly trained psychiatrist will be able to prescribe psychosocial interventions, such as social skills training, as well as prescribe medication. This does not mean that the individual psychiatrist should be able to do everything from social skills training to vocational rehabilitation to psycho-education to family support. It does mean, however, that the psychiatrist must know what is needed and where it can be found and must be able to play a role in directing a team of professionals who can serve these patients. Not only will the patients benefit from such an approach, but so will our discipline.”

Thus according to Cancro, a psychiatrist should be able to not only prescribe medication for management of the disorder but also suggest psychosocial interventions. Further a psychiatrist may also play an important role by contributing his/her expertise in order to help the patient.

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<td>2) Discuss the two intervention strategies in psychiatric rehabilitation.</td>
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### 2.3 CHALLENGES IN PSYCHOSOCIAL/PSYCHIATRIC REHABILITATION

In India and other developing countries, opportunities for rehabilitation are limited, either due to inadequate staff, infrastructure that is rehabilitation center (RC) or training. Even where opportunities exist, occupational activities like making envelopes or baskets, provide little incentive and may not change the quality of life of those with mental illness (Deva, 2006). The absence of national insurance, unemployment benefits or social security transfers the burden to family members who themselves may not be economically well off.

Moreover there are no nodal institutes at national or regional levels for mental illness, as opposed to other disabilities. Full fledge psychosocial rehabilitation services are provided by few departments in the country. Although the need for rehabilitation intervention may be less as compared to developed countries, their unavailability is an issue of concern. Government facilities for rehabilitation centers are virtually non-existent. Most RCs are therefore operated by NGOs and trust based centers, with much of the financial aid coming from non-government sources.

Further, issues of infrastructure and manpower, various factors are also responsible for the poor focus on psychiatric rehabilitation. Mental illness in India has poor visibility due to a lack of cohesive patient/family groups to showcase the problems faced by this population. This in turn could be attributed to stigma, poverty and poor awareness, most of the caretakers’ energies being expended on taking care of livelihood. The lack of visibility and lobbying for patient rights lead to neglect in framing government rules and regulations, allocation of funds as well as providing other supportive programs like vocational opportunities etc. For example, mental illness was the last group to be recognized as causing disability in “Persons with Disability Act”, 1995.

#### Self Assessment Questions 2

1) List the challenges in psychosocial/psychiatric rehabilitation.

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### 2.4 SOCIAL SKILL TRAINING

The term ‘skills’ refers to acquired behaviours based on learning experiences (Kopelowicz et al., 2006). Social skills represent constituent behaviours which when combined in appropriate sequences and used with others in appropriate ways and places enables an individual to have success in daily living reflected by social competence (Bellack et al., 2004). Social competence can be defined as the ability to achieve legitimate personal goals through interacting with others in all situations: work, school, recreation, shopping, consumer services, medical and mental care and legal agencies (Knapczyk and Rodes, 2001).
Thus, social skill training are heterogeneous intervention aimed at improving activities of daily living, hygiene and grooming, basic communication skills, job-finding, and interpersonal problem solving, that is improving social competence.

Social skills and social competence can be viewed as protective factors in the vulnerability-stress-protective factors model of schizophrenia (Kopelowicz et al., 2009). Strengthening social skills and competence of individuals with schizophrenia can reduce the impact of cognitive deficits, stressful events and social maladjustment. Improved social competence confers protection not only against stress induced relapse but also improves interpersonal support, social affiliation and quality of life (Kopelowicz et al., 2006).

Some interventions involve simple advice while other requires elaborate combination of operant conditioning and social learning models. Steps involved in social skills training are as follows:

1) **Problem identification:** Made in collaboration with patient by acknowledging ‘barriers’ and ‘goals’ of the patient.

2) **Goal setting:** Short-term, near-approximation goal that patient and therapist find feasible.

3) **Behaviour rehearsal or role play:** Patient demonstrates the verbal, non-verbal and para-linguistic skills required for successful social interaction.

4) **Corrective feedback:** Required for behaviour exhibited in role play.

5) **Social Modelling:** Demonstration by the therapist of desired interpersonal behaviour in a form that can be learnt by the observing patient.

6) **Behaviour practice:** Facilitate its use in real-life situations.

7) **Positive social reinforcement:** Contingent upon those behaviour skills that showed improvement.

8) **Home-work assignment:** To motivate the patient to implement the learned skill in real-life situations.

9) **Positive reinforcement and problem solving:** To address issues arising in patients experience due to the use of acquired skills.

In recent years, social skills training in psychiatric rehabilitation has become very popular and has been widely promulgated. The most prominent proponent of skills training is Robert Liberman, who has designed systematic and structured skills training since the mid 1970s (Liberman, 1988). Liberman and his colleagues packaged the skills training in the form of modules with different topics. The modules focus on medication management, symptom management, substance abuse management, basic conversational skills, interpersonal problem solving, friendship and intimacy, recreation and leisure, workplace fundamentals, community (re-) entry and family involvement. Each module is composed of skills areas. The skills areas are taught in questions with demonstration videos, role-play and problem solving questions and in vivo and homework assignments (Liberman, 2002).
Social skills training has now been used for more than three decades in developed nations. Studies on its efficacy in diverse treatment settings (In-patient, Out-patient, Residential continuum), diverse practitioners (Psychiatrists, Psychologists, Mental Health Nurse, Social Workers) and covering a broad range of skills (illness management, smoking cessation, securing and retaining jobs) have shown gratifying results (Kopelowicz et al., 2006). In the last decade there has been further refinement in the delivery of social skills training. Firstly, it is now understood that social skills training is more effective when done in natural environment as opposed to class-room teaching (Glynn et al., 2002). Secondly, evidence is emerging that cognitive remediation potentiates skills training (Vauth et al., 2004). This has led to integration of social skills training as an essential element in comprehensive multi-dimensional programs.

**Self Assessment Questions 3**

1) Discuss the steps involved in social skills training.

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2.5 VOCATIONAL REHABILITATION

The beneficial effects of work on mental health have been known for centuries (Barbato et al., 2004). Therefore, vocational rehabilitation has been a core element of psychiatric rehabilitation since its beginning. Vocational rehabilitation is based on the assumption that work does not only improve activity, social contacts etc., but may also promote gains in related areas such as self-esteem and quality of life, as work and employment are a step away from dependency and a step to integration into society. Enhanced self-esteem in turn improves adherence to rehabilitation of individuals with impaired insight (McElroy, 1987).

Vocational rehabilitation originated in psychiatric institutions, where the lack of activity and stimulation led to apathy and withdrawal of inpatients. Long before the introduction of medication, occupational and work therapy contributed to sustainable improvements in long-stay inpatients. Today occupational and work therapy are no longer hospital-based, but represent the starting point for a wide variety of rehabilitative techniques teaching vocational skills (RCP, 1996).

Vocational rehabilitation programs in the community provide a series of graded steps to promote job entry or reentry. For less disabled persons, brief and focused techniques are used to teach how they can find a job, fill out applications and conduct employment interviews (Jacobs et al., 1988). In transitional employment, a temporary work environment is provided to teach vocational skills, which should enable the affected person to move on to competitive employment. But all too often the gap between transitional and competitive employment is so wide that the mentally disabled individuals remain in a temporary work environment. Sheltered workshops providing pre-vocational training also quite often prove a dead end for the disabled persons.
One consequence of the difficulties in integrating mentally disabled individuals into the common labour market has been the steady growth of cooperatives, which operate commercially with disabled and non-disabled staff working together on equal terms and sharing management. The mental health professionals work in the background, providing support and expertise (Grove, 1994).

Today, the most promising vocational rehabilitation model is Supported Employment (SE). The work of Robert Drake and Deborah Becker decisively influenced the conceptualization of SE. In their “individual placement model”, disabled persons are placed in competitive employment according to their choices as soon as possible and receive all support needed to maintain their position (Wallace, 1998; Bond, 2004). The support provided is continued indefinitely. Participation in SE programs is related to an increase in the ability to find and keep employment (Baron et al., 1998; Cook et al., 2005). Links were also found between job tenure and non-vocational outcomes, such as improved self-esteem, social integration, relationships and control of substance abuse (Bond, 2004; Ruesch et al., 2004, Salyers et al, 2004). It was also demonstrated that those who had found long-term employment through SE had improved cognition and quality of life, and better symptom control (Bond, 2004; Salyers et al. 2004).

Though, findings regarding SE are encouraging, some critical issues remain to be answered. Many individuals in SE obtain unskilled part-time jobs. Since most studies only evaluated short (12-18 months) follow-up periods, the long-term impact remains unclear. Currently we do not know which individuals benefit from SE and which do not (Mueser, 1998). After all, we have to realize that the integration into the labour market does by no means only depend on the ability of the persons affected to fulfill a work role and on the provision of sophisticated vocational training and support techniques, but also on the willingness of society to integrate its most disabled members.

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2.6 UNITED NATIONS CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES (UNCRPD)

General Purpose for the Convention: The purpose of the Convention was to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.
Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

**Background information:** The background information about the convention is as follows:

- **Adoption by the United Nations General Assembly** - 13 December 2006
- **Opened for signature** - 30 March 2007
- **Entry into force** – 3 May 2008
- **Unique features:** Both a development and a human rights instrument; A policy instrument which is cross-disability and cross-sectoral; Legally binding.

**Definitions:** Some of the definitions under the Convention areas are as follows:

**Communication:** includes languages, display of text, Braille, tactile communication, large print, accessible multimedia as well as written, audio, plain-language, human-reader and augmentative and alternative modes, means and formats of communication, including accessible information and communication technology;

**Language:** includes spoken and signed languages and other forms of non spoken languages;

**Discrimination on the basis of disability:** means any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation;

**Reasonable accommodation:** means necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms;

**Universal design:** means the design of products, environments, programmes and services to be usable by all people, to the greatest extent possible, without the need for adaptation or specialised design. Universal design shall not exclude assistive devices for particular groups of persons with disabilities where this is needed;

**General Principles of the Convention**

a) Respect for inherent dignity, individual autonomy including the freedom to make one’s own choices, and independence of persons;

b) Non-discrimination;

c) Full and effective participation and inclusion in society;
d) Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;

e) Equality of opportunity;

f) Accessibility;

g) Equality between men and women;

h) Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

Equality and non-discrimination

1) States Parties recognise that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law.

2) States Parties shall prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds.

3) In order to promote equality and eliminate discrimination, States Parties shall take all appropriate steps to ensure that reasonable accommodation is provided.

4) Specific measures which are necessary to accelerate or achieve de facto equality of persons with disabilities shall not be considered discrimination under the terms of the Convention.

Participation and inclusion

- Participation is important to correctly identify specific needs, and to empower the individual.

- Full and effective participation and inclusion in society is recognised in the Convention as:
  - A general principle (article 3)
  - A general obligation (article 4)
  - A right (articles 29 and 30)

Mainstreaming of Disability

Mainstreaming of disability issues according to the Convention are:

- Work of existing human rights treaty bodies.


- Millennium Development Goals (MDG) - national and international strategies.


- Poverty Reduction Strategy Papers (PRSP).

- The development activities of international donors and NGOs.

- Census data.
Mental Health Services

- Sectoral and cross-sectoral policies.
- Programmes and policies for women (article 6) and children (article 7) and others.

Conclusion

- The challenge of implementing the Convention is now.
- Need for training, capacity building, awareness raising, good practices collection and validation, knowledge management.
- Need to mainstream disability in all development activities.
- Need for implementation of Convention principles in the internal operations of organisations.
- Need to include persons with disabilities in all stages of implementation, and build capacity of organisations of persons with disabilities to do so.

Self Assessment Questions 5

1) What are the general principles of United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)?

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2.7 PERSONS WITH DISABILITY ACT (PWD ACT), 1995

“The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995” (PWD Act) is a landmark legislation for the welfare of people with disabilities. It is published by notification of Ministry of Welfare, in the Gazette of India, Extraordinary, Part II - Section 3. The Persons with Disability (Equal Opportunities, Protection of Rights and Full Participation).

PWD Act came into force in 1995 with the purpose of providing equal rights to disabled people and to protect their rights and full participation. It provides for education, employment, creation of barrier free environment, social security, etc. This Act is a major milestone in the care of disabled in India. This act includes seven conditions in its list of what it termed as disabilities:

1) **Blindness:** Total absence of sight or visual acuity not exceeding 6/60 in the better eye with correcting lenses; or limitation of the field of vision subtending an angle of 20 degrees or worse.

2) **Low vision:** A person with impairment of visual functioning even after treatment or standard refractive correction but who uses or is potentially capable of using vision for the planning or execution of a task with appropriate assistive device.
3) **Leprosy-cured person:** Any person cured of leprosy but is suffering from loss of sensation in hands or feet, loss of sensation and paresis in the eye and eye lid with or without other manifest deformity; manifest deformity and paresis, but having sufficient mobility in their hands and feet to enable them to engage in normal economic activity; or extreme physical deformity as well as advanced age which prevents him from undertaking any gainful occupation.

4) **Hearing impairment:** Loss of 60 decibels or more in the better ear in the conversational frequency range.

5) **Locomotor disability:** Disability of bones, joints or muscles leading to substantial restriction of movement of limbs or any form of cerebral palsy.

6) **Mental retardation:** A condition of arrested or incomplete development of mind of a person which is specifically characterized by subnormality of intelligence.

7) **Mental illness:** Any mental disorder other than mental retardation.

The two terms that need to clearly understand here are:

- **“Disability” means** Blindness, Low vision, Leprosy-cured, Hearing impairment, Loco-motor disability, Mental retardation, Mental illness

- **“Person with Disability” means** a person suffering from not less than forty per cent of any disability as certified by a medical authority.

### 2.7.1 The Main Provisions of PWD Act

The main provisions or the scope of the PWD act is discussed as follows:

I) **Prevention and Early Detection of Disabilities**
   1) Surveys, investigations and research.
   2) Promote prevention of disabilities.
   3) Screening of children and awareness campaigns.

II) **Education**
   1) Free education till the age of 18 years.
   2) Appropriate transportation, removal of architectural barriers and modifications in the examination system.
   3) Right to free books, uniforms and other learning materials.
   4) Special school for children with disabilities.
   5) Scholarships.
   6) Non-formal education.
   7) Teacher’s training institutions.

III) **Employment**
   1) Not less than 3% vacancies in government employment reserved for persons with disabilities.
   2) Suitable schemes for training and welfare of persons, relaxation of upper age limit and regulating the employment.
3) Health and safety measures at place of employment.
4) Reservation in poverty alleviation schemes.

**IV) Affirmative Action**

1) Schemes to provide aids and appliances.
2) Allotment of land at concessional rates for house, business, special recreational centers, special schools, research schools, factories by entrepreneurs with disability.

**V) Non-Discrimination**

1) Adapt public buildings, rail compartments, buses, ships and aircrafts to permit easy access to persons with disabilities.
2) Adapt toilets in rail compartments, vessels, aircrafts and waiting rooms in such a way as to permit the wheel chair users to use them conveniently.
3) Braille and sound symbols in lifts.
4) All the places of public utility shall be made barrier-free.
5) No employee can be sacked or demoted if they become disabled during service, although they can be moved to another post with the same pay scale. No promotion can be denied because of impairment.

**VI) Research and Manpower Development**

Research in the following areas may be sponsored and promoted.

1) Prevention of disability.
2) Rehabilitation including Community Based Rehabilitation (CBR).
3) Development of assistive devices.
4) Job identification.
5) On site modifications of offices and factories.
6) Financial assistance for undertaking research.

**IX) Social Security**

1) Financial assistance to Non-governmental organisations (NGO).
2) Insurance coverage.
3) Unemployment allowance.

**X) Miscellaneous**

1) Grievance redressal.
2) Chief Commissioner – Centre.
3) Commissioner for persons with disabilities – States.

The person with disability must have not less than 40% of disability as certified by a medical authority, which has been specified in the Act. The Act enabled the formation of a Central Coordination Committee to serve as the national focal point on disability matters and facilitate the continuous evolution of a comprehensive policy towards solving the problems faced by persons with disabilities.
A Medical Board (consisting of at least three members out of which at least one shall be a specialist in the particular field for assessing locomotor/visual including low vision/hearing and speech disability, mental retardation and leprosy cured, as the case may be issues disability certificate.

Although the inclusion of mental illness as one of the seven disabilities is a welcome step, the Act reflects very little understanding of the nature of the disability and current developments in the field of Psychiatry. The definition of mental illness as conditions other than mental retardation is an exclusive approach, and various psychiatric disorders cannot be included in this rubric. In future, a more inclusive approach including only chronic and severe mental disorders has been suggested so as to facilitate assessment of disability. Currently, the only available tool IDEAS, assess only four psychiatric disorders, Schizophrenia, Bipolar Disorder, Obsessive Compulsive Disorder and Dementia.

**Persons with Disability Act and development of Indian Disability Evaluation and Assessment Scale**

Measuring disability and functioning is a key to formulating and implementing psycho-social rehabilitation programmes for both patients and family members. It was the need for assessing disability in mental illness, which led to the development of the screening tool called “Indian Disability Evaluation and Assessment Scale” commonly referred to as “IDEAS”. The task for developing this tool was initiated by the Indian Psychiatric Society (IPS) and the tentative instrument formed was field tested in eight centers all over the country with the Schizophrenia Research Foundation (SCARF) being the coordinating center. IDEAS was gazetted by the Government of Ministry of Social Justice and Empowerment, Government of India in February, 2002 as the official instrument to measure psychiatric disability for the purpose of certification. IDEAS can be done by trained social workers, psychologists or occupational therapists, the diagnosis and certification can be done by a psychiatrist. After certification, now it is possible to assess the degree of disability due to psychiatric illness and avail the benefits under various provisions of the PWD Act. This was thus a giant step towards rehabilitation of people with mental illness in India.

**Lacunae and shortcomings:** In India and other developing countries, opportunities for rehabilitation are limited either due to inadequate staff, infrastructure i.e. Rehabilitation Center (RC) or training. Community based rehabilitation under government agencies is virtually non-existent, leaving the field entirely to NGO run RCs which are usually quite expensive and unaffordable for the common people. The Department of Psychiatry, Government Medical College, Chandigarh, runs a “Half Way Home” in collaboration with “Prayatan”, a self-help group of family members of mentally ill persons for last ten years in Chandigarh. Admission is open to any person with mental illness referred by his treating psychiatrist. Emphasis is laid on instilling a sense of purpose and responsibility in day to day life. Positive reinforcement is provided for regularity, punctuality, grooming and adherence to treatment etc. Vocational activities include gardening, making paper bags and envelopes. The profit from sale of finished products is shared between members, adding to their sense of achievement. Sheltered placements is provided in ‘juice bars’ and ‘snack bars’ run by Prayatan. This is thus a small step towards rehabilitation of the mentally ill people.
In 2002, following the Erwadi tragedy, the Supreme Court of India directed all state governments to frame policy and initiate steps for establishment of at least one government run mental hospital in each state and envisage a scheme for the rehabilitation of people who do not have any backing support in the community (Desai et al., 2007). Sadly, the court directives have not been implemented so far in most of the states.

Self Assessment Questions 6

1) List the seven conditions as disabilities in Persons with Disability Act (PWD Act), 1995.

2) What is ‘IDEAS’?

2.8 THE REHABILITATION COUNCIL ACT OF INDIA (RCI ACT)

Rehabilitation Council of India Act (1992) deals with the development of manpower for providing rehabilitation services. It was created for constitution of the Rehabilitation Council of India for regulating training of the professionals associated with rehabilitation, maintaining a Central Rehabilitation Register and other related issues. The vision of the body is ‘to provide quality services to persons with disabilities, matching with the best in the World’. The RCI Act was amended in the Parliament in 2000 to make it more broad based. Thus, disability due to mental illness was included within the purview of RCI in 2000.

Handicapped in this Act means a person who is:

1) Visually handicapped;
2) Hearing handicapped;
3) Suffering from locomotor disability;
4) Suffering from mental retardation.

The Act is divided into three chapters. Chapter I is the “Preliminary Chapter”. It contains information on the title, definition etc. The Chapter II is the “Rehabilitation Council of India”. It consists of description on the constitution, term of the office bearers, executive committees, vacancies, dissolution of the
The third Chapter is the “Functions of the Council”. It contains information on all the function of the Council, recognition of qualification by the University, facility for inspectors at examination, registration of professionals, conduct of professionals etc. It also highlights that the employees of the Council would be public servants. Framework regarding the power to make rules and regulations, including rules and regulations before the Parliament are also mentioned in this Chapter.

RCI is the apex government body, set up under an Act of Parliament, to regulate training programmes and courses targeted at disabled, disadvantaged, and special education requirement communities. It is the only statutory council in India that is required to maintain the Central Rehabilitation Register which mainly documents details of all qualified professionals who operate and deliver training and educational programmes for the targeted communities. In the year 2000, the Rehabilitation Council of India (Amendment) Act, 2000, was introduced and notified consequently by the government of India. The amendment brought definitions and discussions provided within the earlier Rehabilitation Council of India Act, 1992, under the ambit of a larger act, namely, Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995.

**Professionals who can apply for RCI accreditation:**

As per RCI, the following categories of professionals can apply for RCI’s accreditation process. (To apply, the requirement is specifically that the professionals be providing services targeted towards communities for which RCI has been set up):

- Prosthetists and Orthotists
- Audiolists and Speech Therapists
- Clinical Psychologists
- Rehabilitation Counselors, Administrators
- Rehabilitation Workshop Managers
- Rehabilitation Psychologists
- Rehabilitation Social Workers
- Rehabilitation Practitioners in Mental Retardation
- Speech Pathologists
- Special Teachers for Educating and Training the Handicapped
- Vocational Counselors, Employment Officers and Placement Officers
- Multi-purpose Rehabilitation Therapists, Technicians
- Orientation and Mobility Specialists
- Community Based Rehabilitation Professionals
- Hearing and Ear Mould Technicians
- Rehabilitation Engineers and Technicians.

The council has reportedly registered around 12,000 such professionals across India.
Self Assessment Questions 7

1) What is Rehabilitation Council of India (RCI)?

2.9 NATIONAL TRUST FOR THE WELFARE OF PERSONS WITH AUTISM, CEREBRAL PALSY, MENTAL RETARDATION AND MULTIPLE DISABILITIES

National Trust for the Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities was set up in the year 2000 by an eponymous Act as an autonomous statutory body under the Ministry of Social Justice and Empowerment, Government of India, set up under the “National Trust for the Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities” Act (Act 44 of 1999). The National Trust is dedicated to the creation of a nation-wide movement, which will lead to affirmative action for the protection, care, and inclusion of persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities within or close to their own communities. Social, financial, emotional and physical security of a comprehensive nature for such persons is the ultimate goal of the National Trust. It will strive for pervasive social change which permeates into mainstream activities of community life so that persons with these disabilities in India can lead a life of quality, dignity, and justice in societies which are free from bias, prejudice, stigma and discrimination. A society which puts the persona of disabled people first, is the larger vision of the National Trust.

Objectives: The basic objectives of the National Trust are:

- To enable and empower persons with disability to live as independently and as fully as possible within and as close to the community to which they belong.
- To strengthen facilities to provide support to persons with disability to live within their own families.
- To extend support to registered organisations to provide need based services during period of crisis in the family of persons with disability.
- To deal with problems of persons with disability who do not have family support.
- To promote measures for the care and protection of persons with disability in the event of death of their parent or guardian.
- To evolve procedures for the appointment of guardians and trustees for persons with disability requiring such protection.
• To facilitate the realisation of equal opportunities, protection of rights and full participation of persons with disability.
• To do any other act which is incidental to the aforesaid objectives.

Main activities/functions
The main activities/functions of National Trust are:

a) To provide financial assistance by way of grant-in-aid to Registered Organisations (ROs) for strengthening infrastructure.
b) To provide training to persons with disabilities, their parents, ROs, Govt. officials, other stakeholders.
c) To provide residential and day care facilities to persons with disabilities.
d) To provide scholarship and financial incentives and support to the persons with disabilities.
e) To constitute Local Level Committees in the districts and to ensure appointment of legal guardians through them.

2.9.1 Services Provided by the National Trust

i) Legal Guardians: Appointments of legal guardians are done by Local Level Committees in every district of the country (except J&K) for such persons with disabilities who need them.

ii) SNAC-SNAP: State Nodal Agency Centre (SNAC) and State Nodal Agency Partner (SNAP) are the institutional arrangements of the National Trust at the State/UT and Divisional levels to support and take forward its activities. One SNAC in every State/UT and one SNAP for around 10 districts in every State/UT are appointed from amongst the reputed and well established NGOs registered with the National Trust.

iii) Samarth: It is a Centre Based Scheme (CBS) which was introduced in July 2005 for residential services - both short term (respite care) and long term (prolonged care). Activities in a Samarth Centre should include early intervention, special education or integrated school, open school, pre-vocational and vocation training, employment oriented training, recreation, sports etc. The facilities in the home shall be available to both men and women- on 50-50% basis and shall cover all the four disabilities under the National Trust.

iv) Aspiration: This is an early intervention programme for school readiness. The scheme is to work with children of 0-6 years with developmental disabilities, to make them ready for mainstream and special schools.

v) GHARAUNDA: Group Home and Rehabilitation Activities under National Trust Act for Disabled Adults (GHARAUNDA) is a new scheme for providing Life Long Shelter and Care to Persons with Disabilities in Group Homes.

vi) Sahyogi: It is a new and revamped scheme of Caregivers Training and Deployment. A new training module has been designed and a system of training and deployment of Caregivers has been provided for under the scheme.
vii) **Niramaya:** Health Insurance Scheme: It covers all the four disabilities mentioned in the National Trust Act and there is no age bar. The insurance cover is up to Rs. 1 lakh per year. The reimbursement is done directly to the beneficiary, on the submission of original documents/bills to the Insurance Company, within a month of the treatment. Renewal of policy is done every year, before the expiry of the coverage date. The online enrolment/renewal is done through our registered organisation. There is a nominal charge for processing/renewal of policy, per year.

viii) **Remote Area Funding:** The objective of this scheme is to stimulate National Trust activities in unrepresented districts. Under the scheme, fund is provided to set up an NGO, including parents association and then to carry out activities for the welfare of persons with disabilities.

ix) **UddyamPrabha:** It is an Interest Subsidy Scheme for self-employment. A PWD who takes a loan from any bank or NHFDC can get interest subsidy of 5% for BPL or 3% for APL on loan amount up to 1 lakh Rs.

tax) **GyanPrabha:** Scholarship Scheme for doing, post schooling, any employment oriented course. Under the Scheme, a monthly scholarship of Rs. 1000 shall be paid for up to 1 year. Any PWD who has done any schooling or has not done any schooling at all can also get scholarship.

x) **ARUNIM:** Association for Rehabilitation under National Trust Initiative of Marketing has been launched to help PWDs in product designing, production processes, packaging and marketing enabling them to live a life with dignity and independence.

xi) **Abiline:** It is a helpline in collaboration with Aarth-Astha (an NGO) for persons with disabilities. It reaches out with Counseling, Referrals & Information on - Laws & Rights, Facilities, Schemes, Disability Certificate, Education, Health, Guardianship & Disability related Other Issues.

xii) **Awareness Programme:** With the help of State Governments, District Collectors, Registered Organisation, LLCs, Information Centers and SNACs, the National Trust organizes sensitisation programmes for District Administration, parents, professionals, NGOs and media persons. Programmes are held at District level, Divisional level, State level and also through live satellite video conferencing.

xiii) **Disability Equity Training Programme:** It has been developed for orientation of the members of Local Level Committees (LLC). In order to carry out this, two tier training plan has been worked out – (a) Training of Trainers at zonal level by dividing the country into 6 zones and then through these Trainers to (b) LLC members in groups of 10 districts. At the zonal level, training of these Trainers namely Zonal Technical Resource Trainers (ZTTR) has been carried out and now training of LLC members are being carried out with the help of State Nodal Agency Centres (SNAC).

A panel of professionals, retired govt. officers and other experts and volunteers has been prepared for inspection and monitoring of various schemes and programmes of the National Trust. Besides, review survey is also conducted in few key schemes and issues like supported guardianship and Samarth. Committee
Rehabilitation of the Mentally Ill Persons

A system of Management Information System (MIS) is also being developed for real time information dissemination.

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2.10 ROLE OF THE NGOs TOWARDS PSYCHOSOCIAL REHABILITATION IN INDIA

The paucity of treatment facilities and psychiatrists in the Government sector has widened the treatment gap in mental health. While the government or public services are the key providers of care for these populations, and therefore need strengthening, the NGO movement in the country has seen a steady upswing in the last two decades to fill the large gaps. Non-Governmental Organizations (NGOs) are institutions, recognized by governments as non-profit or welfare oriented, which play a key role as advocates, service providers, activists and researchers on a range of issues pertaining to human and social development.

2.10.1 Mental Health Non Governmental Organisations (MHNGOs)

Despite the considerable challenges faced in developing mental health programs, it is gratifying to note the achievements made by many MHNGOs are distributed throughout the country, although there are a greater number in urban areas, and in states where there are relatively lesser pressing problems posed by poverty and communicable diseases. Although MHNGOs are predominantly urban in location, many have begun to extend services into rural areas. Most MHNGOs serve a defined community; however, the work of some has spread to more than one center or geographical region. Examples of such NGOs are the Alzheimer and Related Disorders Society of India (ARDSI), which was started in Cochin, and has now spread to more than a dozen centers in India. Similarly, the Richmond
Mental Health Services Fellowship Society has three centers. The oldest MHNGOs in India are probably those working in the field of child mental health, and in particular, mental retardation. The concept of child mental health has broadened from its earlier focus on mental retardation to include the far commoner mental health problems seen in children, such as autism, hyperactivity and conduct disorders. MHNGOs such as Sangath Society (Goa) and Umeed and the Research Society (Mumbai) provide outpatient and school based services for such problems. Other than mental retardation, the other early MHNGOs had care and treatment and rehabilitation as their priorities and developed appropriate models of rehabilitation in diverse settings and for diverse clinical populations.

Treatment: Care and rehabilitation: It was natural for many MHNGOs to identify treatment and rehabilitation as their priorities, based on the felt and largely unmet needs of the populations they wished to serve. Models of care and rehabilitation have been developed, many of which are replicable in diverse settings. While most state-run organisations focus on medical treatment, psychosocial rehabilitation (PSR) is sadly a neglected though major aspect of MHNGO programs. The absence of trained staff to carry out PSR activities has, however, kept it away from mainstream psychiatric services. Hence, many NGOs have taken it upon themselves to develop modules of PSR in both urban and rural areas. The programs include a spectrum of activities such as individual and group counseling, vocational rehabilitation and livelihood skills training, cognitive retraining, family support and counseling, self-help groups, recreation and leisure activities. The range of care facilities depends on the conditions which are the focus and the resources of individual NGOs. Out-patient clinics, in-patient care, day care programs and long term residential care form the spectrum of services provided by MHNGOs, especially the ones dealing with chronic psychotic conditions. Within this spectrum of services, a range of treatments including drug and psychological treatments are offered. Many persons require long-term care to minimize the disability associated with some mental disorders such as schizophrenia and dementia. Typically, about a third of patients with schizophrenia will show signs of long-term disability associated with a variety of factors such as chronic symptoms, stigma and the side effects of medication. Most MHNGOs working in this area have comprehensive services focusing both on the control of symptoms of the acute phase of the illness, as well as rehabilitation to ensure optimal functioning in the longer-term. Providing vocational training in skilled professions such as carpentry and printing, social skills training and family therapy are some examples of the kind of activities undertaken. MHNGOs provide linkages with potential employment by sensitizing employers to the needs of those suffering from chronic mental disorders.

Specific interventions targeted to groups such as children or the elderly are also being offered by some MHNGOs. In the case of child mental health, for example, interventions targeted at children, their parents and class room interventions are offered. Childhood mental disorders also require a range of rehabilitation interventions, particularly in the educational field. MHNGOs working in other areas, such as substance abuse, also provide a range of rehabilitation services.

2.10.2 Rehabilitation Centres

As governmental facilities for Rehabilitation Centers (RCs) is virtually non-existent, so most of these RCs are operated by NGOs. The RCs in India can be grouped as under:
a) Those that provide facilities to patient brought by care givers (eg Richmond fellowship Society)
b) Those that provide shelter and treat the wandering mentally ill (The Banyan in South India, Pingalwara, PrabhAasra etc in North India)

The objectives, enrolment process and intervention methods of both these groups are distinctive.

In day care centers run by the Richmond Fellowship Society admission is open to any person 18 to 45 years of age with a diagnosis of schizophrenia or any other major psychiatric disorder or mild mental retardation. The facilities available include vocational training units of computer, typing, printing, plastic moulding, tailoring and embroidery, arts and craft, yoga, vocational and instrumental music, dancing, painting, vocabulary building etc. In addition to vocational training the center has therapeutic programs such as structured daily activities and afternoon group activities, namely community meeting, group therapy, recreational activities such as going to movies, picnics, group games and horticultural activities. Regular individual and family therapy sessions, and family support group meetings are also held at the center. The half-way home provides residential care to both male and female members suffering from schizophrenia. The period of stay of members is generally for up to 18 months. Therapeutic services are provided by a team of counselors from the field of social work and psychology (Ponnachamy et al., 2005).

At the Banyan, wandering mentally ill women on the streets are brought to the shelter and clinically assessed by a psychiatrist and put on medication. Various therapies are available like individual counseling, music, art, yoga and vocational training (candle making, greeting cards, block printing on napkins, table linen, basket making, threading flowers and making bouquets, etc.). The inmates are entrusted with some housekeeping responsibilities and also take care of other residents. They are given an opportunity to attend meetings for a limited audience, to speak for their cause of inclusion. Recreation includes outings to the beach, movies, celebrating festivals and sports. As the inmate improves, her family address is elicited and traced. The family is enlightened about the illness, the woman’s stay at The Banyan and the need for continuous medication. The duration of stay at The Banyan varies from less than three months to more than three years (NaliniRao, 2004).

Thus we see that the NGOs have played a role in the field of mental health, including rehabilitation. This has ensured at least some hope for the mentally ill, though much more is required to be achieved. Taking a cue from the activities of some of these well functioning NGOs, other organisations, including the government, can definitely plan out different facilities all over the country for the rehabilitation of those with mental illness.

Self Assessment Questions 9

1) Discuss the two groups of rehabilitation centres in India.
2.11 LET US SUM UP

Rehabilitation of those with mental illness is very challenging. Psychosocial rehabilitation plays a crucial role in the well-being of not only the patient, but also the care givers as well. Methods like social skill training and vocational rehabilitation help a person with mental illness tremendously.

It is only recently that mental illness has received attention so far as disability due to mental illness and rehabilitation of the mentally ill is concerned. Acknowledgement of mental illness as being disabling and including it in the ‘Persons with Disability Act’ was a landmark event in terms of psycho-social rehabilitation. Though, rehabilitation initiative in the developed countries is very well organized, India is yet to make notable progress in this area. Government initiative pertaining to service facilities related to rehabilitation, like Rehabilitation Center for example is very few and many of such centers in the country are being run by Non-Governmental Organisation.

To sum up, we have miles to go so far as rehabilitation of people with mental illness is concerned.

2.12 ANSWERS TO SELF ASSESSMENT QUESTIONS

Self Assessment Questions 1

1) WHO (1980) defines it as an application of measures aimed at reducing the impact of disability and handicapping conditions and enabling disabled people to achieve social integration.

Benett (1978) described psychiatric rehabilitation as helping the individual adapt to their deficits in personal skills by making best use of his residual abilities in order to function in as normal environment as possible.

2) The two interventions strategies are

   i) **Individual-centered strategies** that are aimed at developing patient skills in interacting with stressful environment.

   ii) **Ecological strategies** that are directed towards developing environmental resources to reduce potential stressors. Most disabled persons need a combination of both approaches.

Self Assessment Questions 2

1) The challenges to psychosocial/psychiatric rehabilitation are as follows:

   i) The rehabilitation opportunities are limited in India and other developing countries. This can be due to various reasons like inadequate staff, infrastructure i.e. rehabilitation center (RC) or training.

   ii) There is no national insurance, unemployment benefits or social security transfers the burden to family members who themselves may not be economically well off.
iii) Lack of nodal institutes at national or regional levels for mental illness, as opposed to other disabilities.

iv) Government facilities for rehabilitation centers are virtually non-existent. Most RCs are therefore operated by NGOs and trust based centers, with much of the financial aid coming from non-government sources.

v) Lack of awareness about mental health.

**Self Assessment Questions 3**

1) Steps involved in social skills training are as follows:

   i) Problem identification: Made in collaboration with patient by acknowledging ‘barriers’ and ‘goals’ of the patient.

   ii) Goal setting: Short-term, near-approximation goal that patient and therapist find feasible.

   iii) Behaviour rehearsal or role play: Patient demonstrates the verbal, non-verbal and para-linguistic skills required for successful social interaction.

   iv) Corrective feed-back: Required for behaviour exhibited in role play.

   v) Social Modelling: Demonstration by the therapist of desired interpersonal behaviour in a form that can be learnt by the observing patient.

   vi) Behaviour practice: Facilitate its use in real-life situations.

   vii) Positive social reinforcement: Contingent upon those behaviour skills that showed improvement.

   viii) Home-work assignment: To motivate the patient to implement the learned skill in real-life situations.

   ix) Positive reinforcement and problem solving: To address issues arising in patients experience due to the use of acquired skills.

**Self Assessment Questions 4**

1) Supported Employment (SE) is one of the most promising models of vocational rehabilitation. The work of Robert Drake and Deborah Becker decisively influenced the conceptualisation of SE. In their “individual placement model”, disabled persons are placed in competitive employment according to their choices as soon as possible and receive all support needed to maintain their position. The support provided is continued indefinitely. Participation in SE programs is followed by an increase in the ability to find and keep employment.

**Self Assessment Questions 5**

1) The principles of the Convention are:

   i) Respect for inherent dignity, individual autonomy including the freedom to make one’s own choices, and independence of persons;

   ii) Non-discrimination;

   iii) Full and effective participation and inclusion in society;
iv) Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;

v) Equality of opportunity;

vi) Accessibility;

vii) Equality between men and women;

viii) Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

Self Assessment Questions 6

1) The seven conditions termed as disability are as follows:

   i) Blindness

   ii) Low vision

   iii) Leprosy-cured person

   iv) Hearing impairment

   v) Locomotor disability

   vi) Mental retardation

   vii) Mental illness

2) ‘IDEAS’ is “Indian Disability Evaluation and Assessment Scale” commonly referred to as “IDEAS” and its can be used for assessing disability in mental illness. The task for developing this tool was initiated by the Indian Psychiatric Society (IPS).

Self Assessment Questions 7

1) The Rehabilitation Council of India (RCI) is the apex government body, set up under an Act of Parliament, to regulate training programmes and courses targeted at disabled, disadvantaged, and special education requirement communities. It is the only statutory council in India that is required to maintain the Central Rehabilitation Register which mainly documents details of all qualified professionals who operate and deliver training and educational programmes for the targeted communities.

Self Assessment Questions 8

1) Group Home and Rehabilitation Activities under National Trust Act for Disabled Adults (GHARAUNDA) is a new scheme for providing Life Long Shelter & Care to Persons with Disabilities in Group Homes.

2) Association for Rehabilitation under National Trust Initiative of Marketing has been launched to help PWDs in product designing, production processes, packaging and marketing enabling them to live a life with dignity and independence.
Self Assessment Questions 9

1) The rehabilitation centres in India can be grouped as
   i) Those that provide facilities to patient brought by care givers (eg Richmond fellowship Society)
   ii) Those that provide shelter and treat the wandering mentally ill (The Banyan in South India, Pingalwara, PrabhAasraetc in North India).

2.13 UNIT END QUESTIONS

1) Write Short Notes on the following:
   a) Social Skill Training
   b) Vocational Rehabilitation of mentally ill persons
   c) Rehabilitation Council of India
   d) Role of NGOs in psychosocial rehabilitation
   e) UNCRPD
   f) National Trust.

2) Long essay type questions on the following:
   a) What do you understand by psychosocial rehabilitation? How would you rehabilitate a person with chronic schizophrenia?
   b) Write briefly about the PWD Act. Is the act beneficial for all the people with mental illness? Justify.
   c) Write about the government initiatives in rehabilitation of people with mental illness.

2.14 REFERENCES


http://www.ohchr.org
http://www.rehabcouncil.nic.in
http://www.thenationaltrust.co.in
http://www.un.org/disabilities
http://www.unipune.ac.in/dept/Education_Extension/www/PWD.htm

Indian Disability Evaluation and Assessment Scale, 2002. Guidelines for evaluation and assessment of Mental illness and procedure for certification. Published in the Gazette of India (Extraordinary), Part I, Section 1, dated February 27, 2002.


The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 (1 of 1996) Published In Part II, Section 1 of The Extraordinary Gazette of India, Ministry Of Law, Justice and Company Affairs(Legislative Department),New Delhi, the 1st January, 1996/Pausa 11, 1917 (Saka)


2.15 SUGGESTED READINGS


The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 (1 of 1996) Published In Part II, Section 1 of The Extraordinary Gazette of India, Ministry Of Law, Justice and Company Affairs(Legislative Department),New Delhi, the 1st January, 1996/Pausa 11, 1917 (Saka).
UNIT 3  CERTIFICATION FOR DIFFERENT ISSUES RELATED TO MENTAL ILLNESS

Structure

3.0  Introduction
3.1  Objectives
3.2  Medical Certificate for Involuntary Hospitalisation (Indian Mental Health Act, (IMHA) 1987)
   3.2.1  Admission Under Certain Special Circumstances
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3.3  Certificates in Services/jobs and Related Issues
   3.3.1  Treatment Certificate
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   3.3.3  Certification for Leave
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3.4  Benefits of Certification
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3.5  Assessment of Disability in Mental Retardation and Certification
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3.6  Indian Disability Evaluation and Assessment Scale (IDEAS)
3.7  Indian Scale for Autism Assessment
3.8  Assessment of Multiple Disabilities
3.9  Let Us Sum Up
3.10 Answers to Self Assessment Questions
3.11 Unit End Questions
3.12 References
3.13 Suggested Readings

3.0  INTRODUCTION

The dictionary meaning of a medical certificate is “a document stating the result of a satisfactory medical examination” (Collins free online dictionary). Medical Certificate is usually issued regarding the treatment of illness, type of illness, recommendation of leave and fitness for duties. Certification for mental illness may be for different purpose such as certification for admission in a psychiatric hospital or nursing home.
The first requirement of a medical certificate for the detention of a lunatic was by the 1774 Madhouse Act, section 21, but they were called ‘orders’ not ‘certificates’; the name for medical document became certificate under the 1828 Madhouse Act (Roberts, 1981). According to the New Shorter Oxford Dictionary, the word ‘certify’ was first used for declaring a person officially insane in the late 19th century (Roberts, 1981). Presently, certificate in Psychiatry are issued for many purposes other than for committing a patient for hospitalisation.

3.1 OBJECTIVES

After studying this unit, you will be able to:

- develop an overview about the different certificates pertaining to mental health which are in use;
- acquire knowledge regarding the utility and benefits of certification in mental illness;
- assess and evaluate disability in mental retardation, autistic disorders and multiple disability; and
- discuss how disability in mental illness can be assessed with Indian Disability Evaluation and Assessment Scale (IDEAS).

3.2 MEDICAL CERTIFICATE FOR INVOLUNTARY HOSPITALISATION (INDIAN MENTAL HEALTH ACT, (IMHA) 1987)

Involuntary hospitalisation of psychiatric patients is required when a mentally ill person is not willing for admission. Such situations often arise when patient becomes violent and threatens to harm self or others because of mental illness. Alternatively when patients are not able to care for themselves because of mental illness, they may require involuntary commitment. These patients may be admitted under Section 19 (admission under certain special circumstances), Section 22 (Reception Order or Application) and Section 24 (Reception Order on production of mentally ill person) of the Indian Mental Health Act, 1987.

3.2.1 Admission Under Certain Special Circumstances

Psychiatric patients may be admitted and kept as in-patients in a psychiatric hospital or psychiatric nursing home for a maximum period of ninety days if certified by two medical officers as ‘admission under certain special circumstances, prescribed under section 19 of Indian Mental Health Act, 1987. An application is made by the relative or a friend of the mentally ill person to the medical officer-in-charge along with two medical certificates from two medical practitioners (at least one of them should be a Government servant) stating the condition of the mentally ill patient in the prescribed format. Alternatively, the medical officer-in-charge can get the mentally ill examined by two medical practitioners working in the hospital or nursing home.

3.2.2 Reception Order

Reception Order may be obtained under Section 22 (Reception Order on application) and Section 24 (Reception Order on production of mentally ill person)
Certification for Different Issues Related to Mental Illness

There are two situations in which a Reception Order is issued by a magistrate:

**First situation:** When the spouse or any other relative of a mentally ill person, or the medical officer-in-charge of a psychiatric hospital or psychiatric nursing home make an application to the magistrate (under Section 20 of the Mental Health Act, 1987). The medical officer-in-charge makes an application for an admitted mentally ill patient under temporary order, if longer treatment (more than six months) is required. Such applications to the magistrate should be accompanied by two medical practitioners (at least one of them in the service of the Government) stating the mental condition of the alleged mentally ill person. If satisfied, the magistrate issues a Reception Order for commitment of the mentally ill person (under Section 22 of the Mental Health Act, 1987).

**Second situation:** When the officer-in-charge of a police station produces before the magistrate a wandering mentally ill person who is not able to take care of self or is dangerous to self or others (Section 23 of the Mental Health Act, 1987), the magistrate examines the patient personally and gets the patient examined by a medical officer who has to issue a medical certificate stating the condition of the mentally ill person in the prescribed format. If necessary, the magistrate issues a Reception Order for commitment into a psychiatric hospital or psychiatric nursing home (under Section 24 of the Mental Health Act, 1987).

3.2.3 **The Certificates**

Certification usually includes the information about the patient (name, age, gender, father’s name, address etc.), the clinical features of the patient (in brief), opinion about the condition of the patient (by the examining doctor), name and signature of the examining doctor with date and place of examination.

The form and content of medical certificates are described under Section 21 of Mental Health Act, 1987. Every medical certificate that is issued must contain a statement that each of the medical practitioner has: (1) independently examined the alleged mentally ill person (2) formed his opinion on the basis of his own observations and from the particulars communicated to him and (3) that in their opinion the alleged mentally ill person is dangerous to self or others because of the mental disorders which warrants detention of such person in a psychiatric hospital or psychiatric nursing home.

### Self Assessment Questions 1

1) Under what sections of ‘The Mental Health Act, 1987’ there is provision for involuntary hospitalisation of psychiatric patients?

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3.3 CERTIFICATES IN SERVICES/JOBS AND RELATED ISSUES

Certification may be issued for many administrative purposes in which medical officer issues medical certificates stating the health of the patients. There are various circumstances where a Psychiatrist has to issue certificates. Some of these are described below.

3.3.1 Treatment Certificate

Treatment Certificate is a document which certifies that a person has been under treatment from a particular institution for a particular period. This type of certificate is similar to treatment certificates from other non-mental health centers. It is issued by a medical officer and it signifies that the person had been or is currently receiving treatment from a particular centre without further making any comment about the nature of the illness from which the person is suffering. Treatment certificate is required for different purposes such as:

a) To inform the employer that treatment has been initiated or continuing.
b) To apply for leave.
c) To apply for transfer.
d) To get benefit from the employer.

3.3.2 Mental Fitness Certificate

Psychiatrists are the only professionals in the medical community who are called upon to produce legally binding documents that are often presented before the courts and that can determine the course of an individual’s life and liberty and his/her life choices. A person with mental disorder should be assumed to have mental capacity to decide on various matters unless the contrary can be shown. The criteria for incapacity are as follows:

a) The person cannot comprehend and retain information relevant to the decision and its consequences.
b) The person is incapable of believing the information.
c) The person is capable of weighing up information to reach a decision.

The process of deciding fitness or otherwise is of vital importance in various situations. In India, ‘fitness certificates’ are regularly issued by Psychiatrists for the following:

a) To stand trial.
b) To work.
c) For marriage.
d) To take custody of child.
e) To enter into contract.
f) Making a valid will (Testamentary capacity).
g) Fitness to discharge is also given for discharging somebody from mental institutions.

There is no instrument developed in India, unlike in many other countries where legal incapacity decisions are done under very high statutory prescription, ethical dialogue and technical development of tools of assessments. Thus, attribution of “fitness” is often a personal judgment and it should be exercised very carefully.

### 3.3.3 Certification for Leave

When a person who has been working gets mentally ill and is under treatment, it is requested that the Psychiatrist should issue a certificate recommending leave from work for him. He may be given a certificate of leave in the same format which is used for physical illness as recommended by the Medical Council of India (MCI 2002).

The leave, so recommended should be of short duration, for weeks rather than months and should be extended periodically depending on the clinical condition. There are instances when the patient under treatment does not improve and the cumulative leave recommended may be for years. There is no upper limit for recommending leave.

### 3.3.4 Certificate of Fitness to Resume Duties

A mentally ill person who has been treated by a Psychiatrist may demand for fitness certificate to resume his normal duties. It is the solemn duty of a Psychiatrist to issue a fitness certificate if the patient has recovered from the illness and he is fit to resume his duties. To issue a certificate to a person without knowing his designation and nature of job may be risky in some cases. So, if the treating Psychiatrist thinks that the illness was of brief duration, and if the residual symptoms may not hamper the nature of work, certificate of fitness may be issued. However, it is a good practice to issue a treatment certificate and request the employer to write to the treating Psychiatrist stating the designation and nature of work, if an opinion on fitness or otherwise is required.

Although the fitness certificate can be issued by a Psychiatrist, it is advisable that a “Medical Board” is constituted by the Superintendent of the Psychiatric hospital and nursing home. There is no legal or prescribed requirement for such a medical board, but if constituted, it may have a Psychiatrist, a Medical Officer and a Clinical Psychologist. On the recommendation of this board, the hospital may issue appropriate certificate for fitness or otherwise.

### 3.3.5 Certificate for Invalidation from Service (Certificate of Unfitness)

Some of the patients who have been suffering for a long time from psychiatric illness require unfitness certificate so that his family members may get job on compassionate ground or under service rules in certain organisations. Such a written request should be made by the employer requesting for opinion on fitness or otherwise by the employee giving his designation and nature of job. It is not advisable to issue such certificates without any request by the employer and without knowing the nature of the job in detail.
Mental Health Services

Most of such patients are admitted, observed and treated with adequate regimes and for adequate time. They are also assessed by clinical psychologist for fitness for job and investigated (including blood tests, EEG, CT scan, MRI etc.) as required. The patient is then placed before a Medical Board which reviews the cases, clinically examine the patient, reviews investigation, psychological reports and an opinion is formed regarding the unfitness. It is communicated to the employer through a certificate of unfitness if the patient is found to be unfit.

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<td>2) Why is fitness certificate issued?</td>
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3.4 BENEFITS OF CERTIFICATION

Medical certificates serve various purposes. In jobs, it helps a mentally ill person not only for seeking treatment, but also in terms of the “paid leave” that the person gets due to his illness. Many a times these certificates also have medico-legal value.

Government has extended certain benefits to the persons with disabilities. The certification of disability is required to be produced in order to avail benefits. Some of these benefits that can be availed by persons with mental retardation and mental illness will be discussed in the following paragraphs.

3.4.1 Travel Concession

The Indian Railways provide the facility of concession to be used for the mentally retarded persons. The mentally handicapped person and his escort are charged 25% of railway fare to and fro. Various state governments also give concession for using state transport. Presently, only visually impaired are eligible for concessional rates for travel by air.

3.4.2 Income Tax Deduction

Government of India provides the facility of tax deduction benefit for the mentally disabled persons under Section 80 U and 80 DD of the Income Tax Act (ITA),
1961. The current provisions for tax deductions are as follows (Direct Taxes Circular, Sec 80 DD):

a) Handicapped Dependent: The Section DD of ITA includes deduction in respect of maintenance including medical treatment of a dependent who is a person with disability. An assessee, subject to certain conditions, will be allowed to a deduction (Rs 50,000 if the disability is 40% to 75% and Rs 75,000 if disability is severe) from his gross total income in respect of the previous year. The handicapped dependent should be a relative of the assessee and not dependent on any person other than the assessee for his support or maintenance.

b) Handicapped assessee: The Section 80 U of ITA includes deduction from income in cases of disabled persons. If a person has 40% to 75% disability, Rs 50,000 and if disability is ≥ 75%, an amount of Rs 75,000 shall be deducted from his total income in respect of the previous year.

3.4.3 Disability Pension

The Central Civil Services (Extraordinary Pension) Rules, 1978 (further revised in 2000) provided rules for the provision of the disability pension for various diseases. Among these, psychiatric illness has been specified in categories ‘B’ and ‘D’.

Category B: Diseases affected by stress and strain. It includes psychosis and psychoneurosis, hyperpiesia, hypertension, pulmonary tuberculosis etc.

Category D: Diseases affected by training, marching etc. It includes post traumatic epilepsy and other mental changes resulting from skull injury, tetanus, varicose veins, hernia etc.

As per the CCS Rules (clause III and IV), the disability pension is calculated as 50% of the minimum basic pay in the revised scale of the post last held by the employee. It may be reduced proportionately, if the employee did not have the required qualifying service for full pension and disability pension which is 30% of the basic pay, for 10% disability.

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<td>1) What are the benefits of Certification?</td>
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3.5  ASSESSMENT OF DISABILITY IN MENTAL RETARDATION AND CERTIFICATION

Mental retardation is a condition of arrested or incomplete development of the mind, which is especially characterised by impairment of skills manifested during the development period which contributed to the overall level of intelligence, i.e., cognitive, language, motor and social abilities.

3.5.1 Categories of Mental Retardation

**Mild Mental Retardation:** The range of 50 to 69 (standardised IQ test) is indicative of mild retardation. Understanding and use of language tend to be delayed to a varying degree and executive speech problems that interfere with the development of independence may persist into adult life.

**Moderate Mental Retardation:** The IQ is of 35 to 49. Discrepant profiles of abilities are common in this group with some individuals achieving higher levels in visuo-spatial skills than in tasks dependent on language while others are markedly clumsy, do not enjoy social interaction and simple conversation. The level of development of language is variable. Some of those affected can take part in simple conversations while others have only enough language to communicate their basic needs.

**Severe Mental Retardation:** The IQ is usually in the range of 20 to 34. In this category, most of the people suffer from a marked degree of motor impairment or other associated deficits indicating the presence of clinically significant damage to or mal-development of the central nervous system.

**Profound Mental Retardation:** The IQ in this category estimated to be under 20. The ability to understand or comply with requests or instructions are severely limited. Most of such individuals are immobile or severely restricted in mobility, incontinent and capable at most of only very rudimentary forms of non-verbal communication. They possess little or no ability to care for their own basic needs and require constant help and supervision.

3.5.2 Process of Certifications

A disability certificate in this case is issued by a Medical Board consisting of three members duly constituted by the Central/State Government. At least one is a specialist in the area of mental retardation, namely Psychiatrist, Pediatrician and Clinical Psychologist. Whenever required the Chairman of the Board may co-opt other experts.

3.5.3 Variables in Assessing Disability

Following variables need to be taken into consideration while assessing functional loss resulting in permanent Physical Impairment (disability) in Mental Retardation/Mental Illness.

a) Clinical Assessment,

b) Assessment of Adaptive Behaviour, and

c) Intellectual functioning.
A scale for measuring and quantifying disability in mental disorders was developed by the Rehabilitation Committee of Indian Psychiatric Society, (December 2000). Its purpose was the Assessment of Permanent Physical Impairment in Mental Illness based on Indian Disability Evaluation and Assessment Scale (IDEAS).

### 3.5.4 Items of the Scale

i) **Self Care:** Includes taking care of body hygiene, grooming, health including bathing, toileting, dressing eating taking care of one's health.

ii) **Interpersonal Activities (Social Relationships):** Includes initiating and maintaining interactions with others in contextual and social appropriate manner.

iii) **Communication and Understanding:** Includes communication and conversation with others by producing and comprehending spoken/written/nonverbal messages.

iv) **Work:** Three areas are Employment/ Housework/ Education (measures any one aspect).

The above items are to be rated as follows:

- **0-** NO disability (none, absent, negligible)
- **1-** MILD disability (slight, low)
- **2-** MODERATE disability (medium, fair)
- **3-** SEVERE disability (high, extreme)
- **4-** PROFOUND disability (total, cannot do)

**TOTAL SCORE**

Add scores of the 4 items and obtain a total score

**Additional Weightage for Duration of illness (DOI):**

- Less than 2 years: score to be added is 1;
- 2-5 years: add 2;
- 6-10 years: add 3;
- Greater than 10 years: add 4

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<td>1) What is Mental Retardation?</td>
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2) Describe the categories of mental retardation.

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3.6 INDIAN DISABILITY EVALUATION AND ASSESSMENT SCALE (IDEAS)

The Persons with disability act 1995 includes mental illness as disability. The persons with mental illness are eligible to avail all the benefits under the Persons with Disability Act 1995. The disabled people need disability certificate showing more than 40% disability from the competent authority to avail the benefits.

The assessment tools have already existed for the visually impaired, hearing impaired and orthopedic handicap and persons with mental retardation. These people are certified by the authentic body and become eligible by having disability certificates to avail the benefits under the PWD Act 1995. But there were no assessment tools for the certification of mentally ill people and these people did not avail any benefits despite having a disability. Rehabilitation committee of Indian Psychiatric Society developed the assessment tool for disability certification in 2002. This tool is known as Indian Disability Evaluation and Assessment Scale in short (IDEAS). The committee has developed clear guidelines to make use of IDEA easily.

General Guidelines

- IDEAS is best suited for the purpose of measuring and certifying Disability.
- It is therefore a brief and simple instrument, which can be used, even in busy clinical settings.
- Some training is required in the use of IDEAS.
- This is to be used only on out patients and those living in the community. Not appropriate for in-patients.
- Rating should be done only based on interviews of the Primary Care Givers. Case records and patients interviews can be used to supplement information.
- Only in rare instances, when no primary care giver is available, the rating can be based only on patient interview. This should then be documented.
- The gender specification “he” has been used for convenience and refers to both genders.
- Probe questions help to guide one through the interview and to help identify dysfunction in one or more activities.

Diagnostic Categories

Patients with only the following diagnosis as per ICD or DSM criteria are eligible for disability benefits:
• Schizophrenia
• Bipolar Disorder
• Dementia
• Obsessive Compulsive Disorder.

**Duration of illness:** The total duration of illness should be least two years. For the purpose of scoring, the number of months the patients was symptomatic in the last two years (MI 2Y –months of illness in the last two years) should be determined.

**Who does the assessment?**
Only the Psychiatrist can do diagnosis and certification. Trained social workers, psychologist, or occupational therapists can do administration of IDEAS

**Frequency of Re-certification**
Psychiatric Disability will be reassessed every two years and re-certified. The feasibility of doing this in the rural areas will however have to be examined.

**Items**

i) **Self care:** Includes taking care of body hygiene, grooming, health including bathing, toileting, eating and taking care of one’s health.

ii) **Interpersonal Activities** (Social Relationship): Includes initiating and maintaining interactions with others in a contextual and socially appropriate manner.

iii) **Communication and Understanding:** Includes communication and conversation with others by producing and comprehending spoken/ written/ nonverbal messages.

iv) **Work:** Three areas are Employment/ House work/ Education (measures any one aspect).

1) Performing in Work/ Job: Performing in work / employment (paid) employment /self employment family concern or otherwise. Measures ability to perform tasks at employment completely and efficiently and in proper time. Includes seeking employment.

2) Performing in Housework: Maintaining household including cooking, caring for other people at home, taking care of belongings etc. Measures ability to take responsibility for and perform household tasks completely and efficiently and in proper time.


**Scores for Each Item:**

0 – No Disability
1 – Mild Disability
2 – Moderate Disability
3 – Serve Disability
4 – Profound Disability
MI 2 Years < 6 months: score to be added is 1
7-12 months: add 2
13-18 months: add 3
Greater than 18 months: add 4

Global Disability
Total disability score + MI 2Y score = Global Disability Score (range 1-20)

Percentage: For the purpose of welfare benefits, 40% will be cut off point. The scores above 40% have been categorized as Moderate, Severe, and profound based on the Global disability score. This grading will be used to measures change overtime.

Score of 0- No disability = 0%
1-7 – Mild Disability = <40%
8 and above = > 40%
(8-13 moderate disability; 14-19 Severe Disability; 20 Profound Disability)

Self Assessment Questions 5
1) Explain the general guidelines for Indian Disability Evaluation and Assessment Scale in short (IDEAS).

3.7 INDIAN SCALE FOR AUTISM ASSESSMENT

Autism is identified as a cause for disability in the recent working draft of the Persons with Disability Bill 2011 which follows the United Nations Convention for Rights of Persons with Disability. The bill aims to help children with disabilities develop their evolving capacities and preserve their identities. Quantification of disability would help in getting disability benefits.

As there was no Indian scale to diagnose or measure autism, the National Institute for Mentally Handicapped (NIMH) developed the Indian Scale for Assessment of Autism (ISAA) for diagnosing and measuring the severity of autism in 2009. This scale was based on CARS and has 40 items divided under six domains – social relationship and reciprocity; emotional responsiveness; speech, language and communication; behavior patterns; sensory aspects and cognitive component. The items are rated from 1 to 5, increasing score indicating increasing severity of the problem. A score of <70 indicates no autism, 70-106 (mild autism), 107-153 (moderate autism), and >153 (severe autism). It takes about 15 to 20 minutes for administration of ISAA. The ISAA was devised with the aim of quantifying the severity of autistic symptoms so as to enable measurement of associated disability.
Self Assessment Questions 6

1) Describe Indian Scale for Assessment of Autism (ISAA).

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3.8 ASSESSMENT OF MULTIPLE DISABILITIES

The Universal guidelines for assessment and certification of the following Disabilities were finalized by group of experts and were notified by the Ministry of Social Justice and Empowerment, GOI in June 2001.

1) Visual Impairment
2) Locomotor Disability
3) Speech & Hearing
4) Mental Retardation
5) Multiple Disabilities.

Guidelines for certification were also framed.

According to the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Rules, 1996 notified on 31.12.1995 by the Central Government in exercise of the powers conferred by sub-section (1) and (2) of section 73 of the Persons with Disabilities Act, 1995, the empowered persons to give disability certificate, will be a Medical Board, consisting of at least three members, out of which at least one shall be a specialist in the particular field for assessing loco motor/visual including low vision/hearing & speech disability, mental retardation and leprosy cured as the case may be, duly constituted by the Central and State Government. Specified tests as indicated in guidelines should be conducted by the medical board and recorded before a certificate is given. The certificate would be valid for a period of five years for those whose disability is temporary, while in permanent disability the validity is lifelong.

The Director General of Health Services, Ministry of Health & Family Welfare will be the final authority, should there arise any controversy/doubt regarding the interpretation of the definitions/classifications/evaluations/tests etc. The minimum degree of disability should be 40% in order to be eligible for any concession/benefit.

As per PWD Act and in its compliance, various benefits & concessions are to be provided to the ‘persons with disability’. ‘Person with disability’ means a person suffering from not less than forty per cent of any disability as certified by a medical authority;

The ‘disability’ under PWD act means –

i) Blindness,
Mental Health Services

ii) Low vision,
iii) Leprosy-cured,
iv) Hearing impairment,
v) Locomotor disability,
vi) Mental retardation,
vii) Mental illness.

‘Locomotor Disability’ means disability of the bones, joints or muscles leading to substantial restriction of the movement of the limbs or any form of cerebral palsy;

‘Cerebral Palsy’ means a group of non-progressive conditions of a person characterised by abnormal motor control posture resulting from brain insult or injuries occurring in the pre-natal, peri-natal or infant period of development;

‘Leprosy cured person’ means any person who has been cured of leprosy but is suffering from -

i) loss of sensation in hands or feet as well as loss of sensation and paresis in the eye and eye-lid but with no manifest deformity;

ii) manifest deformity and paresis but having sufficient mobility in their hands and feet to enable them to engage in normal economic activity;

iii) extreme physical deformity as well as advanced age which prevents him from undertaking any gainful occupation, and the expression “leprosy cured” shall be construed accordingly;

‘Blindness’ refers to a condition where a person suffers from any of the following conditions, namely:

iv) total absence of sight; or

v) visual acuity not exceeding 6/60 or 20/200 (snellen) in the better eye with correcting lenses; or

vi) Limitation of the field of vision subtending an angle of 20 degree or worse;

‘Person with low vision’ means a person with impairment of visual functioning even after treatment or standard refractive correction but who uses or is potentially capable of using vision for the planning or execution of a task with appropriate assistive device;

‘Hearing Impairment’ means loss of sixty decibels or more in the better ear in the conversational range of frequencies;

‘Mental Illness’ means any mental disorder other than mental retardation;

‘Mental Retardation’ means a condition of arrested or incomplete development of mind of a person which is specially characterised by sub-normality of intelligence;

‘Rehabilitation’ refers to a process aimed at enabling persons with disabilities to reach and maintain their optimal physical, sensory, intellectual, psychiatric or social functional levels;
Multiple disabilities means a combination of two or more of these disabilities as defined in Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995, namely-

i) Loco motor disability including leprosy cured
ii) Blindness/Low vision
iii) Speech & Hearing Impairment
iv) Mental Retardation
v) Mental Illness.

In order to evaluate the multiple disability, the same guidelines shall be used as have been developed by the respective sub-committees of various single disability, viz Mental retardation, Loco motor Disability, Visual Disability, and Speech and Hearing disability.

Disabilities will be evaluated clinically, keeping with the prescribed guidelines (details in the manual) and administration of respective scales e.g. IDEAS (for measuring and quantifying disability in mental disorders).

Self Assessment Questions 7

1) Who is a ‘person with disability’?

2) What is rehabilitation?

3.9 LET US SUM UP

Psychiatrists often have to issue different certificates pertaining to issues like fitness, leave, admission in a mental hospital etc. Certificates have their own utility for the people. Some of them may be useful in obtaining benefits from the government (like disability certificate), whereas some of them may be useful for the judiciary (like fitness to stand trial).

The process of certification should be done of with some care and a thorough assessment of disability is required. There are tools to aid this process along with interview with significant care givers. Certificate of disability can help the person with disability to access some services and concessions by the government which can help them in improving their quality of life.
3.10 ANSWERS TO SELF ASSESSMENT QUESTIONS

Self Assessment Questions 1

1) Under what sections of ‘The Mental Health Act, 1987’ there is provision for involuntary hospitalization of psychiatric patients?

Psychiatric patients may be admitted and kept as in-patients in a psychiatric hospital or psychiatric nursing home for a maximum period of ninety days if certified by two medical officers as ‘admission under certain special circumstances, prescribed under section 19 of Indian Mental Health Act, 1987.

Self Assessment Questions 2

1) A treatment certificate is required for the following purposes:
   i) To inform the employer that treatment has been initiated or continuing
   ii) To apply for leave
   iii) To apply for transfer
   iv) To get benefit from the employer

2) A fitness certificate is issued by Psychiatrists for the following reasons:
   i) To stand trial
   ii) To work
   iii) For marriage
   iv) To take custody of child
   v) To enter into contract
   vi) Making a valid will (Testamentary capacity)
   vii) Fitness to discharge is also given for discharging somebody from mental institutions

Self Assessment Questions 3

1) Medical certificates serve various purposes that are as follows:
   i) In jobs, it helps a mentally ill person not only for seeking treatment, but also in terms of the “paid leave” that the person gets due to his illness.
   ii) Government has extended certain benefits to the persons with disabilities. The certification of disability is required to be produced in order to avail benefits. Some of these benefits are Travel Concession, Income tax deduction and disability pension.

Self Assessment Questions 4

1) Mental retardation is a condition of arrested or incomplete development of the mind, which is especially characterised by impairment of skills manifested during the development period which contributed to the overall level of intelligence, i.e., cognitive, language, motor and social abilities.
2) Categories of Mental Retardation are as follows:

i) Mild Mental Retardation: The range of 50 to 69 (standardized IQ test) is indicative of mild retardation. Understanding and use of language tend to be delayed to a varying degree and executive speech problems that interfere with the development of independence may persist into adult life.

ii) Moderate Mental Retardation: The IQ is of 35 to 49 Discrepant profiles of abilities are common in this group with some individuals achieving higher levels in visuo-spatial skills than in tasks dependent on language while others are markedly clumsy, do not enjoy social interaction and simple conversation. The level of development of language is variable. Some of those affected can take part in simple conversations while others have only enough language to communicate their basic needs.

iii) Severe Mental Retardation: The IQ is usually in the range of 20 to 34. In this category, most of the people suffer from a marked degree of motor impairment or other associated deficits indicating the presence of clinically significant damage to or mal-development of the central nervous system.

iv) Profound Mental Retardation: The IQ in this category estimated to be under 20. The ability to understand or comply with requests or instructions are severely limited. Most of such individuals are immobile or severely restricted in mobility incontinent and capable at most of only very rudimentary forms of non-verbal communication. They posses little or no ability to care for their own basic needs and require constant help and supervision.

Self Assessment Questions 5

1) The general guidelines for IDEAS are:

- IDEAS is best suited for the purpose of measuring and certifying Disability.
- It is therefore a brief and simple instrument, which can be used, even in busy clinical settings.
- Some training is required in the use of IDEAS.
- This is to be used only on out patients and those living in the community. Not appropriate for in- patients.
- Rating should be done only based on interviews of the Primary Care Givers. Case records and patients interviews can be used to supplement information.
- Only in rare instances, when no primary care giver is available, the rating can be based only on patient interview. This should then be documented.
- The gender specification “he” has been used for convenience and refers to both genders.
- Probe questions help to guide one through the interview and to help identify dysfunction in one or more activities.
Self Assessment Questions 6

1) The Indian Scale for Assessment of Autism (ISAA) was developed by the National Institute for Mentally Handicapped (NIMH), for diagnosing and measuring the severity of autism in 2009. This scale was based on CARS and has 40 items divided under six domains – social relationship and reciprocity; emotional responsiveness; speech, language and communication; behavior patterns; sensory aspects and cognitive component. The items are rated from 1 to 5, increasing score indicating increasing severity of the problem. A score of <70 indicates no autism, 70-106 (mild autism), 107-153 (moderate autism), and >153 (severe autism). It takes about 15 to 20 minutes for administration of ISAA. The ISAA was devised with the aim of quantifying the severity of autistic symptoms so as to enable measurement of associated disability.

Self Assessment Questions 7

1) ‘Person with disability’ means a person suffering from not less than forty per cent of any disability as certified by a medical authority.

2) Rehabilitation refers to a process aimed at enabling persons with disabilities to reach and maintain their optimal physical, sensory, intellectual, psychiatric or social functional levels.

3.11 UNIT END QUESTIONS

1) Write Short Notes on the following:
   a) Reception Order
   b) Benefits of certification in mental illness
   c) Disability under PWD Act.
   d) ISAA

2) Read the case study and answer the questions given below:

Mr. A is suffering from chronic schizophrenia. Though he is on medication, his condition has worsened in last four years. He is unemployed for last three years and does not do any work to sustain himself. Household expenses are met from the salary that his wife gets. He is also not able to help in the different household activities. He is unable to maintain his self-care and has to be told to take his bath, brush his teeth etc. He hardly interacts with others including his wife. Many a times, he just mutters something which nobody can understand.

i) How do you proceed to assess the disability of Mr. A.? Discuss in detail.


3.12 REFERENCES


Collins free online dictionary. Available at: http://www.collinslanguage.com/.
Guidelines & Gazette Notification (Committee under chairmanship of DGHS, GOI) issued by Ministry of Social Justice & Empowerment, GOI, Regd No. DL33004/99 (Extraordinary) Part II, Sec. 1, June 13, 2001


http://www.rehabcouncil.nic.in
http://www.thenationaltrust.co.in

Indian Disability Evaluation and Assessment Scale, 2002. Guidelines for evaluation and assessment of Mental illness and procedure for certification. Published in the Gazette of India (Extraordinary), Part I, Section 1, dated February 27, 2002.

Kumar R. Disability, assessment & certification; Guidelines & Explanations, Kolkata: NIOH.


The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 (1 of 1996) Published in Part II, Section 1 of The Extraordinary Gazette of India, Ministry Of Law, Justice and Company Affairs (Legislative Department), New Delhi, the 1st January, 1996/Pausa 11, 1917 (Saka).

3.13 SUGGESTED READINGS

The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 (1 of 1996) Published in Part II, Section 1 of The Extraordinary Gazette of India, Ministry Of Law, Justice and Company Affairs (Legislative Department), New Delhi, the 1st January, 1996/Pausa 11, 1917 (Saka).

The Mental Health Act, 1987 (Act No 14 of 1987), 2007, Delhi, Commercial Law Publishers (India) Pvt Ltd.