

MANUAL OF MENTAL HEALTH FOR SOCIAL WORKERS



सत्यमेव जयते

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



आरोग्यम् सुखसम्पदा

National Institute of Health and Family Welfare





**MANUAL OF
MENTAL HEALTH
FOR
SOCIAL WORKERS**



जगत प्रकाश नड्डा
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स्वास्थ्य एवं परिवार कल्याण मंत्री
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Foreword

Mental health and well-being are fundamental to our collective and individual ability as humans to think, emote, interact with each other, earn a living and enjoy life. Good mental health enables people to realise their potential, cope with the normal stresses of life, work productively and contribute to their communities. Mental health matters, but the world has a long way to go to achieve it. Much more efforts are required to change policy, practice and service delivery systems to ensure mental health needs.

2. Mental, neurological and substance use (MNS) disorders are highly prevalent and burdensome worldwide. The violations of human rights directed towards people with these disorders compound the problem. Human resources with adequate and appropriate training are necessary for scaling up all health interventions, especially for MNS conditions, since care for these conditions relies heavily on health personnel.

3. I am happy to note that the programme division is bringing out a training manual for management of MNS disorders by social workers. It will go a long way in scaling up and expanding District Mental Health Programme in all the districts of the Country. I congratulate the team for this endeavour.

4. My best wishes for success of this important initiative.

(Jagat Prakash Nadda)

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MESSAGE

Mental health is an integral part of health and well-being. It inherently affects physical health and the two are inseparable in terms of achieving a more complete state of wellness. It can be affected by a range of socioeconomic factors that need to be addressed through comprehensive strategies for promotion, prevention, treatment and recovery.

The sheer number of people affected, the associated disability due to mental, neurological and substance use (MNS) disorders, and the fact that effective treatment is available emphasizes the importance of addressing them in primary care. One of the barriers to development of mental health services is the complexity of integrating mental health care effectively with primary care services. The system that provides primary health care is overburdened. Limitations in human resources also contribute to this barrier, because low numbers and types of health professionals have been trained and supervised in mental health care.

I congratulate the program division for bringing out a training manual for management of MNS disorders by Social Workers. The manual shall facilitate in imparting standardized short-term training to Social Workers working at district and sub-district levels.


(B.P. Sharma)

Dr. Jagdish Prasad
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MESSAGE

Mental health is crucial to the overall well-being of individuals, societies and countries. Relative poverty, low education and inequality within communities are associated with increased risk of mental health problems. Mental, Neurological and Substance use (MNS) disorders are also linked in a complex way with many other health conditions. These disorders are often co-morbid with, or act as risk factors for, non-communicable diseases, communicable diseases, sexual & reproductive health of mothers and injuries. Depression and substance use disorders also adversely affect adherence to treatment for other diseases. Despite the prevalence and burden of MNS disorders, a large proportion of people with such problems do not receive treatment and care.

Development of a policy and legislative infrastructure is important to address MNS disorders and to promote and protect the human rights of people with these disorders. It is imperative to have human resources with adequate and appropriate training, especially for MNS conditions. We have shortage of trained human resources in different sub-specialties of mental health. I am happy that the program division is bringing out a training manual for management of MNS disorders by Social Workers, who play an important role in helping patients suffering from mental illness attain improved mental health and well-being.

I congratulate the team for this endeavour.

(Dr. Jagdish Prasad)

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A Brief Overview of Health, Mental Health and Social Work

The World Health Organization defines health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. It is the extent to which an individual or group is able, on the one hand, to realize aspirations and satisfy needs and, on the other hand to change or cope with the environment." (Health Promotion Glossary, p. 1) **Achieving Health For All**, a discussion document released by Health and Welfare Canada in 1986, reflects a growing awareness that health must be viewed in terms of our personal and social resources for action. It speaks of **health as "a resource which gives people the ability to manage and even to change their surroundings...a basic and dynamic force in our daily lives, influenced by our circumstances, our beliefs, our culture and our social, economic and physical environments."** (Achieving Health For All, p. 3)

This active concept of health accords greater prominence than ever to the mental and social determinants of health. It also requires us to think of health as something experienced not only individually, but also collectively. Mental health needs to be understood not just as due to people's traits as individuals but also due to the nature of their interaction with the wider environment. "Environment" includes not only our physical surroundings, both natural and artificial, but also the social, cultural, regulatory and economic conditions and influences that impinge on our everyday lives.

Mental health is very important for every individual, family and the community as a whole. For one to be healthy not only do they have to be physically fit but also emotionally and mentally healthy as well which is necessary for their overall well being and development. A healthy person has a healthy mind and is able to:

- ✓ think clearly;
- ✓ solve problems in life;
- ✓ work productively;
- ✓ enjoy good relationships with other people;
- ✓ feel spiritually at ease; and
- ✓ contribute to the community.

It is these aspects of functioning that can be considered as mental health. To be a healthy person we need to have both mental and physical health, and these are related to each other. Mental health provides individuals with the energy for active living, achieving goals and interacting with people in a fair and respectful way. Although some define mental health as the absence of a mental disorder, it is

not so and means much more than that. The term mental well being is synonymous with health and mental health.

The most commonly quoted definition of health by the World Health Organization (WHO) over half a century ago states it to be *“a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity.”*

World Health Organization (WHO) defined mental health as *‘a state of well-being in which the individual understands his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community’.*

Mental health in earlier times, have usually focused on the psychological and behavioural characteristics of individual people, rather than on conditions in society as a whole. In much the same way, most of the services, programs, laws and professions that have to do with "mental health" are really oriented towards dealing with mental disorder. In these circumstances, it is easy to understand how mental health has come to be viewed simply as freedom from psychiatric symptoms, or the absence of mental disorder.

Mental health is the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective and relational), the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality.

Mental Health encompasses the following themes:

- psychological and social harmony and integration;
- quality of life and general well-being;
- self-actualization and growth;
- effective personal adaptation; and
- the mutual influences of the individual, the group and the environment

Mental Illness / Mental Disorders

Mental illness is one of the most disturbing illnesses that anyone could get in their lifetime. Collective health condition does not solely rely on one’s physical, emotional, and spiritual health but also on their mental health. A mental disorder or mental illness is a change in an individual’s way of thinking and feeling that impedes their ability to perform their daily activities, cognitive, emotions or behaviour. There are several kinds of mental disorders that are classified and detailed in the subsequent chapters.

Mental and behavioural disorders are present at any point in time in about 10% of the adult population. Around 20% of all patients seen by primary health care professionals have one or more mental disorders. It was estimated that, in 1990, mental and neurological disorders accounted for 10% of the total Disability Adjusted Life Years (DALYs) lost due to all diseases and injuries. This was 12% in 2000. By 2020, it is projected that the burden of these disorders will have increased to 15%.

Several myths and misconceptions about mental illness are very commonly seen among people in the community. These need to be appropriately addressed by the Social Workers by allaying their fears and disseminating the right knowledge and information regarding mental illnesses.

Common Myths and Misconceptions:

Myth	Fact
Mental illness is caused by evil spirit or super natural power.	Biological, psychological and social factors are responsible for the causation of mental illness
Mental illnesses are untreatable	Mental illnesses are treatable with proper treatment and counselling
Lack of willpower causes mental illness	Willpower does get affected due to mental illness but is not a cause of mental illness
Marriage can cure mental illness	Marriage cannot cure mental illness; it can act as a stressor
Mentally ill patients belong to hospitals	Majority of persons with mental illness can be treated at out-patient settings or primary care settings. Only those with acute problems require hospitalization
Mental health problems are only seen in illiterate, poor people.	Mental health problems may occur to anybody, irrespective of class, education or class.
People with mental illness can never be productive or do normal work like normal people.	People with mental illness on regular treatment and supervision, can very well lead a productive and qualitative life any normal person.
Mental illness is unlike physical illness; the illness is really all in person's head.	Mental illness is just like physical illness since both are biologically based
Mentally ill people have weak characters since they can't cope with the world in the same way that the rest of us do.	The Development of mental illness has nothing to do with person's character. Mental illness strikes people with all kinds of backgrounds, beliefs, temperament and morals.
Once a psychiatric patient, always a psychiatric patient	A psychiatric patient, with proper treatment, can improve and function well enough in society given the right conditions and opportunities.
Children don't suffer from psychiatric illnesses	Children too get affected by mental illness
Mental health disorders are a result of bad parenting	Bad parenting does not lead to mental illness but may have some role in relapse.
Mental illnesses are contagious	Mental illnesses are not contagious

Myth	Fact
Attempting suicide is a sign of cowardice	Suicide usually is attempted by someone who is depressed and not because he/she is a coward.
Mentally ill patients are violent and dangerous.	Mentally ill patients are no more violent than normal individuals.

What is Social Work?

“The social work profession promotes change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilizing theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work” (International Federation of Social Work, 2001). The purpose of Social Work is problem-solving, empowerment and social change where people interact with their environments (Payne 2006, IFSW 2001).

Why Social Work?

Social work is a profession that focuses upon improving the health and social well-being of individuals, families, groups and communities. Social Workers believe in the rights and dignity of all individuals and to the achievement of social justice. Social workers work with people to assess, resolve, prevent or lessen the impact of psycho-social, physical and mental health related issues.

Social workers are a perfect fit for primary care because primary health care is about-

- Public Participation
- Accessibility of services
- Appropriate Technology
- Interdisciplinary Collaboration
- Health Promotion

The interventions should specifically be person and family centred and focus on:

- Patient Education
- Behavioral Activation
- Relaxation/Stress Reduction
- Enhancing general coping strategies
- Care coordination/care management
- Supportive Listening
- Problem solving/Goal setting
- Pain Management
- Integrated behavioral health

- Emphasis on patient empowerment/self care
- Attention to the social determinants of health
- Team-based care
- advocacy,
- promotion of independence,
- an individualised care plan
- promotion of dignity, respect, client choice and self esteem

Some of the typical and important roles that social workers carry out in the community mental health centres include-

- Providing prevention education on a range of topics (depression screening, sleep hygiene, self care, stress reduction, etc.)
- Conducting a functional assessment and working towards functional restoration using Motivational Interviewing
- Teaching evidence-based skills to patients
- Emphasizing home-based self management
- Providing medication education and supporting adherence
- To stay updated about Govt and welfare schemes for different sections of the population
- To be informed about local melas, camps, community events, resource distribution programs
- Decision making ability- quick and precise at times of crisis, suggesting the best suitable referral service, taking action at times of urgent need
- Critical thinking – ability to evaluate client needs, effectiveness of interventions, needs and issues of associated family members
- Ability to plan and organise work, make notes, document

The requisite knowledge, skills and abilities of a social worker are:

- General knowledge of normal and abnormal human development and behavior.
- General knowledge of recognized treatment interventions such as behavior modification; family, group, and individual psychotherapies; psychosexual education; substance abuse interventions; and use of psychotropic medications.
- Skill in developing and maintaining a therapeutic relationship with mentally ill patients.
- Skill in communicating with patients and families who may be experiencing distress.

- Skill in conducting and teaching individual, family, and group therapies.
- Skill in patient and family education regarding various aspects of mental illness.
- Skill in interviewing to gather data needed to diagnose the needs of individuals and their families.
- Skill in preparing clear, concise written case narratives and reports.
- Skill in functioning as patient advocate to ensure that appropriate social services are being delivered which could include working with State and Federal agencies and community organizations for the coordination of services.
- Ability to maintain effective working relationships with both professional and paraprofessional institution staff and public and private sector professional staff.
- Ability to understand organizational systems and how to work within them for the benefit of the patient.
- Ability to assess the level of dangerousness of patients and the potential for explosive behavior.
- Ability to build and maintain effective working relationships with representatives of a wide variety of community agencies.
- Ability to work as a member of a treatment team

Social Workers also have a strong ethical responsibility towards their Clients-

- Commitment to Clients
- Self-Determination
- Informed Consent
- Competence
- Cultural Competence and Social Diversity
- Conflicts of Interest
- Privacy and Confidentiality
- Follow ethical and moral standards with clients
- Responsible decision making
- Termination of Services.

This manual is intended to provide an orientation to Social Workers working in the community on different kinds of mental health problems and disorders, identification of these disorders by understanding the symptoms and clinical picture, means of assessment and diagnosis and other aspects related to both medical and psychosocial interventions and rehabilitation of persons with mental disorders.

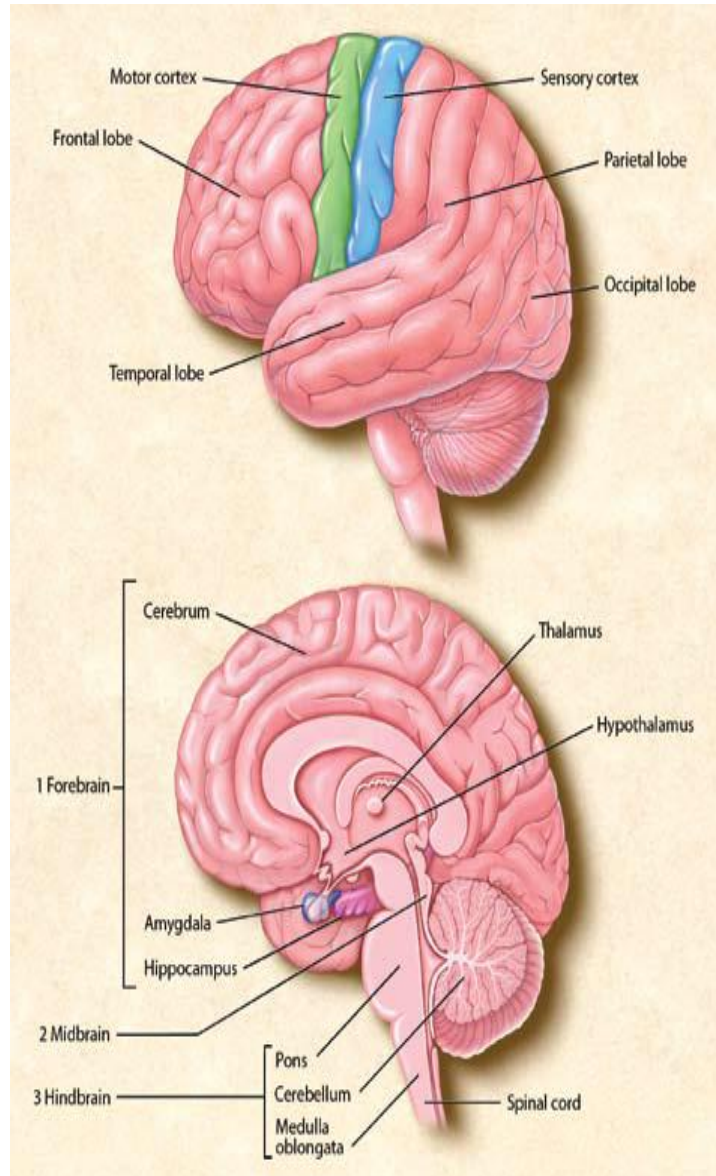
CHAPTER 1

BRAIN AND BEHAVIOUR

Introduction:

The human brain is the most complex organ of the body, and arguably the most complex thing on earth. Weighing about 1.5 kg, it consists of billions of tiny cells. It enables us to sense the world around us, to think and to talk.

Brain has nerve cells - its building blocks - and these are connected together in networks. These networks are in a constant state of electrical and chemical activity. The brain we describe can see and feel. It can sense pain and its chemical tricks help control the uncomfortable effects of pain. It has several areas devoted to co-ordinating our movements to carry out sophisticated actions. A brain that can do these and many other things doesn't come fully formed: it develops gradually. When one or more of these genes goes wrong, various conditions develop. There are similarities between how the brain develops and the



mechanisms responsible for altering the connections between nerve cells which is responsible for learning and remembering.

Basic structure: The brain consists of the stem and the cerebral hemispheres. The human brain and nervous system begin to develop at about three weeks' gestation. The largest part of the brain in volume is the *cerebral cortex*, which is divided into two *hemispheres*. Each is half divided into four *lobes*, the occipital lobe, the temporal lobe, the parietal lobe, and the frontal lobe. Functions, such as

vision, hearing, and speech, are distributed in selected regions. Some regions are associated with more than one function.

The temporal lobe is involved in primary auditory perception, such as hearing, and holds the primary auditory cortex. The occipital lobe is the visual processing center of the brain containing most of the anatomical region of the visual cortex. The frontal lobes are involved in motor function, problem solving, spontaneity, memory, language, initiation, judgement, impulse control, and social and sexual behavior. The parietal lobes can be divided into two functional regions. One involves sensation and perception and the other is concerned with integrating sensory input, primarily with the visual system. The first function integrates sensory information to form a single perception (cognition). The corpus callosum is a large bundle of axons connecting the two cerebral hemispheres. Speech and grammar are localized to the left hemisphere, which mainly controls this ability in most people. Understanding aspects of language such as humour and metaphors is localized in the right hemisphere, which is involved in the processing of nonverbal information. Complex thinking involves both sides of the brain. Major internal structures; The (1) forebrain is credited with the highest intellectual functions — thinking, planning, and problem-solving. The hippocampus is involved in memory. The thalamus serves as a relay station for almost all the information coming into the brain. Neurons in the hypothalamus serve as relay stations for internal regulatory systems by monitoring information coming in from the autonomic nervous system and commanding the body through those nerves and the pituitary gland. On the upper surface of the (2) midbrain are two pairs of small hills, colliculi, collections of cells that relay specific sensory information from sense organs to the brain. The (3) hindbrain consists of the pons and medulla oblongata, which help control respiration and heart rhythms, and the cerebellum, which helps control movement as well as cognitive processes that require precise timing.

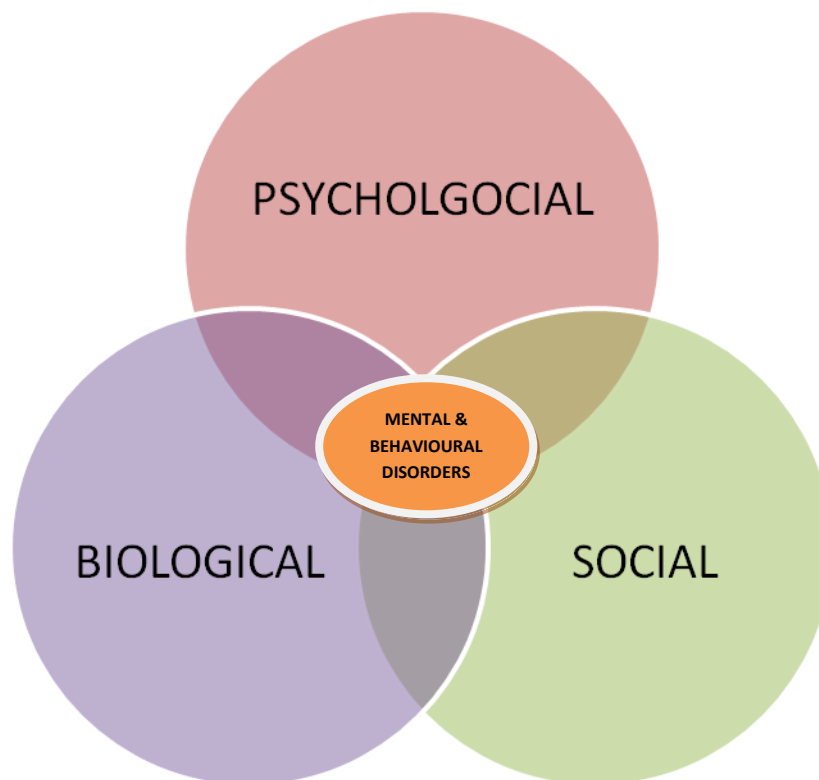
Neurons:

Cells that carry input to the brain are called *sensory neurons*; those that carry output from the brain are called *motor neurons*. Most of the communication in the nervous system takes place through neural networks, which are nerve cells that integrate sensory input and motor output.

The nervous system is divided into the central nervous system and the peripheral nervous system. The central nervous system consists of the brain and the spinal cord. The peripheral nervous system connects the brain and the spinal cord to the other parts of the body. The peripheral nervous system is divided into the somatic nervous system, which contains sensory and motor nerves, and the autonomic nervous system, which monitors the body's internal organs.

Bio-psycho-social cause of mental illness:

Mental disorders are NOT the result of possession by evil spirits, curses, astrological influences, character weakness, laziness, karma or black magic. There are many factors that play a vital role in the onset and course of the mental disorders. Most mental disorders are caused by a combination of factors including: Stressful life events, Biological factors, Individual psychological factors e.g. poor self-esteem, negative thinking, adverse life experiences during childhood e.g. abuse, neglect, death of parents or other traumatic experiences, social factors like poverty, migration, access to health and sanitation etc.



Both physical and mental health is the result of a complex interplay between many individual and environmental factors, including:

- family history of illness and disease/genetics
- lifestyle and health behaviours (e.g., smoking, exercise, substance use)
- levels of personal and workplace stress
- exposure to toxins
- exposure to trauma
- personal life circumstances and history
- access to supports (e.g., timely healthcare, social supports)
- coping skills

When a person is unable to cope effectively with any situation, his/her mental health gets negatively affected. Situations such as economic hardships, unemployment, underemployment and poverty also have the potential to harm and disturb the state of mental health of a person leading to mental illness or mental disorders.

Public Health Approach:

The essential links between biological, psychological and social factors in the development and progression of mental and behavioural disorders are the grounds for a message of hope for the millions who suffer from these disabling problems. While there is much yet to be learned, the emerging scientific evidence is clear: we have at our disposal the knowledge and power to significantly reduce the burden of mental and behavioural disorders worldwide.

This message is a call of action to reduce the burden of the estimated 450 million people with mental and behavioural disorders. Given the sheer magnitude of the problem, its multifaceted etiology, widespread stigma and discrimination, and the significant treatment gap that exists around the world, a public health approach is the most appropriate method of response.

From a public health perspective, there is much to be accomplished in reducing the burden of mental disorders:

- Formulating policies designed to improve the mental health of populations;
- Assuring universal access to appropriate and cost-effective services, including mental health promotion and prevention services;
- Ensuring adequate care and protection of human rights for institutionalized patients with most severe mental disorders;
- Assessment and monitoring of the mental health of communities, including vulnerable populations such as children, women and the elderly;
- Promoting healthy lifestyles and reducing risk factors for mental and behavioural disorders, such as unstable family environments, abuse and civil unrest;
- Supporting stable family life, social cohesion and human development;
- Enhancing research into the causes of mental and behavioural disorders, the development of effective treatments, and the monitoring and evaluation of mental health systems.

The public health approach warrants for the community based approach in the treatment of mental disorders as well as the prevention and promotion of mental health. In order to achieve this goal, the

manpower in the community should be strengthened and capacitated to provide effective care in the community by reducing treatment gap and Disability Adjusted Life Years (DALYs)

Stress:

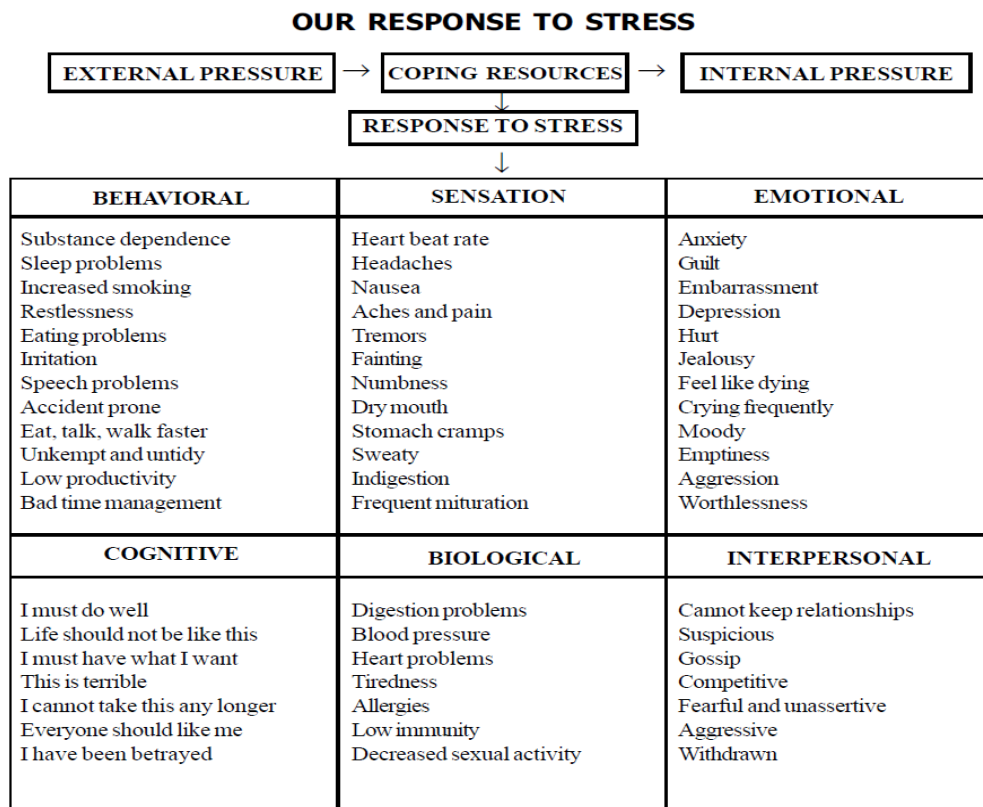
Stress can be a result of both positive and negative experiences, and it is a necessary part of our daily lives. From an evolutionary standpoint stress was necessary for survival (i.e., imagine hunting large prey on which one's entire tribe is dependent) and some stress continues to be a helpful part of our modern lives since it motivates us to accomplish tasks or make needed changes. We all feel the pressure of our environment during times of transition (i.e., at the time of high school graduation) and in preparation for significant life events (i.e., in anticipation of a job interview). Although response to stress is often adaptive (i.e., feeling stress before an exam may be a critical motivator in studying for it), too much stress or an inability to cope with it can cause negative emotional and physical symptoms, including, but not limited to anxiety, irritability, and increased heart rate which would some time result in common mental disorders such as Anxiety, Depression etc.

These sources of stress include hassles such as not being able to hand in an essay, concerns about weight, etc. Finally another source of stress that is worthy to mention is 'work-related stressors.' This source of stress encompasses all the social and environmental conditions at the work place, such as noise, co-worker relationships, but they depend on the nature of the job.

Reactions to stress

The responses to stressors are multidimensional that includes behavioural, sensations, emotional, cognitive, biological and interpersonal responses.

Table: Responses to Stress



Coping:

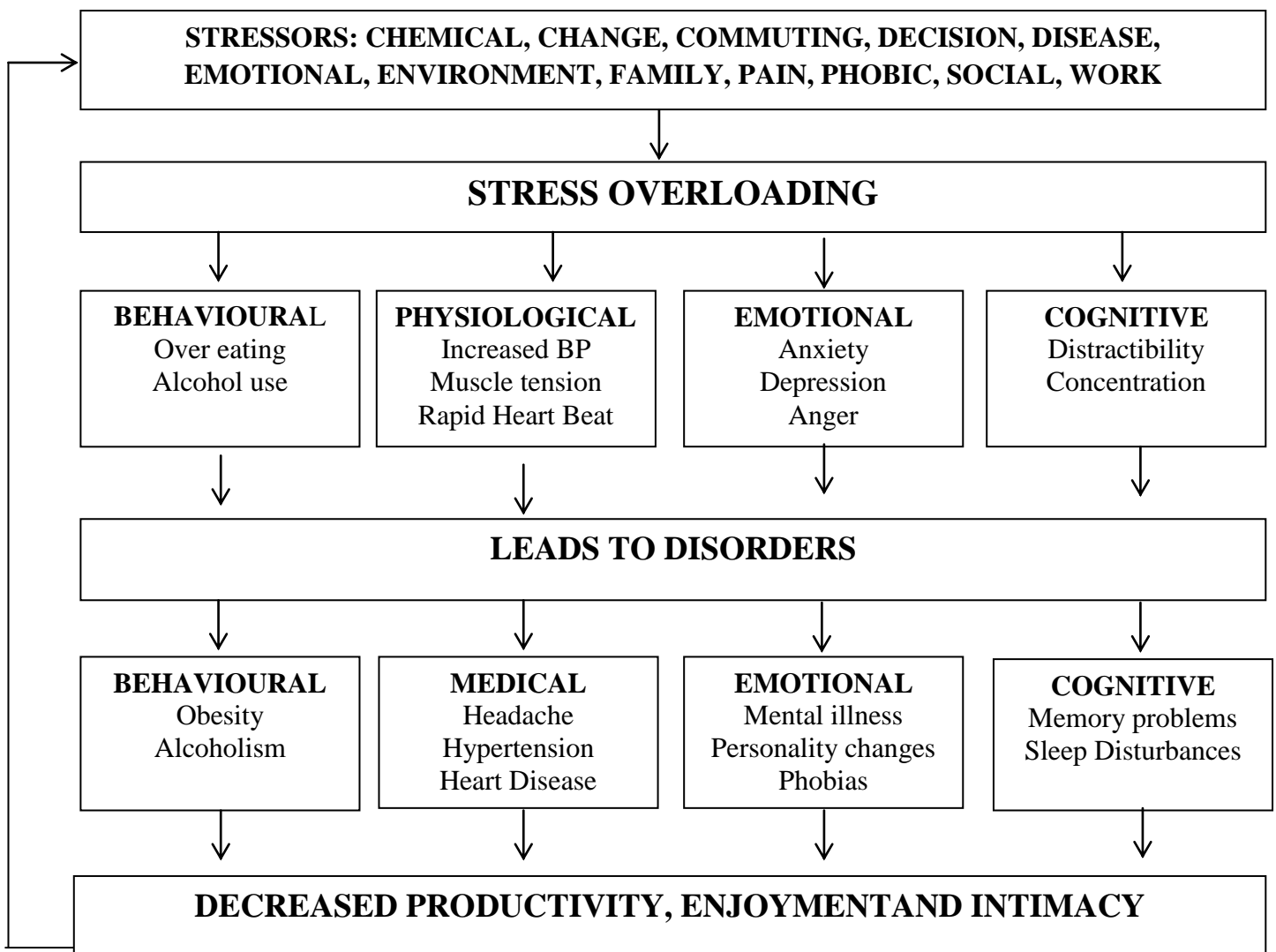
Folkman and Lazarus (1980) define coping as ‘the cognitive and behavioural efforts made to master, tolerate, or reduce external and internal demands and conflicts among them. This definition contains the following implications. (a) Coping actions are not classified according to their effects (e.g., as reality-distorting), but according to certain characteristics of the coping process. (b) This process encompasses behavioral as well as cognitive reactions in the individual. (c) In most cases, coping consists of different single acts and is organized sequentially, forming a coping episode. In this sense, coping is often characterized by the simultaneous occurrence of different action sequences and, hence, an interconnection of coping episodes. (d) Coping actions can be distinguished by their focus on different elements of a stressful encounter (Lazarus and Folkman 1984). They can attempt to change the person–environment realities behind negative emotions or stress (problem-focused coping). They can also relate to internal elements and try to reduce a negative emotional state, or change the appraisal of the demanding situation (emotion-focused coping).

Coping has also a temporal aspect. One can cope before a stressful event takes place, while it is happening (e.g., during the progress of a disease), or afterwards. Beehr and McGrath (1996) distinguish five situations that create a particular temporal context: (a) Preventive coping: Long before the stressful event occurs, or might occur; for example, a smoker might quit well in time to avoid the risk of lung cancer; (b) Anticipatory coping: when the event is anticipated soon; for example,

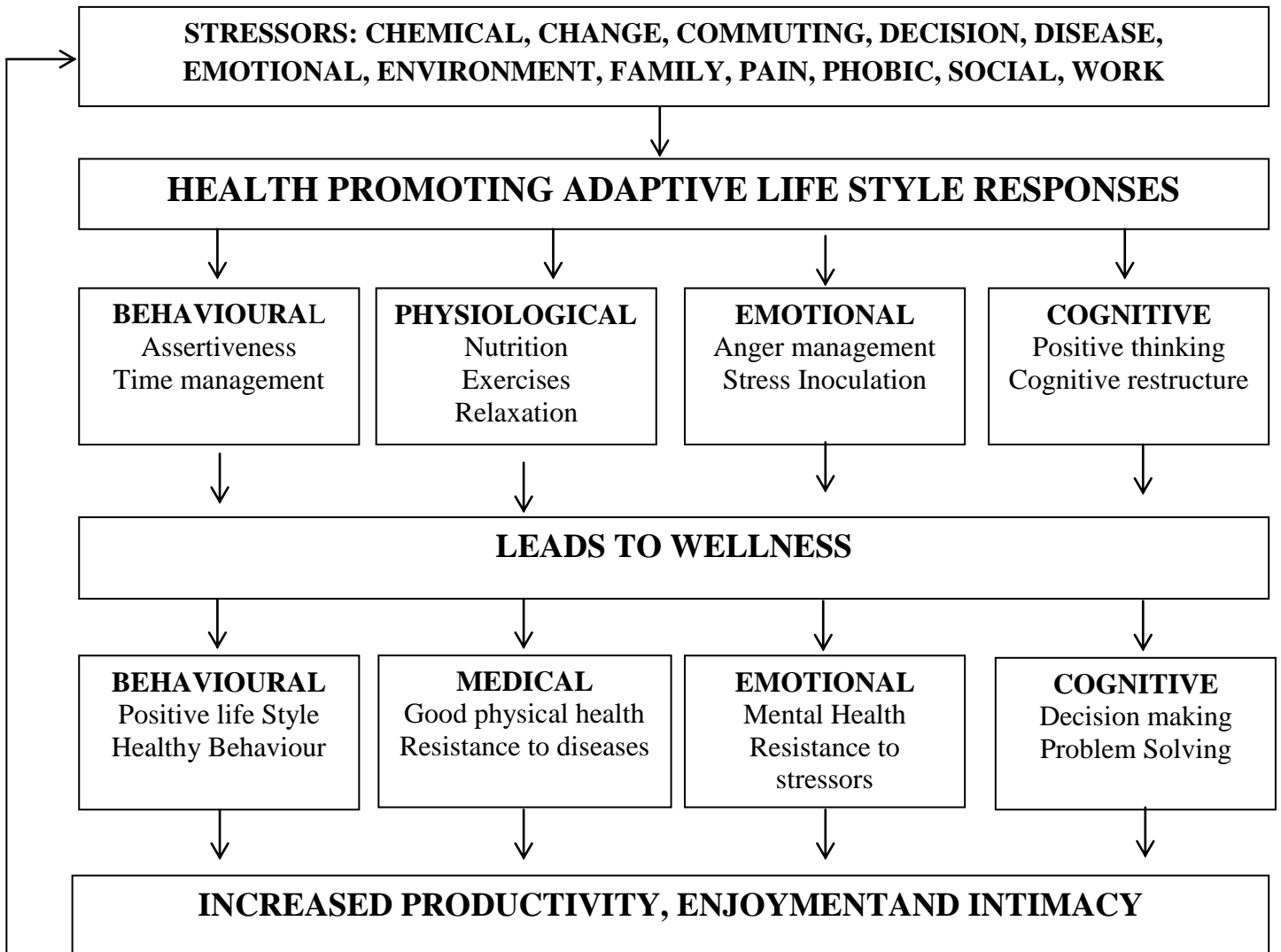
someone might take a tranquillizer while waiting for surgery; (c) Dynamic coping: while it is ongoing; for example, diverting attention to reduce chronic pain; (d) Reactive coping: after it has happened; for example, changing one's life after losing a limb; and (e) Residual coping: long afterward, by contending with long-run effects; for example, controlling one's intrusive thoughts years after a traumatic accident has happened. Five coping strategies were identified Klauer and Filipp (1993) that turned up as dimensions in a factor analysis: (a) Seeking social integration, (b) rumination, (c) threat minimization, (d) turning to religion, and (e) seeking information.

The coping also can be classified as positive and negative coping where the negative coping leads to disorders and positive coping leads to wellness. Below flowcharts show the response of negative and positive coping cycle.

Stress and negative coping:



Stress and Positive coping:



Vulnerability:

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

Some of the common vulnerable factors that could trigger various types of mental illness are:

- childhood abuse, trauma, violence or neglect

- social isolation, loneliness or discrimination
- death of loved ones
- stress
- homelessness or poor housing
- social disadvantage, poverty or debt
- unemployment
- caring for a family member or friend
- a long-term physical health condition
- significant trauma as an adult, such as military combat, being involved in a serious accident or being the victim of a violent crime
- physical causes – for example, a head injury or a condition such as epilepsy can have an impact on behaviour and mood (it is important to rule out causes such as this before seeking further treatment for a mental health problem)
- genetic factors – there are genes that cause physical illnesses, so there may be genes that play a role in the development of mental health problems.

Mental health conditions and vulnerability

Persons with mental and psychosocial disabilities comprise a vulnerable group as they are subjected to high levels of stigma and discrimination, due to widely held misconceptions about the causes and nature of mental health conditions. This group also experiences high levels of physical and sexual abuse. This can occur in a range of settings, including prisons and hospitals. They often encounter restrictions in the exercise of their political and civil rights, largely due to the incorrect assumption that people with mental health conditions are not able to carry their responsibilities, manage their own affairs and make decisions about their lives. In the majority of countries, people with mental and psychosocial disabilities are not able to participate fully in their societies by taking part in public affairs, such as policy decision-making processes.

The majority of people with mental health conditions in low and middle income countries are not able to access essential health and social care. People with severe mental and psychosocial disabilities are also much less likely to receive treatment for physical illnesses.

They also face significant barriers in attending school and finding employment. The exclusion of children with mental and psychosocial disabilities from education leads to further marginalization of this already vulnerable group. Poor educational outcomes also lead to poor employment opportunities. People with these disabilities experience the highest rates of unemployment of people

with disabilities. Due to these factors, people with mental and psychosocial disabilities are much more likely to experience disability and die prematurely, compared with the general population.

Resilience

Resilience, which has been broadly, defined as a dynamic process where individuals display positive adaptation despite experiences of significant adversity or trauma (Goldberg & Williams, 1988). Resilience is often conceptualized as existing along a continuum with vulnerability and implies a resistance to psychopathology, though not total invulnerability to the development of psychiatric disorder (Goldberg, 1972). Resilience is seen as more than simple recovery from insult, rather it can be defined as positive growth or adaptation following periods of homeostatic disruption (Richardson, 2002).

Resilience is the ability to bounce back after experiencing trauma or stress, to adapt to changing circumstances and respond positively to difficult situations. It is the ability to learn and grow through the positive and the negative experiences of life, turning potentially traumatic experiences into constructive ones. Being resilient involves engaging with friends and family for support, and using coping strategies and problem-solving skills effectively to work through difficulties. The term resilience is used in mental health to describe a person's capacity to cope with changes and challenges, and to bounce back during difficult times.

The concept developed from research looking at risk factors for developing mental health problems and substance use. Risk factors are circumstances or experiences which increase the possibility of a person developing a mental health problem or illness, such as having a parent with a mental illness, being bullied or abused, or experiencing a stressful life event. Research showed that some young people, in spite of having a number of risk factors, adapted very well to life's changes and did not develop mental health problems. These people came to be described as resilient, able to bounce back even under difficult circumstances.

Being resilient – being able to overcome challenges and setbacks – helps to promote social and emotional wellbeing. A person who is resilient and has positive social / emotional wellbeing is likely to show the following:

- The capacity for positive personal development in several domains, including
- emotionally, intellectually and creatively
- The capacity to form and maintain positive and respectful relationships with others
- The ability to identify and manage one's own emotions and to understand the
- feelings of others

- Skills in communication, including assertiveness, empathy and negotiation
- The ability to solve problems, make informed decisions and accept responsibility for one's actions
- The capacity to set realistic but rewarding goals and to actively work toward these.

Socially, resilient young people are more caring, responsive to others and have better communication skills. They have a sense of empathy with other people and may have a good sense of humour. As a result, they tend to establish more positive relationships, including friendships with their peers. They may also be more willing to seek help from others when they do experience personal difficulties. This provides the young person with access to an important support network when things become difficult. Good problem-solving skills help young people to think abstractly, reflectively and flexibly.

Building Resilience and Wellbeing

Resilience and wellbeing are dependent upon both internal and external factors. A person's innate way of looking at the world and solving problems can influence their resilience and wellbeing – but people can learn new skills to help them respond more positively to life's challenges. The environment is also important, as people develop working models about social interaction and come to an understanding of what other people expect of them. In a school setting, creating a supportive and caring environment is important. Young people are likely to behave and perform more positively in a classroom and school in which they feel safe and accepted. Schools can also teach or encourage specific skills (such as communication and problem solving), perhaps in the context of a subject on health or personal development. Such skills can also be incorporated into other learning areas or into a home room or pastoral care period.

This dual focus - on both the school/classroom environment and the incorporation of specific skills into the curriculum – means that all teachers (regardless of their learning area) can benefit from an understanding of how to build resilience and wellbeing. This will make your job easier in terms of behaviour management and promoting learning. A caring and supportive environment promotes a sense of connection and belonging, aiding the development of resilience. Studies have shown that a caring relationship with just one adult (such as a parent, grandparent or teacher) can enhance resilience significantly. Young people who have difficult family experiences, such as discord or abuse, may be particularly reliant on a supportive school environment for their wellbeing.

Continuum of Mental Health:

Mental health problems affect society as a whole, and not just a small, isolated segment. These are, therefore, a major challenge to global development. No group is immune to mental disorders, but the risk is higher among the poor, homeless, the unemployed, persons with low education, victims of violence, migrants and refugees, indigenous populations, children and adolescents, abused women and the neglected elderly. For all individuals, mental, physical and social health is closely interwoven vital strands of life. As health, mental health also lies in a continuum from mental health to mental illness.

CHAPTER 2

PSYCHIATRIC ASSESSMENT AND DIAGNOSIS

Psychiatric Assessment:

Purpose of psychiatric diagnostic interview is to collect information that will enable the mental health professional to make a proper diagnosis. A proper diagnosis will help the clinician to predict the future course of illness, treatment and foundation for all subsequent therapeutic decision. Unlike physical medicine, psychiatry has no external validating, no laboratory tests to confirm diagnosis. Diagnosis in psychiatry is solely depends on the skills and knowledge of the mental health professionals, who makes the assessment.

Psychiatric evaluation comprises of two sections. The first section contains psychiatric case history taking which includes socio-demographic details of the client and his/her description about symptoms, current episode, a review of past episodes and treatments. The first section also includes the description about family history of psychiatric problems and client's personal history. The second section of the psychiatric evaluation is the client's current mental status examination, which includes systematic reviews of emotional and cognitive functioning of the client. Information for the mental status examination will be collected from the client, from the significant family members or carer and also from the previous treatment records and other available sources.

Psychiatric History

Socio-demographic details: It includes name, age, sex, socioeconomic background, religion family type, educational status and occupation...etc.

e.g. Mr. B, 34 year old married gentleman, Hindu, completed his B.Sc., currently unemployed from a middle socio economic status of urban background. He is currently staying with his wife and two children.

Chief complaints: The chief complaint is the recording of patient's reasons for taking treatment. It is important to write the details in patient's own words, even if it is senseless because the information from the patient will help the mental health professional to get an idea about patient's insight into the problem.

History of present illness: This section is a chronological description of patient's symptoms of the current episode. This section will focus on the detailed description of nature of symptoms, when these symptoms are started and also detailed explanation of the progression of these symptoms. It is

important to describe even small distinctions in the symptoms which will be helpful in diagnosis. For example; decreased sleep may not be that useful in diagnosis but the detailed description about the sleep disturbance like difficulty in maintaining sleep, difficulty in falling asleep, decreased need for sleep, and early morning awakening which are associated with different diagnosis and will be helpful in making proper diagnosis. As the example given above each symptoms presented in chief complaints should be described in detail in this section.

History of present illness can be divided into two parts in order to make it more simple and clear.

Course of illness

Onset: ‘when did this symptom become a problem?’

Precipitating factors: ‘Can you think of anything that might have caused it?’

- Recent stressors/life events
- Any physical illness/head injury
- Alcohol or substance abuse
- Non-compliance to medications etc

Development: ‘How has it changed over time?’

Reason for referral: ‘why did you seek treatment?’

Associated features: It includes other psychological symptoms related to the present illness.

Past psychiatric history: The past psychiatric history describes all the previous episodes, length of each episodes, symptoms and treatment. History should begin with the first onset of illness and its progress chronologically to current episode. In the case of chronic relapsing and episodic illness each episodes and symptoms should be noted in chronological order. It is important to note down the information about the treatments sought by the client in the past. Detailed history of treatment is necessary to predict the response and non-response to the treatment and also helpful in understanding the effects and adverse effects of medications to the patient. Similarly it is important to collect information about the psychosocial therapies received by the client in the past to understand the modality, frequency, length and benefits of the therapy.

Family history: Information about family history is important because many of the psychiatric disorders are appears to have a familial/genetic component to the cause. Representation of family by using a family tree will be the easiest and comprehensible way to convey the information about family. A detailed description of the psychiatric disorder in the family, who are the person, his/her relationship with the patient, type of psychiatric disorder and treatment availed or not are the significant information which should be covered under this heading. On the other hand family history should convey the information such as who are all there in the family, who is the primary care giver,

nature and extent of support from the family members, financial background of the family, and alcohol or substance use history in the family. The information about family history also should have a significant role in establishing diagnosis.

Personal History: Personal history is intended to describe about the major significant events happened in a person's life which will have some etiological significance. This section includes

- Birth and early development
- Schooling, higher education and academic performance
- Employment history (what age patient started working? Stability in employment, adjustment with other co-workers etc.)
- Sexual history (Puberty, menstrual history if the client is a female, sources of knowledge about sex, premarital exposure to sexual relationship, etc.)
- Legal history (any legal problems)
- Substance use or abuse history

Premorbid personality: Premorbid personality history will assist in diagnostic clarification and give insight into person's strength and weakness. Information which will be collected in this section should focus on patient's behavior and attitudes before the onset of illness. Some of the components of this section are:

- Attitude to self and others
- Predominant mood
- Moral values and religiosity
- Interaction with others
- Hobbies and interests
- Reaction to stress

Mental Status Examination

Appearance: A brief description about patient's appearance such as patient's general appearance, dressing, self-care, non-verbal communications and behavior.

Speech: This section focus on the physical production of speech. Observation may be made about volume, rate, spontaneity, tone and tempo. For example speech of a manic patient will be loud and patient appears to be over familiar where in speech output of a depressed patient will be less and patient appears to be sad and hesitant to talk.

Mood and affect: A brief description about the subjective and objective assessment of mood. Subjective description of mood means the individuals description about his/her inner emotional state:

I feel happy, I feel sad, I am anxious, I am fearful etc. The objective component describes the way in which emotion is communicated through facial expression, speech, and body language etc.

Thought and perception: This section examines the abnormalities present in the thought. The major dimensions to assess about thought are logic, relevance, organization, flow and coherence of thought in response to the general questioning during interview.

A person's thought generally assess on the basis of the thought content (nature) and thought form (process).

Thought - content: Thought content describes a patient's ideas. The important abnormalities needed to be assessed in the thought content are given below:

- Delusions (false unshakeable belief that are not shared by others as a part of religious or sub-cultural group.)
- Overvalued ideas (false or exaggerated belief sustained beyond logic, but with less rigidity than delusions.)
- Preoccupations (thoughts which predominate a person's thinking but are not usually experienced as unwanted)
- Depressive thoughts
- Self-harm, suicidal, aggressive or homicidal ideas
- Obsessions (unwanted, intrusive, and recurrent, patient's own thoughts. Example: repeated and recurrent thoughts about contamination, dirt and germs.)
- Anxiety (excessive long lasting worry about a specific or non-specific events, objects, or situation. e.g. fear of insects (specific phobias)

Thought - form: Thought refers to the formation and coherence of thought and it inferred through the person's speech and expression of ideas.

- Highly irrelevant comments (loose of associations or derailment)
- Frequent change of topics (flight of ideas)
- Excessive vagueness (circumstantial thinking)
- Nonsense words
- Pressured or halted speech (thought racing and blocking).

Perception: Identification of perceptual abnormalities can be critical for detecting serious mental health problems. Hallucinations and illusions are the perceptual abnormalities seen in people with psychiatric problems. Hallucinations are the sensory perceptions occur without the presence of an external sensory stimulus. It can occur at any sensory modalities such as visual, auditory, tactile, olfactory, and gustatory.

- Hallucinations are the most widely known perceptual abnormality
- Hallucinations can affect any sensory modality, though auditory hallucinations are the most common
- It is important to assess the degree of fear and distress associated with hallucinations

Illusion means misinterpretation of a sensory stimulus. Illusions are commonly seen in delirium than in other psychiatric disorders.

Cognitive functions: Examines a person's current capacity to process information and it is important because cognitive functions are often sensitive to mental health problems. Major cognitive functions to be assessed are given below:

- **Level of consciousness** (e.g. alert, drowsy, intoxicated etc.)
- **Orientation** (often expressed in regard to time/place/person – e.g. ability to provide personal information, awareness of time/day/ date/place etc.)
- **Attention and concentration** (concentration is the ability to sustain attention over time. It can be assessed simply by talking with a patient or else ask the patient to count backward from 7's from 100)
- **Memory** (including immediate, recent, remote and short term memory. Immediate memory can be tested by asking a series of numbers and whether the patient repeats the series. Both forward and backward recall can be tested. Most adult could recall five or six numbers forward and three or four numbers backward. Recent memory can be tested by asking about events which happened several minutes or hours before or else give a list of unrelated objects to patient and ask the patient to repeat it after five or ten minutes. Remote memory can be tested by exploring the events, which are two or more years old. It is necessary to corroborate the information with family members or informants.)
- **Abstract thinking** (the ability to mentally shift back and forth between general and specific concepts. Abstract thinking can be assessed by using proverb testing or by asking similarity and difference between two or more items.)
- **Visuospatial processing** (e.g., copying a diagram, drawing a picture)
- **Literacy and arithmetic skills** (to assess the ability to manipulate the numbers mentally. E.g., simple additions, subtraction, or multiplications. Money and change can be used with patients with lower educational background.)
- **Language** (e.g. naming objects, following instructions)
- **General knowledge** (The client's general awareness about the various general information and trends about the society, country, state etc)

Insight and judgment:

Insight: This portion of mental status examination examines patient’s capacity to recognize and understand their own symptoms and illness. It does not measure the severity of the illness. Three important aspects will help in assessing insight of a patient are given below:

- Acknowledgement of a possible mental health problem
- Understanding of possible treatment options and the ability to comply with these.
- Ability to identify and recognize possible pathological actions (e.g. hallucinations or suicidal thoughts)

Judgment: Assessing judgment is helpful to understand about the patient’s responses and decision making in terms of his/her own interactions, self-care or other aspects related to recent or current situation and behavior. Judgment can be examined by assessing a person’s problem solving ability and also can be assessed by exploring recent decision making or asking for patient’s response to a hypothetical situation (e.g. what would you do if you find a closed envelope on the road side? Or what would you do if you see smoke coming out of a house?)

Techniques for psychiatric assessment

- Peaceful and comfortable environment enhances interviewing process. (Interview should be conducted in a comfortable setting without any interruptions and should give adequate time to the client to explain about his/her problems and concerns)
- Communication should be simple, clear and should be sensitive to the age, gender and cultural background of the client.
- Non-verbal communications such as nodding, leaning slightly toward the client demonstrates caring and attentiveness will be helpful in gathering information.
- Choosing appropriate questions. (Use both open-ended and closed-ended questions to gather information. Start with open-ended questions and use closed-ended questions for clarifying information.)
- Recording of the significant information without interrupting the session.

Tips to remember during Psychiatric Assessment:

COMPONENT	DETAILS
Basic information	Information about patient, informants, other medical records.
Chief complaints	What brought the patient to the hospital?
History of present illness	Symptoms, onset, course, severity, triggering events.

COMPONENT	DETAILS
Past psychiatric history	Previous evaluations, therapies, medications, hospitalizations, history of violent behavior, suicide attempt
Family history	History of psychiatric illness, suicide, substance abuse.
Personal history	Birth and childhood development, education, occupation, sexual and substance use history.
Premorbid history	Behaviour, attitudes, hobbies etc. of the patient before the onset of the illness
Mental status examination	Examinations of speech, mood, thought, cognitions, judgment and insight.

The main purpose of assessment and diagnosis in psychiatry is to provide relevant information about the signs, symptoms and other information, which justify the diagnosis and through that to plan for a comprehensive treatment and interventions.

Common Psychiatric Disorders and Diagnosis

Mental disorders comprise a broad range of problems, with different symptoms. However, they are generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others. Examples are schizophrenia, depression, intellectual disabilities and disorders due to drug abuse. The most common psychiatric disorders presenting in general health care are delirium, dementia, depression, anxiety, psychoses, substance dependence and unexplained physical symptoms. This chapter gives a summary of mental disorders and diagnostic criteria for mental disorders.

Organic mental disorders

Organic psychiatric disorders are those with demonstrable pathology or etiology, or which arise directly from a medical disorder. They are thereby distinguished from all other psychiatric disorders, which are traditionally called functional. The major two organic disorders are Dementia and Delirium.

Dementia

Dementia is also known as chronic brain syndrome. Its cardinal feature is memory impairment (short term worse than long-term) without impaired consciousness (delirium). Dementia is the loss of cognitive functioning, which means the loss of the ability to think, remember, or reason, as well as behavioral abilities, to such an extent that it interferes with a person's daily life and activities.

Symptoms of Dementia

1. Memory loss
2. Difficulty performing familiar tasks

3. Problems with language
4. Disorientation to time and place
5. Poor or decreased judgment
6. Problems with abstract thinking
7. Misplacing things
8. Changes in mood or behaviour
9. Loss of initiative

Delirium

Delirium is understood as a complex neuropsychiatric syndrome that is characterized by disturbances in consciousness, orientation, memory, thought, perception, and behaviour due to one or more structural and/or physiological abnormalities directly or indirectly affecting the brain. Clouding of consciousness is the most important diagnostic sign. It refers to drowsiness, decreased awareness of surroundings, disorientation in time and place, and distractibility.

Symptoms of delirium

1. Fluctuating level of consciousness
2. Inattention
3. Disorientation
4. Memory impairment (especially recent events)
5. Sleep disturbance
6. Perceptual disturbances
7. Thought process abnormalities Inability to think clearly and coherently
8. Agitation
9. Apathy and withdrawal
10. Emotional (affective) disturbances

Substance use disorder:

According to World health organization drug is any substance that, when taken into the living organism, may modify one or more its functions. Substance dependence or addiction is a chronic relapsing disorder which not only affects individual but also the family and society. Alcohol, nicotine, cannabis, opioids, inhalants (glue, petrol, etc.) and other prescription drug are the commonly seen substances of abuse.

Different types of Substances includes Depressants, Narcotic Analgesics, Cannabis, Stimulants, Hallucinogens, Inhalants

- a. Identification of substance abuse or addiction can be made on the basis of self-report data from the patient, clinical symptoms and signs and also by laboratory reports of blood and urine. There is a criteria given by WHO (ICD-10) to diagnose addiction which is given below,
- b. Strong desire or sense of compulsion to take the substance.
- c. Loss of control – difficulty in controlling taking substances in terms of onset, quantity of use and termination
- d. Physiological withdrawal state – when substance use has stopped or been reduced lead to withdrawal symptoms (e.g. tremors, vomiting, sleep disturbances, restlessness, body pains and aches, sweating etc.)
- e. Tolerance – In order to get the effects of the substances obtained with lower doses, person has to take higher doses.
- f. Progressive neglect of alternative pleasures or interests – because individual tends to spend more time on procuring and using the substances.

Continue to use substances despite of harmful effects caused by the substances.

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

Schizophrenia:

Schizophrenia is a disorder characterized by apathy, absence of initiative (avolition), and affective blunting. These patients have alterations in thoughts, perceptions, mood, and behavior. Many persons with schizophrenia display delusions, hallucinations and misinterpretations of reality.

Clinical Features of Schizophrenia:

- a. Prior history of schizotypal or schizoid personality traits or disorder is often present.
- b. Symptoms of schizophrenia have been traditionally categorized as either positive or negative.
- c. Depression and neuro-cognitive dysfunction are gaining acceptance as terms to describe two other core symptoms of schizophrenia.

A. Positive symptoms

- a. Hallucinations are most commonly auditory or visual, but hallucinations can occur in any sensory modality.
- b. Delusions.
- c. Disorganized behaviour.
- d. Thought disorder is characterized by loose associations, tangentiality, incoherent thoughts, neologisms, thought blocking, thought insertion, thought broadcasting, and ideas of reference.

B. Negative symptoms

- a. Poverty of speech (alogia) or poverty of thought content.
- b. Anhedonia.

- c. Flat affect.
- d. Loss of motivation (avolition).
- e. Attentional deficits.
- f. Loss of social interest.

C. Cognitive impairment.

Cognitive dysfunction (including attention, executive function, and particular types of memory) contribute to disability and can be an obstacle in long-term treatment. Atypical antipsychotics may improve cognitive impairment.

D. The presence of tactile, olfactory or gustatory hallucinations

Delusional Disorders

The main feature of this disorder is the presence of delusions, which are unshakable beliefs in something untrue. People with delusional disorder experience non-bizarre delusions, which involve situations that could occur in real life, such as being followed, poisoned, deceived, conspired against, or loved from a distance. These delusions usually involve the misinterpretation of perceptions or experiences. In reality, however, the situations are either not true at all or highly exaggerated.

People with delusional disorder often can continue to socialize and function normally, apart from the subject of their delusion, and generally do not behave in an obviously odd or bizarre manner.

Mood (affective) disorders

It is the most common, severe and persistent psychiatric disorder. In these disorders, the fundamental disturbance is a change in mood or affect, usually to depression (with or without associated anxiety) or to elation. This mood change is normally accompanied by a change in the overall level of activity, and most other symptoms are either secondary to, or easily understood in the context of, such changes. Most of these disorders tend to be recurrent, and the onset of individual episodes is often related to stressful events or situations. Depression, mania, and bipolar are major categories come under mood disorders.

Depression

Many people use the word depression to describe feelings of sadness and loss. These feelings often pass within a few hours or a few days. During this time people are able to carry out their normal activities. The medical illness called depression is different from transient feelings of sadness. In depression, as a medical disorder, sad feelings are felt much more intensely and for a longer period of time. It can be affected different dimensions such as motivation and mood, psychological functioning,

as well as physical activity of the client. These symptoms can be disruptive to work, social life and family life.

Mood and Motivation	Psychological	Physical
<ul style="list-style-type: none"> • Continuous low mood • Loss of interest or pleasure • Hopelessness • Helplessness • Worthlessness 	<ul style="list-style-type: none"> • Guilt / negative attitude to self • Poor concentration/memory • Thoughts of death or suicide • Tearfulness 	<ul style="list-style-type: none"> • Slowing down or agitation • Tiredness / lack of energy • Sleep problems • Disturbed appetite (weight loss/increase)

Depression can be graded into mild, moderate, and severe based on the severity of symptoms. According to ICD-10 symptoms of depression is divided into two, first is the core symptoms of depression and the second one is called secondary symptoms. Severity of depression can be diagnosed based on the criteria given below:

Core symptoms of depression

1. Depressed mood
2. Loss of interest
3. Reduced energy or increased fatigue

Secondary Symptoms

1. Reduced attention and concentration
2. Reduced self-esteem
3. Ideas of guilt and worthlessness
4. Ideas or acts of suicide
5. Disturbed sleep
6. Decreased appetite

A. Mild depression

Depressed mood, loss of interest, and reduced energy are the typical symptoms of depression, and if a client presented with at least two of these symptoms plus any of two secondary symptoms of depression and if these episode last minimum period of two weeks can be diagnosed with mild depression. An individual with a mild depressive episode is usually distressed by the symptoms, usually present with some somatic symptoms and has some difficulty in continuing with ordinary work and social activities, but will probably not stop to function completely.

B. Moderate depression

A client present with at least any two of the core symptoms of depression plus three of the secondary symptoms of the depression with minimum duration of two weeks can be diagnosed with moderate depression. A person with moderate depression will have considerable difficulty in continuing with personal, familial, and social functioning.

C. Severe depression

In severe depression, the client usually presents with considerable distress, agitation and marked dysfunction in personal, occupational, familial and social life. Person with severe depression present with all three core symptoms of depression plus at least four secondary symptoms for minimum duration of two weeks. Loss of self-esteem or feelings of uselessness or guilt are likely to be prominent, and suicide is a distinct danger in particularly severe cases. Severe depression can be presented with or without psychotic symptoms.

Mania

Mania is characterized by feelings of heightened energy, over talkativeness, over activity, and decreed need for sleep. Other symptoms of mania are given below:

- a) Client usually appears cheerful and euphoric but may be irritable, which can quickly turn into anger.
- b) Rapid speech ('pressure of speech') and sometimes may rapidly shift from one topic to another ('flight of idea')
- c) Increased mental and physical activities
- d) Social disinhibition
- e) Decreased need for sleep and increased or reduced appetite
- f) Poor insight
- g) Psychotic symptoms such as delusions (e.g. Delusions of grandiosity) or hallucinations.

Mania can be divided into hypomania and mania (symptoms are mentioned above) on the basis of severity of symptoms.

Bipolar Affective Disorder

This disorder is characterized by repeated (i.e. at least two) episodes in which the patient's mood and activity levels are significantly disturbed, this disturbance consisting on some occasions of an elevation of mood and increased energy and activity (mania or hypomania), and on others of a lowering of mood and decreased energy and activity (depression). Characteristically, recovery is usually complete between episodes. The cycles of bipolar disorder last for days, weeks, or months.

And unlike ordinary mood swings, the mood changes of bipolar disorder are so intense that they interfere with your ability to function. Other characteristics of bipolar affective disorder are:

- Manic episode usually begin abruptly last for between two weeks to five months.
- Depressive episode lasts for six months.
- Inter-episodic remissions between episodes.

Bipolar I and bipolar II disorders are the major two types of bipolar affective disorder.

Case example of depression

Ms. L is a 28 year-old married female from a middle class family. She has a very demanding, high stress job as an IT professional. Ms. L has always been a high achiever. She graduated with top honors in her graduation and post-graduation. She has very high standards for herself and can be very self-critical when she fails to meet them. Lately, she has struggled with significant feelings of worthlessness and shame due to her inability to perform as well as she always has in the past.

For the past few weeks Ms. L has felt unusually fatigued and found it increasingly difficult to concentrate at work. Her co-workers have noticed that she is often irritable and withdrawn, which is quite different from her typically cheerful and friendly nature. She has called in sick on several occasions, which is completely unlike her. On those days she stays in bed all day, watching TV or sleeping.

At home, Ms. L's husband has noticed changes as well. She's shown little interest in day to day activities and has had difficulties falling asleep at night. Her sleep disturbances had been keeping him awake for an hour or two after they go to bed. He has observed that she is looking sad and tearful without any proper reason. When he tries to get her to open up about what's bothering her, she pushes him away with an abrupt "everything's fine".

Although she hasn't ever considered suicide, Ms. L has found herself increasingly dissatisfied with her life. She's been having frequent thoughts of wishing she was dead. She gets frustrated with herself because she feels like she has every reason to be happy, yet can't seem to shake the sense of doom and gloom that has been clouding each day as of late.

2.2.5. Anxiety disorders:

An anxiety disorder is a common mental illness defined by feelings of uneasiness, worry and fear. While anxiety occurs for everyone sometimes, a person with an anxiety disorder feels an inappropriate amount of anxiety more often than is reasonable.

Generalized Anxiety Disorder

Generalized anxiety disorder (GAD) is the most common of the anxiety disorders. It is characterized by unrealistic or excessive anxiety and worry about two or more life circumstances for at least six months.

Clinical Features of Generalized Anxiety Disorder

- a. Other features often include insomnia, irritability, trembling, muscle aches and soreness, muscle twitches, clammy hands, dry mouth, and a heightened startle reflex. Patients may also report palpitations, dizziness, difficulty breathing, urinary frequency, dysphagia, light-headedness, abdominal pain, and diarrhoea.
- b. Patients often complain that they “can't stop worrying,” which may revolve around valid concerns about money, jobs, marriage, health, and the safety of children.
- c. Chronic worry is a prominent feature of generalized anxiety disorder, unlike the intermittent terror that characterizes panic disorder.
- d. Mood disorders, substance- and stress-related disorders (headaches, dyspepsia) commonly coexist with GAD. Up to one-fourth of GAD patients develop panic disorder. Excessive worry and somatic symptoms, including autonomic hyperactivity and hypervigilance, occur most days.
- e. About 30-50% of patients with anxiety disorders will also meet criteria for major depressive disorder. Drugs and alcohol may cause anxiety or may be an attempt at self-treatment. Substance abuse may be a complication of GAD.

Panic disorder

Patients with panic disorder report discrete periods of intense terror and fear of impending doom, which are almost intolerable.

Symptoms of Panic Disorder

- A. Recurrent unexpected panic attacks occur, during which four of the following symptoms begin abruptly and reach a peak within 10 minutes in the presence of intense fear:
 - a. Palpitations, increased heart rate.
 - b. Sweating.
 - c. Trembling or shaking.
 - d. Sensation of shortness of breath.
 - e. Feeling of choking.
 - f. Chest pain or discomfort.
 - g. Nausea or abdominal distress.

- h. Feeling dizzy, lightheaded or faint.
 - i. De-realization or depersonalization.
 - j. Fear of losing control or going crazy.
 - k. Fear of dying.
 - l. Chills or hot flushes.
- B. At least one of the attacks has been followed by one month of one of the following:
- a. Persistent concern about having additional attacks.
 - b. Worry about the implications of the attack, such as fear of having a heart attack or going crazy.
 - c. A significant change in behaviour related to the attacks.

Obsessive-Compulsive Disorder (OCD)

Obsessive-compulsive disorder (OCD) is an anxiety disorder characterized by uncontrollable, unwanted thoughts and repetitive, ritualized behaviors you feel compelled to perform.

Clinical Features of Obsessive-Compulsive Disorder

- a. Compulsions often occupy a large portion of an individual's day, leading to marked occupational and social impairment.
- b. Situations that provoke symptoms are often avoided, such as when an individual with obsessions of contamination avoids touching anything that might be dirty.
- c. Depression is common in patients with OCD.
- d. Alcohol or sedative-hypnotic drug abuse is common in patients with OCD because they attempt to use the drug to reduce distress.

2.2.6. Social Phobia

Social anxiety disorder, also called social phobia, is an anxiety disorder in which a person has an excessive and unreasonable fear of social situations. Anxiety (intense nervousness) and self-consciousness arise from a fear of being closely watched, judged, and criticized by others.

Clinical Features of Social Phobia

- A. Patients often display hypersensitivity to criticism, difficulty being assertive, low self-esteem, and inadequate social skills.
- B. Avoidance of speaking in front of groups may lead to work or school difficulties. Most patients with social phobia fear public speaking, while less than half fear meeting new people.
- C. Less common fears include fear of eating, drinking, or writing in public, or of using a public restroom.

Case example

A 25 year old young man named Mr. R., an electrical engineer by profession, wants to go to parties and other social events... indeed, he is very, very lonely... but he never goes anywhere because he's very nervous about meeting new people. Too many people will be there and crowds only make things worse for him. The thought of meeting new people scares him... will he know what to say? Will they stare at him and make him feel even more insignificant? Will they reject him outright? Even if they seem nice, they're sure to notice his frozen look and his inability to fully smile. They'll sense his discomfort and tenseness and they won't like him... there's just no way to win... "I'm always going to be an outcast," he predicts. And he spends the night alone, at home, watching television again. He feels comfortable at home. In fact, home is the only place he does feel completely comfortable. He hasn't gone anywhere else in the last couple of years.

Post-Traumatic Stress Disorder (PTSD)

Post-Traumatic Stress Disorder a condition of persistent mental and emotional stress occurring as a result of injury or severe psychological shock, typically involving disturbance of sleep and constant vivid recall of the experience, with dulled responses to others and to the outside world

Clinical Features of Post-Traumatic Stress Disorder

- A. Survivor guilt (guilt over surviving when others have died) may be experienced if the trauma was associated with a loss of life.
- B. Personality change, poor impulse control, aggression, dissociative symptoms, and perceptual disturbances may occur.
- C. The risk of depression, substance abuse, other anxiety disorders, somatization disorder, and suicide are increased.

Somatiform disorder

The main feature of somatoform disorders is repeated presentation of physical symptoms, together with persistent requests for medical investigations, in spite of repeated negative findings and reassurances by doctors that the symptoms have no physical basis. If any physical disorders are present, they do not explain the nature and extent of the symptoms or the distress and preoccupation of the patient. Even when the onset and continuation of the symptoms bear a close relationship with unpleasant life events or with difficulties or conflicts, the patient usually resists attempts to discuss the possibility of psychological causation; this may even be the case in the presence of obvious depressive and anxiety symptoms.

Clinical Features of Somatization Disorder

- A. Somatization disorder is a chronic problem, and patients frequently seek medical treatment or pursue multiple concurrent treatments. Patients undergo multiple procedures, surgeries, and hospitalizations. The disorder often begins during adolescence.
- B. Frequently encountered symptoms include nausea, vomiting, extremity pain, shortness of breath, and pregnancy or menstruation associated complaints.
- C. The frequency and severity of symptoms may vary with level of stress.

Dissociative disorder

Dissociative disorders are characterized by a disturbance or alteration in the normally integrative functions of identity, memory, and consciousness. These disorders range from disturbances in memory to developing a feeling that one's own reality is lost to manifesting additional personalities. Dissociative disorders usually have some relation to trauma, personal conflict, and conflictual relationships with others. "Dissociation" is thought to develop in individuals as self-Defence against trauma whereby a person alters consciousness as a way of dealing with an emotional conflict or external stressor.

Types of dissociative disorder

A. Dissociative amnesia

It is characterized by severe impairment in remembering important information about one's self. This is perhaps the most common of the dissociative disorders and like all other dissociative illnesses is associated with traumatic events. This amnesia can be limited to specific details or events but can also encompass entire aspects of a person's life.

B. Dissociative fugue

It is a massive disorientation of self that leads to confusion about one's personal identity and potentially the assumption of a new identity

C. Depersonalization disorder

It is marked by recurrent feelings of detachment or distance from one's own experiences and can be associated with the experience that the world is unreal. While many people experience these sensations at one point in their lives, an individual with depersonalization disorder has this experience so frequently or severely that it interrupts his or her functioning.

D. Dissociative Identify disorder (DID)

DID is the most famous and controversial of the dissociative disorders. This is characterized by having multiple “alters” (personal identities) that control an individual’s behavior and actions at different times.

E. Dissociative convulsions

Dissociative convulsions (pseudoseizures) may mimic epileptic seizures very closely in terms of movements, but tongue-biting, serious bruising due to falling, and incontinence of urine are rare in dissociative convulsion, and loss of consciousness is absent or replaced by a state of stupor or trance.

Common mental health problems in children:

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

Mental retardation (MR)	Attention Deficit Hyperactivity Disorder	Learning disability
<ul style="list-style-type: none"> • Impairment in skills • Developmental delay in all the areas such as cognitive, motor, language and social. • Difficulties with functioning in everyday activities of life • Poor academic performance • Difficulty in comprehension especially complex instructions • Developmental delay can occur with or without any other physical or mental problems 	<ul style="list-style-type: none"> • Impaired attention and over activity • Frequent change from one activity to another activity • Accident prone • Difficulty to discipline • Frequently makes careless mistakes • Frequently lose things • Easily get distracted or get bored • Often interrupts others or other children in the class. • Early onset (within 5years of age) 	<ul style="list-style-type: none"> • Difficulty in reading/writing/calculations • Difficulty in remembering • Trouble in following directions • Problems in staying organized • Inconsistent school performance • Problems in understanding words and concepts • Problems in eye-hand coordination • Difficulty in placing letters in correct sequence / sounding out words • Delayed speech development • Normal IQ

Detection of Mental Illness in the Community:

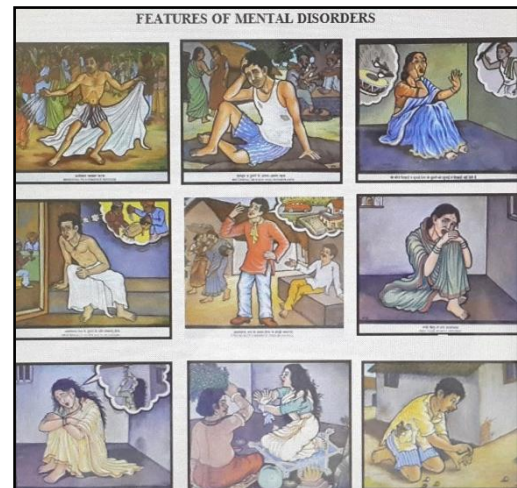
Mental disorders are highly prevalent and cause considerable suffering and disease burden. Adding fuel to this public health problem, many individuals with psychiatric disorders remain untreated in the community although effective treatments exist. Only a minority of individuals with these disorders ever receive treatment in the specialized mental health care system or in the general health care system. Persons with these disorders are failing to seek treatment because the problem is not acknowledged, perceiving that treatment is not effective, believing that the problem will go away by itself, deciding to deal with the problem without outside help, stigma, financial problems, issues of accessibility and limited or lack of availability of resources.

Majority of the persons with mental illness remain in the community untreated. Untreated mental illness increases the disability associated with mental illness. So it is very important to detect them in the community and link them to the mental health care system. If the detection and treatment initiated at the early stages of the illness, the recovery will be better and the disability can be prevented to a large extent.

Ways to improve detection of mental illness in the community:

Mental health awareness to the community

Mental health awareness programme is the process of developing awareness in the community about mental illness using methods like face to face talk, public meeting and lectures, pamphlets, street theatres, folk dance and drama. Programmes aimed at increasing awareness about mental illness will help the common people to identify person with mental health problems in the community, sensitize the common man to mental health issues and destigmatize mental illness among the general population. It increases treatment and help seeking behaviour among common people. Therefore one of the methods of detection of mental illness in the community is to increase awareness about mental disorders.



Examples: SCARF (Schizophrenia Research Foundation) Chennai, Tamil Nadu had initiated a programme in 2011. A bus with multiple facilities travels from village to village spreading awareness about mental illness using TV and other means along with psychiatric consultation and medicine. Please follow the link for further details about the programme (<http://www.scarfindia.org/community-mental-health/>).

Capacity building:

Capacity building is the process of developing and strengthening the skills, abilities, process and resources. Lack of adequate number of mental health professionals is one of the key issues in identifying and treating person with mental health problems. Non-Governmental Organizations(NGO) staff members, health workers, lay counselors, ICDS (Integrated Child Development Scheme) workers, ASHA workers, school and college teachers, NSS volunteers, retired government officials, village leaders and Self Help Group(SHG) members are other groups of professionals and non-professionals, who have close contact with community people. These groups of professionals or semi-professionals can be trained for identifying and referring persons with mental health issues. They can identify persons with mental health problems and can work as a mediator between mental health care system and persons affected with mental health problems. Initial screening can be done by the trained personnel using simple screening tools developed for the purpose of community level workers.

ICMR CENTRE FOR ADVANCED RESEARCH ON COMMUNITY MENTAL HEALTH
 DEPARTMENT OF PSYCHIATRY, NIMHANS, BANGALORE 560 029, INDIA
LONGITUDINAL STUDY OF MENTAL HEALTH PROBLEMS IN A PHC AREA
INITIAL PROFORMA FOR SCREENING

1. PHC: _____ 2. PHU: _____ 3. SC: _____ 4. VILLAGE: _____
 5. Str. No.: _____ 6. H.H. No.: _____ 7. Name of the informant: _____

	1. YES	2. NO	3. NK	
1. Who is admitted to Mental Hospital? ಯಾರಾದರೂ ಮಾನಸಿಕ ಆಸ್ಪತ್ರೆಗೆ ಸೇರಿದರಾಗಿದೆಯೇ?				16
2. Who is mad, talks nonsense and acts in a strange manner? ಯಾರಾದರೂ ಹುಚ್ಚು, ಓದಿಮ, ಅರ್ಥವಿಲ್ಲದ ಮಾತಾಡುವುದು ಅಥವಾ ವಿಚಿತ್ರವಾಗಿ ವರ್ತಿಸುವುದು ಮಾಡುತ್ತಾರೆಯೇ?				17
3. Who suffer from fits or loss of consciousness? ಯಾರಾದರೂ ಮೂರ್ಛ ರೋಗಿಯಿಂದ ಅಥವಾ ಶ್ರಮ್ಭ ತಪ್ಪಿ ದೀನುವ ತೊಂದರೆಯಿಂದ ಬಳಲುತ್ತಾರೆಯೇ?				18
4. Who has become very quiet and does not talk to people? ಯಾರಾದರೂ ಬಹು ಶೂಂತ ಮಾತಾಡದೆ, ಬಹು ಮಂಚಾಗಿರುವುದುಂಟೆ?				19
5. Who claims to hear voices or see things others cannot hear or see? ಯಾರಾದರೂ, ಬೆರೆಯಬರೆಗೆ ಕಾಣಿಸದ ಧ್ವನಿ ತನಗೆ ಕಾಣುತ್ತದೆ ಅಥವಾ ಬೆರೆಯಬರೆಗೆ ಕಾಣಿಸದ ವಸ್ತು ತನಗೆ ಕಾಣುತ್ತದೆ ಎನ್ನುತ್ತಾರೆಯೇ?				20
6. Who is very suspicious and claims that some people are trying to harm him? ಯಾರಾದರೂ, ಎಲ್ಲರ ಬಗ್ಗೆ ಸಂಶಯ ಪಡುವುದು, ತನಗೆ ಎಲ್ಲರೂ ತೊಂದರೆ ಕೊಡುತ್ತಾರೆ ಎಂದು ಹೇಳುತ್ತಾರೆಯೇ?				21
7. Who has become unusually cheerful, makes jokes and brags that he is a big man? ಯಾರಾದರೂ, ವಿವರತ ಒಮ್ಮೆಯಿದ್ದು, ಆತ ಸಾಧಾರಣ ವ್ಯಕ್ತಿಯಾದರೂ, ತಾನು ಬಹು ದೊಡ್ಡ ಮನುಷ್ಯ ಎಂದು ಹಂಬಕೊಳ್ಳುತ್ತಾರೆಯೇ?				22
8. Who has become very sad lately, and cries without reason? ಯಾರಾದರೂ, ಇತ್ತೀಚೆಗೆ ಬಹು ದುಃಖವಿಟ್ಟುಕೊಂಡು ಕಾರಣವಿಲ್ಲದೆ ಅಳುತ್ತಾರೆಯೇ?				23
9. Who has lost his memory, or is losing his memory? ಯಾರಾದರೂ, ತನ್ನ ಜ್ಞಾನ ಪಾಕತತ್ವವನ್ನು ಕಳೆದುಕೊಂಡಿದ್ದಾರೆಯೇ ಅಥವಾ ಕಳೆದುಕೊಳ್ಳುತ್ತಿದ್ದಾರೆಯೇ?				24
10. Who has always from birth been stupid or dull like a child? ಯಾರಾದರೂ, ಹುಟ್ಟಿನಿಂದಲೂ ಮಂದ ಬುದ್ಧಿ ಇದ್ದು, ದೊಡ್ಡ ವಯಸ್ಸಿನಲ್ಲಿ ಸಣ್ಣ ಮಗುವಿನಂತಿದ್ದಾರೆಯೇ?				25
11. Who has tried to commit suicide? ಯಾರಾದರೂ, ಆತ್ಮಹತ್ಯೆಗೆ ಪ್ರಯತ್ನಿಸಿದ್ದಾರೆಯೇ?				26
12. Who actually committed suicide? ಯಾರಾದರೂ, ಆತ್ಮಹತ್ಯೆ ಮಾಡಿಕೊಂಡಿದ್ದಾರೆಯೇ?				27
13. Who gets possessed by bhutas and spirits? ಯಾರಿಗಾದರೂ, ಮೈಮೇಲೆ ದೆವ್ವ ಧೂತ ಬರುವುದುಂಟೆ?				28
14. Who is lazy and does not work, though physically healthy? ಯಾರಾದರೂ, ತಾರಲಕವಾಗಿ ಅಡ್ಡಗೊಡ್ಡಗಿದ್ದರೂ, ಸೋಮಾರಿಯಾಗಿ, ಕೆಲಸ ಮಾಡದೆ ಇದ್ದಾರೆಯೇ?				29
15. Who drinks too much or gambles too much or has other bad habits? ಯಾರಾದರೂ, ತುಂಬಾ ಕುಡಿಯುವುದು, ತುಂಬಾ ಜೂಜಾಡುವುದು ಅಥವಾ ಇನ್ನಾವುದೇ ಕಟ್ಟು ಅಭ್ಯಾಸ ಇರುವವರು ಇದ್ದಾರೆಯೇ?				30

Example: 'MANAS' (Manasanti SusharShodh) was a research trail carried out in Goa. Lay counselors were trained in handling Common Mental Disorders (CMD) and it was found that the trained counselors led intervention can lead to an improvement in the recovery from Common Mental Disorders in the community. Follow the link to have more details about the trail. (<http://www.sciencedirect.com/science/article/pii/S0140673610615085>)

Community mental health camp (Camp approach):

Another way to detect mental health problems in the community is to conduct community mental health camp in the community. Psychiatric camp is the extension of mental health services from

hospital to the community. A mental health multi-disciplinary team will go to the community and render psychiatric services in the community. These types of mental health camps can cover vast number of people in the community.

Example: NIMHANS community mental health camp is the example. A team consisted of psychiatrists; psychiatric social workers, psychologists, psychiatric nurses, and medical record staff visit fixed places in the community once in a month. Assessment, diagnosis, medical management, psychosocial assessment and management, disability benefits, IQ assessment and certification will be provided through the camp. (<http://repository.ias.ac.in/31108/1/323.pdf>).

Treatment seeking behaviour among person with mental health problems is low. Treatment gap of mental disorders is very high due to multiple reasons. Treatment gap escalates severity of mental illness as well as disability associated with mental illness. Social workers can play pivotal role in identifying mental illness in community. They can perform the role of a coordinator, manager, clinician, researcher, trainer, leader, and liaison worker for the detention of mental illness in the community.

ICD 10/ICF Application and Emphasis on Z Category

International Statistical Classification of Diseases and Related Health Problems (ICD-10):

The public health sector of United Nations, World Health Organization (WHO) works for attainment by all people for the highest possible level of health. WHO's constitution, ratified by all 193 current WHO member countries, enumerates its core responsibilities, as establishing and revising international nomenclatures of diseases, causes of death and public health practice; and standardizing diagnostic procedures as necessary. Classification systems are therefore a core constitutional responsibility of WHO. ICD-10 and ICF belong to the family of international classifications developed by the WHO for the application of various aspects of health.

International Statistical Classification of Diseases and Related Health Problems (ICD-10) is a medical classification which contains codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases. ICD uses alpha numeric system in coding. It has some 68000 codes, spread over 22 chapters. Chapter V (F00-F99) deals with mental and behavioural disorders and Chapter XXI (Z00-Z99) deals with factors influencing health status and contact with health services.

The purpose of the ICD is to serve as an international standard for health information to enable the assessment and monitoring of mortality, morbidity, and other relevant parameters related to health. WHO's classification systems are also among the core building blocks for the electronic health information systems that are of increasing importance in many countries.

Five main uses of the ICD-10 mental and behavioural disorders classification are in clinical practice, research, teaching and training, health statistic and public health.

The Z codes in chapter 21 talks about relevant circumstantial factors associated with health conditions. There is no doubt that psychosocial stressors have a major impact on the aetiology, course and outcome of many psychiatric disorders. So these factors should be recorded so that these factors will not be discarded while planning the comprehensive management of the person with a particular health condition.

2.5.2. International Classification of Functioning, Disability and Health (ICF):

The International Classification of Functioning, Disability and Health (ICF) is a frame work by WHO for describing and organizing information on functioning and disability. It provides a standard language and a conceptual basis for the definition and measurement of health and disability.

ICF conceptualizes disability not solely as a problem that resides in the individual, but as an outcome of interaction between health condition (e.g., mental disorder) and contextual factors. ICF has two parts. Part one deals with functioning and disability. Part two covers the contextual factors. Each part has two components.

1. Components of functioning and disability

It consists of body function, body structure, activity limitation, and participation restriction. It covers impairment in body structure and function and also covers all the aspects of functioning from individual to societal perspectives.

2. Components of contextual factors

The environmental factors (support and relationships, attitudes, and service system and policies) which interact and influence disability are listed out under the contextual factors.

Implication of ICF

ICF provides a checklist which is now widely used for multi-center studies and collecting data regarding health and disability. It enhances research in the field of health and disability. ICF brings out a conceptual framework of disability, which is a common language for communication, documentation and coding of disability. The conceptual framework given by ICF about health and disability is a guideline and helps in formulating and developing interview schedule and questionnaire for research in the same field. ICF helps in assessing the areas of disability and assists to identify environmental factors such as family, peers, societal attitude and stigma, contributing to disability. This baseline understanding will help to plan and implement effective interventions to address disability and environmental factors. Many countries started incorporating ICF into the assessment

and documentation of severity of disability and issuing disability cards in availing social security and disability benefits.

In nutshell, ICF gives a bio-psycho-social approach into the concept of health and disability. Biological, psychological and social aspects of an individual have equal roles in determining the health of an individual. Social aspect is the operational area of a social worker. ICF helps each social worker to get oriented about the important social aspects of health and disability, identify important social aspects contributing to disability of a given individual and helps to plan and implement effective intervention strategies targeting identified areas of the individual.

CHAPTER 3

PSYCHOSOCIAL ASSESSMENT

Psychosocial assessment across various mental health conditions

The growth and development of every human being takes place through the fulfilment of needs namely (i) biological (physical) and (ii) psychosocial. The biological needs are meant for the physical growth and development while the psychosocial needs are the mental or psychic needs of an individual that include feeling of belongingness, love and affection, security and self-esteem that simultaneously help an individual's personality growth.

This section has guidelines for psychosocial assessment of mental health problems and disorders. This section contains the following topics of psychosocial assessment:

1. Psychosocial assessment for severe and common mental disorder
2. Psycho social assessment for disaster
3. Psychosocial assessment for children and adolescent problems
4. Psycho-social assessment of mental health among women
5. Psychosocial assessment of older adults
6. Psychosocial assessment for sexuality minority
7. Psycho social assessment of disability

What does the term 'psychosocial' mean?

The word *psychosocial* indicates that psychic (mental) needs have a social dimension. This social dimension includes the environment which provides resources for fulfilling various needs and as demands it makes on the individual. Personality development is also determined and influenced by the social dimensions.

Socialization is a crucial factor in understanding the complex phenomenon of a developing personality. It is essential to understand and comprehend the interplay of psychosocial factors that influence the development of this complex structure of adult personality development. The role of different social agents and agencies in the environment thus play a vital role in the process of diagnosis and treatment of any mental health conditions and/or psychopathology.

Psychosocial theory says that individual and his environment are intertwined. Changes in one system create changes in other systems. In other words individual's behaviour is the product of psychological forces and societal factors. His problem triggers not only due to psychological forces or

social factors but by the combination of both. Therefore, the intervention strategy must address both the factors.

The nature and diagnostic use of the client's social history:

The social worker or the caseworker recognizes that client's social history exists in his current interpretation of past events and in his present feeling about the past. The presence of past events or current emotions has significance to the understanding of the facts and appropriateness of helping.

Social history forms an integral part of diagnosis and treatment. It involves collecting a wide ranging and comprehensive information from different sources. The diagnosis involves an attempt to construct conceptual patterns which interprets and highlights a client's needs and life experiences. These experiences include thoughts, feelings, purposes and aspirations which accompany the client's presentation of his social difficulty. These determine the quantity and quality of help he needs and can use. The understanding which social diagnosis provides is more than evident objective data and their interrelationships. It includes the state of mind of the client, what the facts mean to him at this moment and in this particular situation. It involves the possession of skill and method in obtaining and interpreting facts, and an awareness of the purpose for which information and understanding are sought.

Psychosocial assessment for severe and common mental disorders

A psychosocial assessment is an evaluation of an individual mental health and social well being. It assesses the perception of self and the individuals' ability to function in the community. It typically involves a number of questions asked by the social worker to assess multiple domains to understand the individual. The goal of the psychosocial assessment is to understand the client to help provide the best care possible and help the individual to obtain optimal health. Before going into the psychosocial assessment, let us understand what severe mental illness means.

Severe mental illness usually refers to illnesses where psychosis occurs. Psychosis describes the loss of reality a person experiences so that they stop seeing and responding appropriately to the world they are used to. Schizophrenia and bipolar disorder are the two forms of severe mental illness considered in this section. Other severe mental illnesses include schizo-affective disorder, severe clinical depression and personality disorders.

The exact causes of severe mental illness are not known. There may be a genetic vulnerability in some people that can be triggered by environmental and emotional factors. Many people who experience severe mental illness can and do recover to lead a meaningful and fulfilling life. Treatments and

support that address all needs of a person are required to enhance recovery. This includes medicines, talking therapies, appropriate housing, employment, social networks and financial independence.

A *psychotic episode* commonly isolates the person from others and disturbs peer relationships. The person's personal and social development will be put on hold, or may even slip backwards. Impairment of school and work performance is common with the potential for profound damage to future vocational prospects and consequent financial insecurity. It can cause strained relationship in the family and increased psychological morbidity amongst family members. In addition substance abuse may begin or intensify and the risk of suicide is increased. The longer the illness is left untreated the greater the risk of permanent derailment of the person's psychosocial development.

Common mental disorders are a group of distress states manifesting with anxiety, depressive and unexplained somatic symptoms typically encountered in community and primary care settings. They are the leading mental health cause of disability in the global burden of disease. Cross-sectional population-based studies consistently show that the poor and marginalized are at greater risk of having these disorders.

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

Social worker requires a positive, nonjudgmental approach and a willingness to discuss sensitive issues, good communication skill and knowledge of socio-cultural background in order to provide appropriate psycho social care for persons with common mental disorders. A social worker should endeavor to build a supportive and collaborative relationship with person with mental illness and their family.

Psychosocial history:

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

The psychosocial history can be assessed in the following dimensions

<ul style="list-style-type: none"> • Developmental and early Childhood history • Current living situation • Socio economic wellbeing • Socio economic status • Educational history • Occupational history • Coping skills • Support system • Strength assessment 	<ul style="list-style-type: none"> • Alcohol and drug use history • Risk and suicide assessment • Legal history • Spiritual assessment • Cultural assessment • Life events • Marital history • Family assessment • Community assessment
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Developmental and early Childhood history

Developmental milestones are a set of functional skills or age-specific tasks that most children can do at a certain age range. Development history will provide insight into the origin of behaviors and help in diagnosis and management, assessment for gross motor skills, fine motor skills, language skills, thinking skills and social interaction is important.

Initial enquiry should include the date and place of birth and describe the family circumstances (social, economic, emotional) at the time of the pregnancy and birth, including the parents’ health and marital relationship. Was the pregnancy desired?, Was the birth full term and normal?, What was the patient’s birth weight?, Was the patient breast or bottle fed?, Did he feed normally and gain weight? Was he healthy?

Note the ages at: walking, talking, weaning, and toilet training. Obtain information concerning the formation of habits with special reference to bedwetting, night terrors, sleepwalking, fingernail biting, thumb sucking and stuttering; any history of stomach and bowel complaints, headaches, or other special invalidism and psychosomatic disorders. Obtain information about personal problems that were experienced during puberty and adolescence, especially in terms of social relationships in school, in play, hero worship, interpersonal relationships, tendency to associate with the same or opposite sex, religious and sexual attitudes, evidence of philosophical ruminations, obsessive thinking, compulsions or phobias. Judgment must be used when requesting sexual information.

Current Living Situation:

The following enquiries need to be assessed:

With whom does the patient live? (Spouse, children, parents, friends, significant other, relatives other than immediate family)

Does he live in a house or an apartment? What is the neighborhood like?

Does he own or rent his habitation?

Is he responsible for maintaining it?

Has there been any recent change in any of these factors?

Socio -economic well being:

Socio-economic well-being is defined as the status of a household where the basic social and economic needs for survival are fulfilled and the household has the capacity to improve its quality of life. Socio -economic well-being (SEWB) can be measured with the parameters of literacy and education, employment, income and consumption, shelter and urban services, health and nutrition, environmental concerns, safety and security, time use and availability

Socio economic status:

Socio-economic status can be assessed through the use of certain quantitative scales like Wealth Index Scale Patel et al (2007)

Assessment based on the following areas namely, house type, source of lighting, toilet facility, main fuel for cooking, source of drinking water, separate room for cooking, ownership of the house, ownership of agricultural land, ownership of irrigated land, ownership of livestock, and ownership of durable goods.

Educational history:

It is required to enquire on educational history of the client. Did the parents prepare the child for formal education – his likes and dislikes regarding schooling, encountered difficulty by the parents regarding studies? What is the highest grade that the patient completed?, Where did the patient go to school?, Were there any conduct or discipline problems at school?, Assessing academic achievements and extracurricular activities, how the patient functions at work and school can provide helpful clues to the mental health picture.

Occupational history:

Occupational history would be different in urban and rural settings. There is a need to record what a person does for living and /or the patient's current employment status. When the person started working, job satisfaction, relationship with superiors and colleagues, promotions, work environment, change in job whether for betterment in terms of status, income and satisfaction.

In the rural setting enquiry into person's livelihood and income generating activities, regularity and productivity, relationship with employers, other farmhands or helpers, rise in status.

Sexual history:

Information pertaining to sex (first sexual experience, knowledge and source of sexual information, fantasy, masturbatory habits, homo–sexual, hetero – sexual, aversive experiences and sexual abuse, if any)

Marital history:

In marital history we need to assess the age at marriage, willingness for marriage, arranged or marriage of choice, consanguinity, age of the spouse, personality of the spouse – expectation from marriage, relationship and compatibility with the spouse, with the in – laws and the offspring, sexual gratification, leisure time activities, birth of the first child and / its impact on the marital life; Dynamics of marital relationship – leadership, communication, role playing, concerns, reinforcement, stress managing patterns, conflict resolution and social support.

Coping skills:

Current coping skills and techniques adopted by the client - Describe how the patient copes with stressful situations; the client's ability to address difficult situations and to make positive changes to resolve them. For assessing coping mechanisms question can be asked like: how does the client usually cope with stress? What helped/what didn't help in the past? What is the client's degree of coping now? Techniques employed for overcoming problems- Coping mechanism that caregivers use when managing life changes and stresses.

Social Support system

Availability and accessibility of primary, secondary and tertiary support system- Kind of supports- informational, emotional and material. Perceived social support from family and friends can also be assessed.

Strengths assessment

Strengths assessments focus on the individual's talents, abilities, resources and strengths. Whether individual has significant interpersonal and family strengths? Whether individual has a strong and stable optimistic outlook on his/her life or not?

Alcohol and drug use history

History of alcohol and drug use, amount of use, frequency and periodicity of use.

Legal history

The individual's involvement with the legal system, history of legal problems, has serious current or pending legal difficulties that place him/her at risk for incarceration.

Spiritual assessment

The spiritual assessment should note the patient's religious background. In addition, the degree of involvement within the religious community and any spiritual practices should be assessed.

Cultural assessment

The cultural assessment should list any important issues regarding the patient's ethnic and cultural background. It is impossible for a therapist to have a full understanding of every culture, but a good cultural assessment will help the therapist to understand the patient's cultural beliefs, values and practices. The meaning of the illness in terms of the patient's unique culture needs to be explored. How embedded the patient is in his or her traditional culture.

Identify recent life changes and stressors/life events

Identify the recent life events and stressors the patient and his family is undergoing. Major stressful life events in a specific time line; usually the last year need to be assessed. Examples of events include: marriage, birth of child, change in job and place of residence, death of a loved one, loss of a job, being divorced, distance from family, transfers and legal involvement.

Risk assessment

Risk assessment is an integral part of every clinical observation or assessment. While assessing the risk factors following parameters need to be explored:

- Previous suicide attempt
- Major physical and mental illnesses, especially with chronic pain, Central nervous system disorders, mental disorders, particularly mood disorders, schizophrenia, anxiety disorders (e.g., PTSD), and alcohol and other substance use disorders; personality disorders (such as Borderline PD, Antisocial PD, and Obsessive-Compulsive PD).
- Impulsive and/or aggressive tendencies
- History of trauma or abuse
- Family history of suicide
- Precipitants/triggering events leading to humiliation, shame, or despair
- Chaotic family history (e.g., separation or divorce, change in caretaker, change in living situation or residence, incarcerations)
- Lack of social support and increasing isolation
- Easy access to/familiarity with lethal means (e.g., guns, illicit drugs, medications)
- Legal difficulties/contact with law enforcement/incarceration
- Barriers to accessing health care, especially mental health and substance abuse treatment

A comprehensive suicide risk assessment should explore the following elements.

- Level of distress
- Level of motivation
- Current suicidal thoughts
- History of suicidal behavior
- Lethality/intention of attempt
- Presence of a suicide plan
- Access to means and knowledge
- Safety of others

Family assessment:

A family assessment looks at the needs of individual family members, as well as the family as a whole. A key distinguishing factor of family assessment is that it looks at the interrelationships between family members and how these relationships impact on individuals within the family. Family environments influence all aspects of the development and wellbeing of person with mental illness. Following Information should be covered in the following areas.

Genogram:

- Three generations genogram (A genogram is a family map or history that uses special symbols to describe relationships, major events, and the dynamics of a family over multiple generations.)
- General information such as names and birthdates
- Family of orientation (Composition – Parents – Sibs)
- Family's origin or racial/ethnic background
- Health status
- Age at death and cause of death of each family member
- Personality of the parents
- Interaction among family members (parents, siblings, spouse etc)

Family life cycle

The family life cycle has been defined as a series of stages through which most families' progress, with varying characteristics across varies stages; these characteristics relate to marital status, size of the family, the age profile of the family members (focusing on the age of the oldest and/or youngest child), the employment status of the head of household, the income level and the disposable income at hand.

Family history

Family history is important because many mental illnesses are hereditary. Record any history of mental illness in the patient's family

Family dynamics

The family can be conceptualized as a dynamic system that changes over time as membership changes, individuals change and develop, relationships change, and the family's context changes. Family dynamics assessment can be done in the following areas: Boundary, Leadership, Communication, Cohesiveness, Role playing, reinforcement, Stress managing patterns and Social Support and Expressed emotion.

Therefore, a Family “well-being” is existent in the family if they are “healthy” and the following are existent:

- there is cohesion, clear difference among generations, individual autonomy
- there is a good relationship among members (parents, parent-sons, sons-parents, among brothers and sisters)
- there is stability and organisational adaptability
- family members have enough competence for problem solving and decision making, conflict mediation and solution, family management

Current psychosocial needs and assessment:

At individual level:

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

At family level:

- **Roles of family members:** ability to carry out expected roles, who plays which role, felt difficulties in carrying out roles,

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

Community needs and resources assessment

A comprehensive assessment of the community is aimed at understanding the social context in which people with a mental illness and their families live. It also entails developing an understanding of local resources, assets and supports available to the people with a mental illness and their families, together with stressors and problems in the community.

Psychosocial assessment for children and adolescent problems

Children rarely initiate psychiatric assessment and the *referral is typically requested by someone other than the patient* (e.g., parents, teachers, paediatricians, courts). Children need to be evaluated in the context of the family, the school, the community and the culture, which means that no child can be assessed in isolation. Moreover, most children function differently in different settings and it is helpful to know which surroundings improve or worsen the distressing behaviour – also to identify the child's areas of strength. Thus, the simultaneous examination of parental and family functioning is crucial, as is the need for multiple informants.

The following checklist lists all relevant parts of a medical history in child mental health:

Pre- and Peri-natal development

- Consanguinity of the parents?

- Use of assisted reproductive technologies?
- Pregnancy (use of alcohol, tobacco, illicit substances, medications; history of rashes and fever during pregnancy – may indicate exposure to congenital viral infection)
- Previous neonatal deaths or acute life-threatening episodes in siblings (could be a pointer towards inborn error of metabolism)
- Previous spontaneous abortions (two or more) – one in 20 of these parents will carry a chromosome translocation or inversion.
- Birth and neonatal history: gestational age at birth; weight (difficult birth is a risk factor for developmental problems).

Developmental history: A detailed account of the child's development from the beginning of the pregnancy to birth and early development is important. It is helpful and time efficient to use a structured approach with screening questions about important milestones and follow-up questions, if necessary.

Parents often vary in their recollection and timing of developmental milestones. Check for problems in:

- **Basic functions:** sleeping, eating, toilet training
- **Psychomotor milestones:** walking, sitting, fine and gross motor skills, handwriting skills
- **Cognitive development and school functioning:** history of the child's language development, reading, writing and math skills. Progress at school requires some innate cognitive abilities but also reflects the child's motivation, capacity to concentrate, attitude towards authority, capacity for peer relations, tolerance for frustration and delayed gratification, and a degree of parental support for learning
- **Interpersonal development:** reaction to separation early in life, ability to play with other children, stability of relationships, number of friends, types of activities shared
- **Emotional development and temperament**
- **Trauma history:** physical, sexual, emotional, neglect, acute or chronic, intra- or extra-familial, violence, natural disaster
- **Harmful behaviour:** head banging or self-injurious behaviour, thoughts or comments about death, self-mutilation, cutting, and harmful acts toward other people or animals.

Family history: includes questions about current and past family functioning and about neuropsychiatric disorders in other members of the family (e.g., alcohol dependency, substance abuse, suicide, and unusual or odd behaviour in relatives). Knowing about mental health disorders in the family can help in finding the right diagnosis (e.g., a mother with alcohol dependency could lead to the consideration of a fetal alcohol syndrome).

The possible parental genetic contribution to the disorder of the child should be assessed (e.g., the existence of bipolar disorder in the father would cast his son's depressive symptoms in a different light), but almost no psychiatric disorder appears through genetic transmission alone, although increased vulnerability to various disorders is likely. Though unspoken during the psychiatric evaluation, many parents fear that their other children may be destined to be affected when one sibling has a disorder, so clarification of the genetic contribution to the expression of disorders can often be helpful in reducing fear, guilt, and distress among parents and siblings.

Social, cultural and contextual factors: Factors in the social context, the degree of cultural and social isolation or support, financial security and parental employment. Socioeconomic status is a powerful predictor of infant developmental outcome but the family's ability and willingness to access and use support is crucial.

Factors to be considered include:

- The context and the interaction between the family and the social environment
- Family functioning, for example, poverty, unemployment, responses to stress, social or cultural isolation
- Potential for stability in relationships and social circumstances
- Relationship with others and the ability to use interventions and community support.
- The extended networks that support or abandon the family at this time of rapid developmental change
- The social and cultural factors that affect the family
- Relationship quality and interactions
- Family violence
- Practical issues and circumstances; the practical reality of the family situation, including housing, poverty, employment, and educational opportunities.

What parents bring to parenting?

- Their psychological and social strengths and resources
- Their fantasies of what and who the child will be for them
- The history that precedes conception and birth, including their experiences in their own family and their experiences of being parented
- Their expectations of themselves as parents, influenced by their own experiences of family life
- Their psychopathology – the parents' past and family psychiatric history and current difficulties including parental substance abuse
- Parental age and life cycle stage

Psycho-social assessment of mental health among women

The topic of 'women's health' includes health issues and diseases that are unique to women, such as gynaecological conditions; disease that are more prevalent in women and disease that are expressed differently in women and men, meaning that women may present with different symptoms, have more serious form or a different course of illness, or respond differently to interventions.

Women's health also includes issues of access to care, quality of care and prevention of disease. Many women experience barriers to good health care, including limited access, intensive attitudes in the medical profession, and poorly coordinated referral systems.

Psychosocial assessment should include the following (apart from those already mentioned in the earlier section on severe and common mental health):

- Age at menarche and emotional response to the same
- Detail assessment of Last menstrual period should be done.
- Premenstrual symptoms
- Check for clinically significant menstrual-related emotional as well as physical symptoms.
- Social beliefs about menstruation
- Pregnancy related experiences and stressors if applicable
- Post partum mental health changes
- Physical and emotional changes during menopause
- Sexual abuse and violence
- Domestic violence
- Access to resource and decision making
- Attitude towards self and body image

Psychosocial assessment of elderly adults

Mental health and emotional well-being are as important in older age as at any other time of life. While most have good mental health, many older adults are at risk of developing mental disorders, neurological disorders or substance use problems as well as other health conditions such as diabetes, hearing loss, and osteoarthritis. Furthermore, as people age, they are more likely to experience several conditions at the same time.

- **Physical assessment:** complete physical assessment includes:
 - *Functional status:* Activities of Daily Living (ADLs) Bathing, dressing, transferring, toileting, grooming, feeding, mobility
 - *Nutrition:* Poor nutrition may reflect medical illness, depression, functional losses, financial hardship

- *Vision*: Cataracts, glaucoma, macular degeneration, and abnormalities of accommodation worsen with age
- *Hearing*: Hearing loss is common among older adults. Impaired hearing could lead to depression or social withdrawal.

- **Cognitive capabilities**: Prevalence of Alzheimer’s disease is 10% of those aged 65+ and nearly 50% of those aged 85+. Most people with dementia do not complain of memory loss. Cognitively impaired older persons are at risk for accidents, delirium, medical non-adherence, and disability. Although prevalence of major depression among older adults is low (1%-2%), “subclinical” depression is common
 - Ask “Do you often feel sad or depressed?”
 - If “Yes,” do further evaluation, e.g., Geriatric Depression Scale
 - Watch for signs of anxiety, bereavement

- **Psychosocial status**:
 - Availability of a personal support system
 - Caregiver burden
 - Economic well-being
 - Elder mistreatment/ abuse (*If concerned, consider referral to visiting nurse to assess home safety, level of personal risk*)
 - Advance directives (decisions about what individual would like to do with his property, his/her body, funeral etc after death)

Psychosocial assessment of disability

The term disability refers to any restriction or lack of ability to perform an activity in the manner or within the range considered normal for human being. It is the outcome of the interaction between a person with impairment and the environmental and attitudinal barriers one may face. Disability impacts on the daily life of an individual and it acts as a hindrance towards his development. The restriction or the inability to perform in itself disrupts the family routine leading to financial burden and impaired family interactions and this in turn makes the individual consider himself/herself as a burden to the society. This is why psycho social assessment of disability comes into play.

Psycho-social assessment would further cater to the needs of the individual in making them more self reliant in spite of their disability and it would also further help to guide the development of individual care plans.

Psychosocial assessment for survivors of disaster

The impact of disaster on people's life is manifold. Hence, the psychosocial assessment of survivors of disaster must go alongside assessment of structural, economic and social losses. Psychosocial assessment is a vital and valued dimension of immediate as well as long term disaster response. It must be remembered that, in disaster situations, affected survivors who need psychosocial interventions are far more than the trained professionals available to render services.

Usually, disaster affected people are divided into three broad categories based on their psychological response to the disaster situation and the intensity of psychosocial care they need:

1. Those who display normal psychosocial reactions to the disaster and require no psychological intervention.
2. Those who display psychological symptoms resulting in distress, or dysfunction lasting from a few days to many weeks and who would benefit from minimal, but specific, psychosocial intervention.
3. Those that require treatment from a mental health professional because they suffer from either
a) An acute anxiety reaction that is so severe that it limits basic functioning (such as not being able to talk to people) Or (b) They suffer from severely distressing or disabling psychological symptoms that do not improve over time and that do not improve through psychosocial interventions.

Psychosocial Assessment

The first task of the social worker after tending to the rescue and care needs is assessment to understand the impact of disaster on survivors of disaster.

The following aspects need to be assessed:

1. Socio demographic profile- this include the social and demographic background of the individual, number of family members lost and survived,
2. Psychological responses to disaster

Social worker has to assess the following psychological reactions/responses of the survivor to the disaster

Immediate Reactions (within 24 hours):

- Tension, anxiety, panic
- Stunned, dazed, shocked, disbelief
- Elation or euphoria among survivors/ or people suffering lesser losses

- Restlessness, confusion
- Reactions with agitation, crying and withdrawal
- Survivor's guilt

These reactions are seen in nearly everybody in the affected region and can be considered to be what is called '**normal reactions to abnormal situations**'. This does not require any specific psycho social intervention.

Within days to weeks after the disaster:

- Being fearful, vigilant, hyper-alert (irritable, angry, and unable to sleep)
- Worried, despondent
- Repeated 'flashbacks' (memories of the event coming to mind again and again)
- Weeping, guilt feeling (including survivors guilt)
- Sadness
- Positive reactions including: hoping / thinking of future, getting involved in relief and rescue work
- Acceptance of disaster as nature's doing

All the above can be considered as normal responses that may need only minimal psychosocial intervention.

After about three weeks after disaster:

The previously noted reactions may persist and involve symptoms such as:

- Restlessness
- Panic feelings
- Continued deep sadness, quite unrealistic pessimistic thoughts
- Outward inactivity, isolated and withdrawn behavior
- Anxiety manifested as physical symptoms like palpitations, dizziness, restlessness, nausea, headache etc.

These responses do not necessarily amount to a mental illness. The individuals reporting the symptoms can likely be helped by providing some basic psycho social intervention skills.

3. Assess coping skills of disaster survivors: The social worker needs to assess both the positive and negative coping skills employed by the disaster survivor in the aftermath of a disaster

Positive coping skills

- Ability to orient oneself rapidly
- Planning and execution of decisive action
- Appropriate use of assistance resources
- Appropriate expression of painful emotions
- Tolerance of uncertainty without resorting to impulsive action

Negative coping skills of the disaster affected population

- Excessive denial and avoidance
- Impulsive behaviour
- Over-dependence
- Inability to evoke caring feelings from others
- Emotional suppression
- Substance abuse

Not all emotional consequences of the disaster among the survivors are maladaptive.

A majority of the people demonstrates healthy and mature coping response to the situation.

4. Assess the survivor for any common mental health problems after disaster like:

- Acute stress reaction
- Bereavement and grief
- Depression
- Anxiety disorders
- Adjustment disorders
- Somatoform disorders
- Alcohol and drug abuse
- Post-traumatic stress disorder
- Exacerbation/ Relapse of pre-existing mental disorders

These mental disorders require specialist mental health intervention and referral

5. Assess the overall impact of the disaster on the person in carrying out his or her daily functioning

Psychosocial assessment of survivors is carried out with the help of both quantitative and qualitative measures. Some of the quantitative measures used for assessment are given below:

- **Socio demographic profile**
- **Impact Event Scale-** used to study the problems faced by affected persons after stressful life events (for adults and children)

Instruments to assess Disability and Distress:

Psycho social assessment of disability mainly consist of two major instruments, one is the Indian Disability Evaluation and Assessment Scale (IDEAS) and Assessment of disability in persons with Mental Retardation (ADPMR). These are two instruments available in India that have been standardized and are accepted by Government of India for measuring disability in mental illnesses or mental retardation. The main purpose of assessment and diagnosis in psychiatry is to provide relevant information about the signs, symptoms and other information, which justify the diagnosis and through that to plan for a comprehensive treatment and interventions. Self Reporting Questionnaire (SRQ 20) by World health organization can be used to screen for psychological distress among

Indian Disability Evaluation and Assessment Scale (IDEAS)

IDEAS was developed by the Rehabilitation Committee of Indian Psychiatric Society in December 2000. It is used to measure and quantify disability in mental disorders. The scale consists of four items, namely:

- **Self Care:** Includes taking care of body hygiene, grooming, health including bathing, toileting, eating and taking care of one's health.
- **Interpersonal Activities (Social Relationship):** Includes initiating and maintaining interactions with others in a contextual and socially appropriate manner.
- **Communication and Understanding:** Includes communication and conversation with others by producing and comprehending spoken/ written/ nonverbal messages.
- **Work:** measures any one of the following aspects:
 1. **Performance in Work/ Job:** Performance 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. **Performance 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.
 3. **Performance in school/ college:** measures performance in education related tasks.

IDEAS can be used only for evaluation of four mental illnesses:

1. Schizophrenia
2. Bipolar Affective Disorder
3. Obsessive Compulsive Disorder
4. Dementia

Duration of illness should be at least 2 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. The cutoff point is taken as 40 % for various welfare measures. The scores above 40% have been categorized as moderate, severe and profound based on Global Disability Score which is calculated as

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

Assessment of Disability in Persons with Mental Retardation (ADPMR)

ADPMR scale is a scale used to measure the level of Mental Retardation. It is a 5 point rating scale. It gives numerical disability score as well as in percentage. In ADPMR, the cut off score is kept as 40%. The five items are namely:

- I **Perceptual-Motor:** Describes and measures performance in gross motor and fine motor areas in which movement, coordination, balances and postures of the body and its parts are assessed.
- II. **Self-care:** Describes and measures performance in eating, toileting, brushing, bathing, dressing, grooming, and maintaining healthy body hygiene and safety.
- III. **Communication & Social:** Describes and measures performance in receptive and expressive verbal or non-verbal communication and maintaining relationships within community in socially accepted manner.
- IV. **Academic:** Describes and measures performance in formal & non-formal educational activities. Concepts like body parts, colour, shape, size, sex, number, time, money, reading, writing & arithmetic, reasoning and problem solving ability.
- V. **Occupational:** Describes and measures performances in domestic, pre-vocational and vocational activities.
 - a. **Domestic:** Competencies like cooking, stitching, maintaining cleanliness in house, small repair & maintenance work, taking care of younger siblings and belongings etc.
 - b. **Prevocational:** Visits for vocational placements such as work habits, work-related behaviours, unskilled & semi-skilled etc. Competency in using simple tools like scissor, hammer, screwdriver, stapler, etc. Has work habits, able to work under supervision, aware of works hazards.

- c. **Vocational:** Includes performances in work settings, quality and quantity of work, job related behaviour and skills.

Self Reporting Questionnaire (SRQ):

SELF REPORTING QUESTIONNAIRE (SRQ)

Sl. No. _____	Yes	No
1. Do you often have headaches?	<input type="checkbox"/>	<input type="checkbox"/>
2. Is your appetite poor?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you sleep badly?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you easily frightened?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do your hands shake?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you feel nervous, tense or worried?	<input type="checkbox"/>	<input type="checkbox"/>
7. Is your digestion poor?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have trouble thinking clearly?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you feel unhappy?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you cry more than usual?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you find it difficult to enjoy your daily activities?	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you find it difficult to make decision?	<input type="checkbox"/>	<input type="checkbox"/>
13. Is your daily work suffering?	<input type="checkbox"/>	<input type="checkbox"/>
14. Are you unable to play a useful part in life?	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you lost interest in things?	<input type="checkbox"/>	<input type="checkbox"/>
16. Do you feel that you are a worthless person?	<input type="checkbox"/>	<input type="checkbox"/>
17. Has the thought of ending your life been on your mind?	<input type="checkbox"/>	<input type="checkbox"/>
18. Do you feel tired all the time?	<input type="checkbox"/>	<input type="checkbox"/>
19. Do you have uncomfortable feeling in your stomach?	<input type="checkbox"/>	<input type="checkbox"/>
20. Are you easily tired?	<input type="checkbox"/>	<input type="checkbox"/>

Ref. World Health Organization (1980) Self reporting questionnaire in : Harding T.W. et. al. (eds.) Mental disorders in primary health care : A study of their frequency and diagnosis in four developing countries. Psychological Medicine 10:231-24.

It consists of 20 items that reflects the multidimensional nature of 'mental illnesses. It taps into a somatic factor (headaches, appetite, digestion, sleep); depressive/anxiety symptoms (frightened, unhappy, cry, worthless); and cognitive/decreased energy factor (can't think or make decisions, work suffering, can't enjoy daily activities). A cut-off point of 7/8 (7 'yes's' a non-case, 8 'yes's' a case) is common.

Social diagnosis

Social diagnosis is a psychosocial process. It is a process of discovering patterns of significance in the information directly obtained or inferred. It is tentatively constructed and refined throughout the whole period of contact with the client. To understand the social dimension of an individual's psychological construct calls for the expertise of the social worker.

Social diagnosis emphasizes that treatment will be fruitful only when the dynamics of the client's personality is understood in relation to the dynamics of social environment and the wider social pressures and expectations.

Diagnosis starts with the attempt to answer questions as-

- What is the problem?
- How is the client coping with it and reacting to it?
- What is he trying to say about his problem and the quality of help he needs?

In an attempt to understand these questions the social worker begins to form assumptions and hypothesis about the patterns made by the facts and their implication for help. The facts of the situation need to be understood by the worker *objectively* and *affectively*.

Reference has also been made to the *value* elements in diagnosis. Various social expectation of how the client ought to behave alongside what the client can realistically be expected to achieve in the light of his life history, his personal resources and his immediate environment should be considered in order to discover the best form of intervention. Social Diagnosis can be arrived through qualitative and quantitative measures which include clinical interviews, social enquiries (work spot enquiries, school and college enquiries), interviews with significant persons, home and neighborhood visits, assessment of individual, family and social context of the person. These are commonly called as psychosocial assessments.

CHAPTER 4

PSYCHOSOCIAL INTERVENTIONS

Pharmacological Management and Drug Adherence:

Medication is a vital component in the treatment of patients with severe mental disorder. They can reduce symptoms and prevent relapses of psychiatric disorders but it can be a challenge for clinician to motivate patient to stay on medication.

Psycho pharmacotherapy should always be a part of a comprehensive treatment plan arrived at after a thorough Psychiatric Evaluation that result in a diagnosis or at minimum a working diagnosis.

Pharmacological Management

After identification of the case, antipsychotic medications should be started depending on clinical status. The treatment can be broadly divided into two phases acute and maintenance. The goals of acute phase of treatment are to reduce symptoms, to prevent harm to self/others and improve biological functions. The goal of maintenance phase of treatment is to prevent relapse and to help patient improve one's level of functioning.

Antipsychotic drugs: Two classes of antipsychotic drugs are available, typical antipsychotics (haloperidol, chlorpromazine, trifluoperazine) and atypical antipsychotics (risperidone, olanzapine, quetiapine). Both the groups are equally effective, but differ in their side effect profiles. In typical antipsychotics, high potency drugs (e.g. haloperidol) have more extrapyramidal side (EPS) effects and low potency drugs (e.g. chlorpromazine, fluphenazine, trifluoperazine) have more anticholinergic side effects (e.g. dryness of mouth, urinary retention, constipation) and cardiovascular side effects (e.g. tachycardia, postural hypotension).

Other types of psychotropic drugs include Mood Stabilizers, Anti-depressants, anxiolytic and Benzodiazepines.

Drugs for Various Disorders:

Schizophrenia: Chlorpromazine, Trifluoperazine, Fluphenazine, Haloperidol and Risperidone

Depression:

Tricyclic anti-depressants (TCA): Imipramine, Amitriptyline Selective

Serotonin Reuptake Inhibitors(SSRI): Fluoxetine, Sertraline, Escitalopram

Serotonin Norepinephrine receptorinhibitors: Venlafaxine

Mania: Lithium, Valproate and Carbamazepine or with antipsychotics.

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

Attention Deficit Hyperactivity Disorder: Dextroamphetamine and Methylphenidate

Epilepsy: Some of the common **anti-epileptic Drugs** are Carbamazepine, Phenobarbitone, Phenytoin, Valproate etc.

Drug Adherence:

Medication Adherence is a critical aspect in the treatment of and recovery from a psychiatric disorder. The personal and economic costs of non-adherence are profound and solutions to this problem have been less than desirable. Adherence has been defined as the extent to which a person's behavior coincides with medical or health advice. Reluctance to comply with prescription seems to be a human trait and non-adherence is a ubiquitous problem in medicine (Powsner & Spitzer, 2003).

POOR ADHERENCE

Account for significant worsening of disease, death and increased health care costs.

Incomplete or partial adherence is more common than non-adherence when patients discontinue treatment in spite of the introduction of Psychotropic drugs with fewer side effects; Non-Adherence in serious Psychiatric disorder is extremely prevalent. Adherence is generally better in acute disorders compared to chronic conditions. Prescribed medications play a key role in the treatment. They can reduce symptoms and prevent relapses of psychiatric disorders. The efficacy of antipsychotics medications in preventing relapses has been well – established. However, Adherence in itself does not guarantee a Normal life for patients, but does lower the rate of Relapse, an Important Precondition for achieving Recovery.

Assessment of Barriers to Adherence

- **Lack of Awareness or Insight into the illness.**
- **Medication Side-Effects.**
- **Patients' Lack of Belief in Benefit of Treatment.**
- **Barriers to care or medications**
- **Complexity of Treatments.**
- **The perceived costs of Treatment.**
- **Poor relationship with one's health care provider.**

- **Core Psychiatric symptoms.**
- **Missed Appointments.**
- **Inadequate Follow-up or discharge planning etc.**

Compliance with treatment, or Treatment adherence, is a very important clinical issue. Health care Practitioners should be adequately educated and embrace the importance of addressing adherence behavior in patient's care.

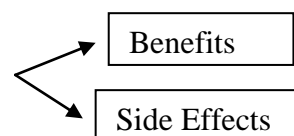
Efforts should be to:

- Maximize Information gathering for practitioners/ Health Providers
- Facilitate provider-care relationship
- Enhance communication skills
- Involve in mutual decision making

This will meet need related to Behavioral Health Treatment Adherence

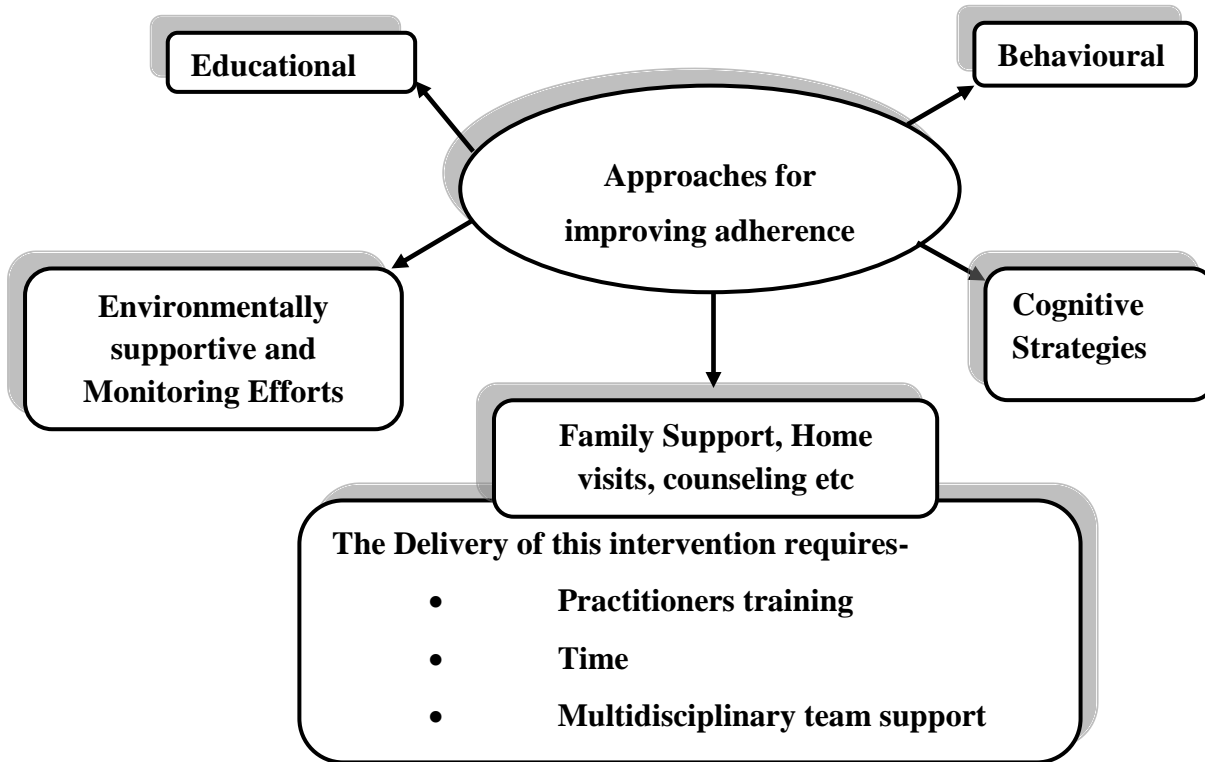
Strategies for Improving Compliance:

- Enhanced communication between the patient and health care team members.
- Strong Alliance with the patients as patients need a positive relationship with health care provider at every level of care as they have poor insight into their disorder and lack clear treatment instruction hence leading to poor adherence.
- Assessment of personal, social and economic conditions.
- Development of a routine for taking medicine
- Provisions of systems/ Medication compliance assistance to assist taking medications (e.g. medication alarms clocks that reminds patient to take their medication, pill boxes, etc).
- Patients who discontinue medication due to side effects should be given instructions about how to monitor and understand the effects of the medication
- Compliance can often be improved by enlisting the patient's active participation in the treatment.
- Simplification of medication regime
- Recognition of factors leading to non compliance.
- Define illness from patient perspective/patient point of view
- Define Target Symptoms and severity
- Empathy, support
- Provide Rationale for use of medication. Disclose:-
- Elicit Patients Resistance
- Disclose the need of medicine and prescribe dose



- Convey hope & optimism,
- Develop therapeutic Alliance,
- Discuss alternative Treatments (Fawcett,1995)

APPROACHES TO IMPROVE ADHERENCE



Cognitive Behavior Therapy-The goal is to improve insight into illness increase adherence to medication, ameliorate the severity of symptoms and mitigate other negative consequences.

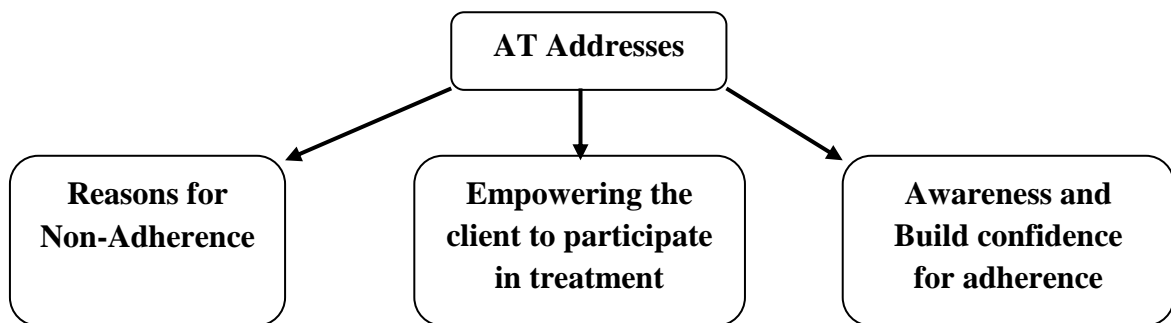
- Addressing distorted beliefs about illness and developing cues to support adherence Behaviors.
- Improving the ability to recognize clinical symptoms which aware the patient about need for maintenance treatment and benefit of medication.
- Linking the positive effect of medication to the patient's personal goal and desires for better functioning and quality of life.

CBT has been effective in reducing residual symptoms, which indirectly improves medication adherence.

Adherence Therapy-Adherence therapy is a collaborative consumer centered approach to enhance medication adherence. It uses elements of cognitive behavior therapy and motivational interviewing to address the individuals beliefs about medication-

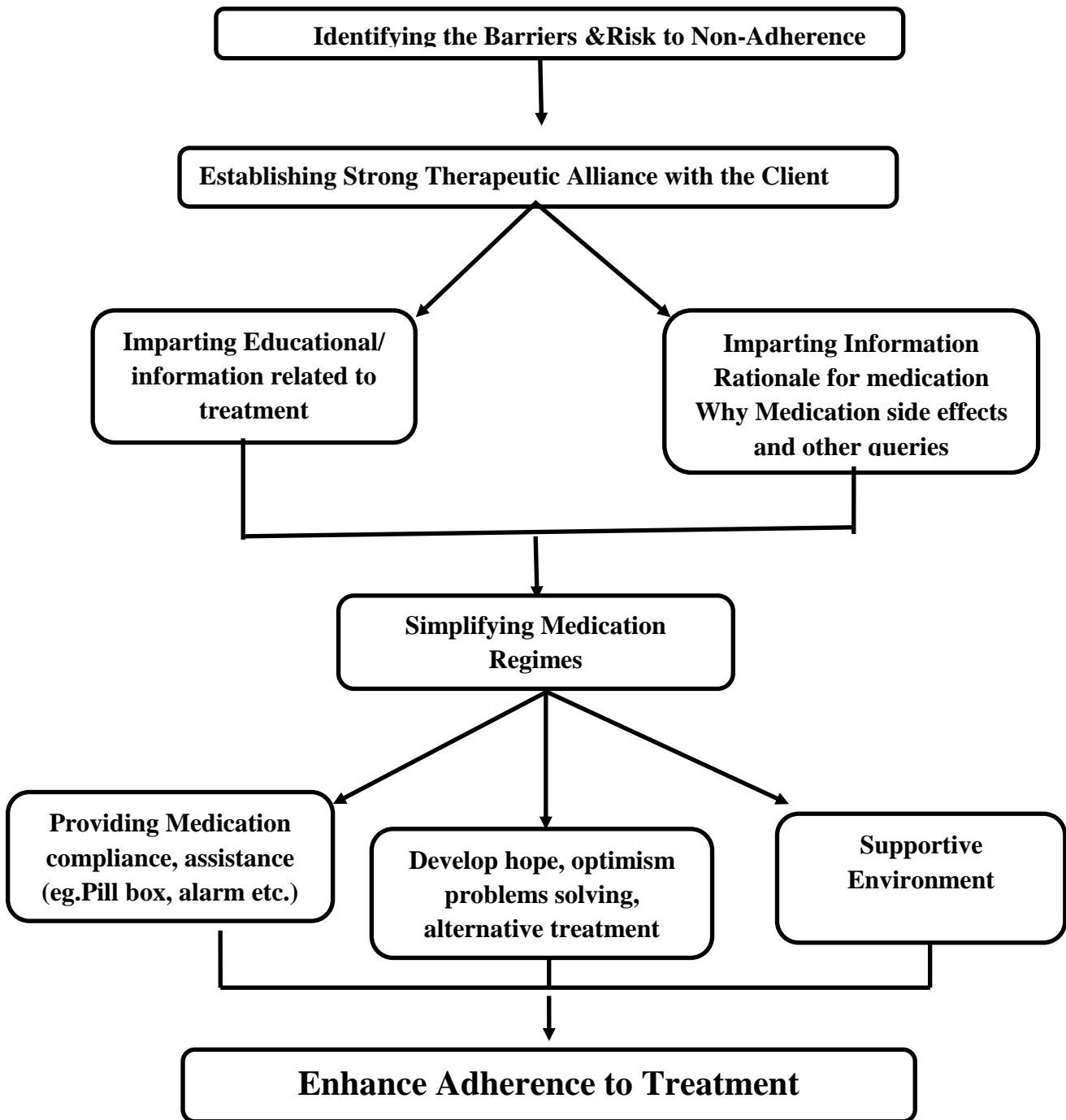
- **Identifying treatment barriers**
- **Develop individually specific strategies to overcome**
- **Enhance problem solving**
- **Goal setting techniques**

AT approach may be effective because it tailors the intervention to the specific needs of client, addressing the reasons for their non adherence and empowering the client to participate actively in their own treatment. Thus, through open ended questioning, reflective listening, the therapist aims to build the client's awareness of the importance of taking medication and develop confidence in adhering to his or her treatment regime. However, follow up visits are also very important for enhancing and monitoring compliance.



Managing Side Effects:

- a) Empathetic attention to the difficulty and reassurance
- b) Serious side effects should be addressed by changing the time of dose of the medication or to take with or without food or using another medication etc.
- c) At times, Medication switch will be required to address non adherence



Adherence is often misjudged by the Health providers and underestimated by the patients. However, adherence education information when engaged with supportive provider care relationship has proven to be highly beneficial. As highlighted poor adherence is often associated with lack of insight, unclear treatment instructions and poor communication skills, if these queries are met it facilitates adherence behaviors. Thus, effort should be on – Educational + **Behavioral**+ **Environmental Techniques** and needs multidisciplinary team and client can be benefited by adherence- education information along

with supportive therapeutic relationships, as it may counter many of the barriers and provide answers to their questions and concern related to illness facilitates adherence behavior.

Psychosocial Management/ Interventions:

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

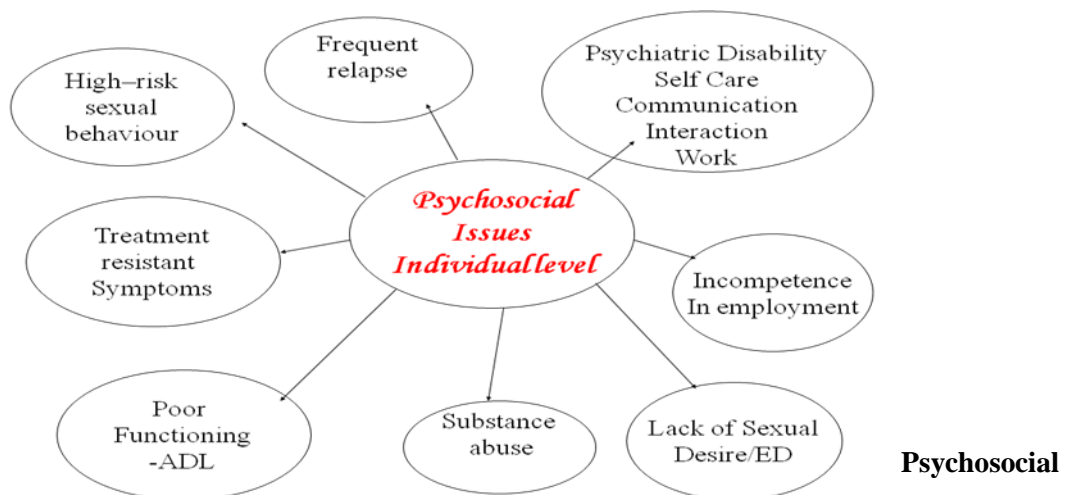
Caring for mental illnesses no longer just means relieving symptoms but it also means having to cope with the different resulting needs. All in all, caring for these people requires integrating psychopharmacological interventions and psychosocial interventions into a mental health network comprised of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

Psychosocial Interventions include a variety of Psychological Interventions, individual and family interventions, psycho-educational interventions, Community based residential and non residential programmes, leisure and spare time programmes, programmes aimed at employment etc.

Psycho-social interventions can be broadly grouped into:

- Individual patient interventions
- Family interventions
- Community based interventions

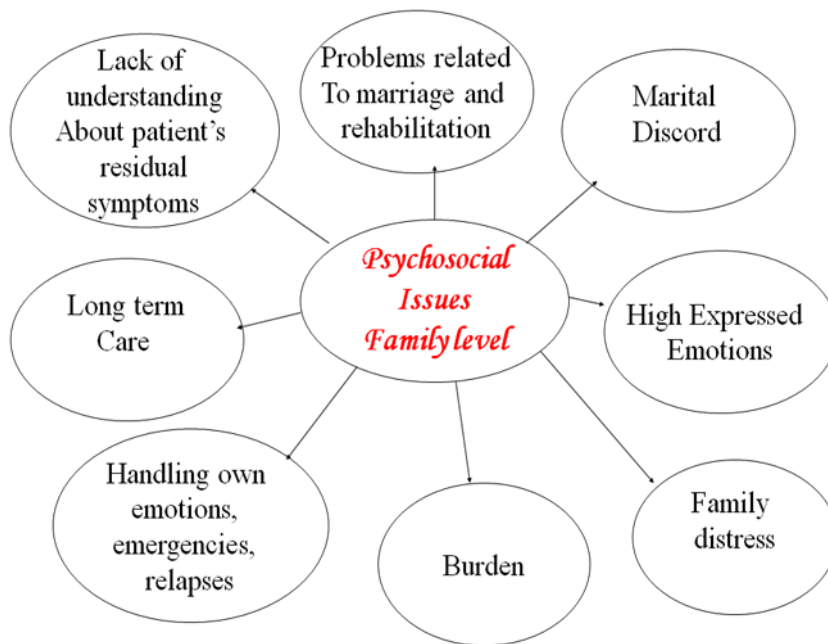
I Psychosocial issues at Individual Level:



interventions at Individual Level

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

II Psychosocial issues at Family Level -

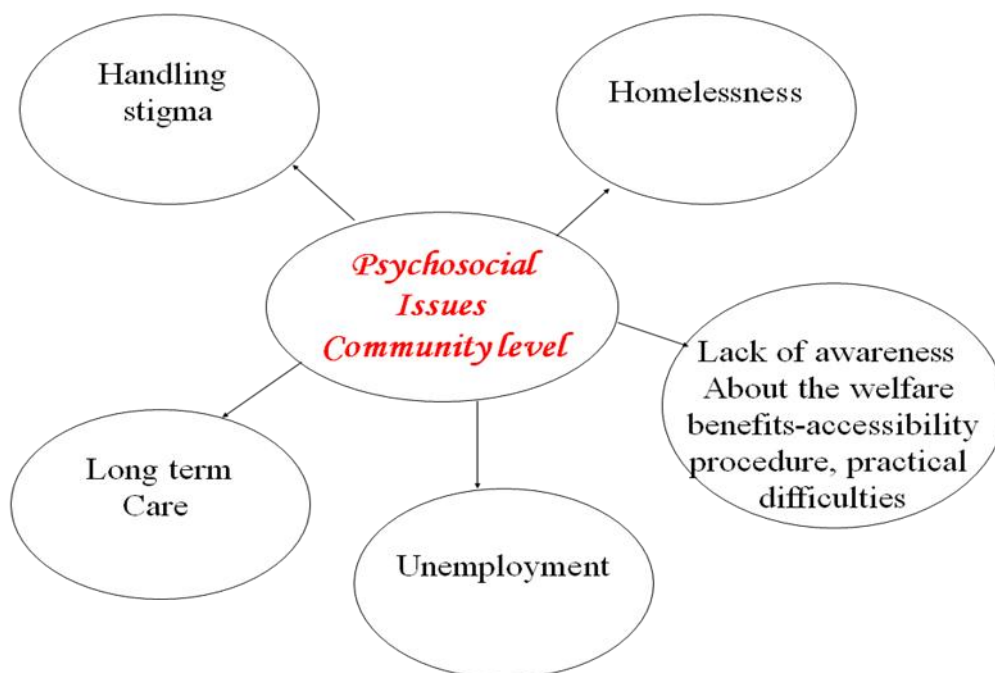


Psychosocial Interventions at family Level

- Build a relationship with care givers based on empathetic understanding
- Focusing on the strengths of caregivers and assisting them to identify community resources.
- Promote Medication compliance.
- Promote early identification of relapse and swift resolution of crises.
- Reduce personal and social disability.
- Reframe expectations and moderate the affect in the home environment.

- Emotional support to caregivers.
- Develop self-help groups for mutual support and networking among families
- Provide information about services, welfare benefits.
- Address family burden
- Strengthen the coping strategies of family
- Provide crisis management
- Respite care
- Deal with expressed emotions in the family
- Provide family support services

III Psychosocial issues at Community Level -



A. Psychosocial Interventions at Community Level

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

B. Programmes aimed at leisure and spare time

The objective of these programmes is to help people with SMI recover, fostering social relations and the use of free time, fostering participation in community atmospheres and meeting activities, holidays and activities of personal enrichment.

C. Programmes aimed at employment

Vocational rehabilitation (or labour rehabilitation) starts up social skills training and professional preparation programmes for the subsequent incorporation into a job. They adapt both to the special difficulties of the candidate and to their counselling, support and monitoring needs in the job, and they can incorporate occupational learning workshops with occupational activities. They risk losing their efficiency and just providing training and repetitive learning if there is no perspective of immediate incorporation into employment, either sheltered or ordinary.

Supported employment is directed at immediate placement in the competitive market, accompanied by training and individual monitoring measures at work, as well as support to the employer, with no definite time interval to guarantee maintenance of the job. This approach places emphasis on quick access and attention to personal preferences and motivations; on considering that there is no need for long processes of evaluation and re-training.

D. Service level interventions:

Service level interventions in the form of Care Programme Approach, Intensive Case management and Assertive Community Treatment are very important activities that can be carried out by a Social Worker in the community.

E. **Care Programme Approach** is a systematic methodology to assess the social and health needs. A Care plan needs to be prepared for each client that identifies the social and health care required for a series of providers that involve regular contact with the case Manager.

F. **Intensive Case Management** is characterised by a burden of less than 20 patients per case manager (normally one psychiatrist/ Psychiatric Social worker). The ICM (Intensive case management) model is adopted to cover the needs of high frequency patients.

G. **Assertive Community Treatment** is a form of intervention provided by a team of multidisciplinary mental health team members within the community in an active manner.

H. Day centres and/or psychosocial rehabilitation centres/Half way homes

I. Community Mental Health Centres

Psychoeducation:

Psycho-Education is an educative method based on clinical findings for providing information and training to families with psychiatrically ill persons to work together with mental health professionals as part of an overall clinical treatment plan for their ill family members. **Imminent goals of psycho-education are to prevent patients with severe mental illnesses from having frequent relapsing**

episodes of illness, ensuring medicine as well as treatment adherence, and to reintegrate them back to their home communities, with particular regard for their social and occupational functioning. Thus the goal is to make the client to deal with the presented illness, strengthen his capabilities, resources and coping skill which may help in over all well-being on long term basis.

Definition

Psycho-Education is the “*process of teaching clients with mental illness and their family members about the nature of the illness, including its aetiology, progression, consequences, prognosis, treatment and alternatives*” (Barker, 2003).

Focus of Psycho-Education is on:

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

The supreme goal lies in the empowerment of the afflicted and their families so that they are able to tackle their illness in as optimal away as possible. The Psycho-education Intervention should also dispel negative attitudinal factors like Expressed Emotion and Sense of Burden.

Basic Components of Psycho education

<p><u>Basic facts about disorder</u></p> <ul style="list-style-type: none"> • Diagnosis • Common myths • Prevalence • Course of disorder • Establishing diagnosis 	<p><u>Causes of psychiatric disorders</u></p> <ul style="list-style-type: none"> • Psychobiological vulnerability to disorders • Effects of alcohol/drug abuse, medication on symptoms • Effects of stress on symptoms • Family and patient coping skills as mediators of stress • How family can help
<p><u>Medication</u></p> <ul style="list-style-type: none"> • Effects of medication on disorder • Names of medication • Side effects • Strategies for managing side effects • Talking with physicians about medication • Importance of regular medication 	<p><u>Early warning signs of relapse</u></p> <ul style="list-style-type: none"> • Identification • Monitoring symptoms and early warning signs

Type of Psycho-Education

It can be implemented in a number of different in a Number of different format and setting-

- **Individual Based**
- **Group Based**
- **Families based/Parent based**

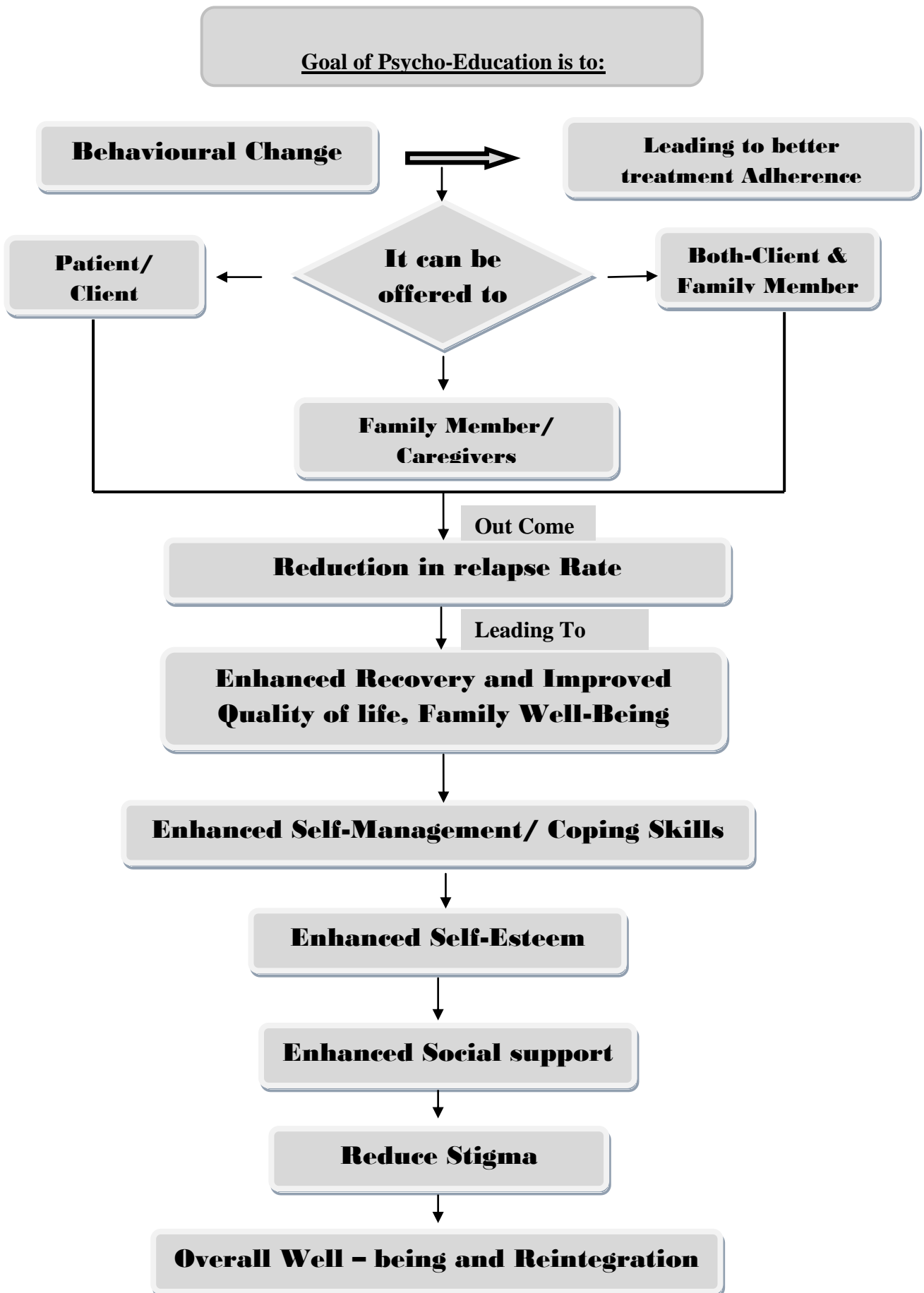
It commonly involves the individuals with the illness, (the patient or client) and who deal with the patient on a day to day basis as family, friend, caregivers etc.

Psycho-education with Family, Peer or caregivers should focus on the following:

- Understanding the nature of the illness.
- The main symptoms of the disorder and it Identification (early sign and symptoms).
- Identification the triggering factors
- Treatment Adherence- and their role as a caregivers how to help the client to adhere to the schedule in managing the condition.

Following question needs to be addressed regarding medication

- What it does?
- How does it work?
- What are the benefits?
- What are the side effects?
- How often it must be taken?
- What happens when not taken?
- What to do in times of emergencies, how to handle the situation.
- The financial, legal and social support needs to be addressed.



AYUSH as a complementary and alternative treatment for mental health prevention and promotion:

AYUSH is the acronym of the medical systems that are being practiced in India such as **Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homeopathy**. These systems are based on definite medical philosophies and represent a way of healthy living with established concepts on prevention of diseases and promotion of health. The basic approach of all these systems on health, disease and treatment are holistic. Because of this, there is a resurgence of interest on AYUSH systems. Yoga has now become the icon of global health and many countries have started integrating it in their health care delivery system. Similarly there is great curiosity to understand the principles and practice of Ayurveda, Homeopathy, Siddha and Unani especially due to growing challenges in medicine in Non-Communicable Diseases (NCDs), Life style disorders, long term diseases, multi drug resistant diseases, emergence of new diseases etc.

The word Ayurveda derived from *AYU* and *VEDA*. *AYU* means life *VEDA* means science or knowledge. Ayurveda means the science of life. Charaka defines "That science is designated as Ayurveda which deals with advantage and disadvantage as well as happy and unhappy states of life along with what is good and bad for life, its measurement and the life itself (Charaka Sutra 1 - 4)". Ayurveda believes that positive health is the basis for attaining four cherished goals of life (*chaturvidh purushartha*) viz., Dharma, Artha, Kama, Moksha. All these four goals cannot be achieved without sound positive health.

A number of western models of social case work and psychotherapy have emerged in the past decades for treating persons with mental health issues. However, mental health professionals have observed that western psychotherapy was not only alien to the culture, but also the socio cultural milieu of the country. Indian philosophy on the other hand, for example the Atharva Veda presents theory of mental illness which occurs due to an imbalance in the person's mind and or body or the connection between the mind and body, the interconnection between the mind (Gunas) and the body (Doshas, and states that the curative factor is creating a holistic balance with in the individual. Yoga through successive stimulation – relaxation helps break the loop of uncontrolled speed of thoughts (Stress), gains control over the mind and harmonizes the disturbances at each of the five levels of human existence to tackle psychosomatic problems.

Unani is a comprehensive medical system, which meticulously deals with the various states of health and disease. It provides promotive, preventive, curative and rehabilitative healthcare. The fundamentals, diagnosis and treatment modalities of the system are based on scientific principles and holistic concepts of health and healing. The Unani System of Medicine offers treatment of diseases

related to all the systems and organs of the human body. The treatments for chronic ailments and diseases of skin, liver, musculo-skeletal and reproductive systems, immunological and lifestyle disorders have been found to be highly effective and acceptable.

The Siddha system of medicine is mainly practised in the Southern part of India. It is one of the earliest traditional medicine systems in the world which treats not only the body but also the mind and the soul. The word Siddha has its origin in the Tamil word *Siddhi* which means "an object to be attained" or "perfection" or "heavenly bliss". India being the birth place of many traditional philosophies also gave birth to Siddha.

Since homoeopathy is the medicine of individualisation, all that is related to the individual must be known. A homoeopathic doctor will start with asking the preliminaries like your name, age, education, address, profession. The mental distress will then be identified by its symptoms along with certain individual components such as for example if the patient is suffering from loss of a loved one, is depressed, every individual will have different thoughts and react in ways individual to them. Some may experience loss of sleep, some lack of concentration, some restlessness; some might indulge in overwork and tire themselves to get over the low feeling. There may be physical symptoms which may accompany the psychological complaints like increased desire for eating a particular type of food or aversion to a particular type of food, some joint complaint which might have started at the same time as the event causing distress. This comes from the observation that what affects the mind, affects the body and vice versa.

Yoga is an Art and Science of healthy living. It is a spiritual discipline based on an extremely subtle science, which focuses on bringing harmony between mind and body. The holistic approach of Yoga is well established and it brings harmony in all walks of life and thus, known for disease prevention, promotion of health and management of many lifestyle –related disorders. Today, Yoga is popular across the globe, not just because of its efficacy in the management of some diseases, but also of its strength in providing relief to the practitioner, from mental and emotional distress and providing a feeling of well-being. Hence, now-a-days Yoga is being practiced as part of healthy life style across the globe.

As per Yogic scriptures the practice of Yoga leads to the union of individual consciousness with that of the Universal Consciousness, indicating a perfect harmony between the mind and body, Man & Nature.

The aim of Yoga is Self-Realization, to overcome all kinds of sufferings leading to 'the state of liberation'. This is one of the oldest sciences of the world, which originated in India. Yoga is very useful for preserving and maintaining one's physical and mental health and also for 'spiritual evolution'. The practice of Yoga is believed to have started with the very dawn of civilization.

Yoga and its relation to positive psychology

The foundation of yoga is in line with the recent shift of focus to positive psychology, since the development of awareness and stillness is a key point in yoga (Büssing et al., 2012). Whereas a purely medical perspective (which was the main focus before positive psychology arose) focused on merely reducing negative symptoms, positive psychology and yoga seek to accept the current situations and stimuli as they come and not to evaluate. Yoga fits with this approach, because it is a way of practicing these traits. Yoga for example focuses on the contemplative practice of focused attention and controlled breathing; also, reducing external stimuli and viewing emotions as being temporary (Kabat-Zinn, 1994).

The conceptual background of yoga has its origins in the philosophy of ancient India. There are multiple schools of yoga, all of which have their unique way of practice (i.e., Iyengar, Viniyoga, Sivananda). The schools differ in elements of yoga, such as physical postures (*asanas*), breathing techniques (*pranayama*), relaxation and meditation which ultimately cultivates 'higher states of consciousness' (Büssing et al., 2012). It is often important to see the meditation and yoga practices outside the context of the eastern philosophy. Practically seen, the physical exercises (*asanas*) is associated with patient's physical flexibility, coordination and strength, whereas the breathing practices and meditation calm and focus the mind to develop greater awareness and diminish anxiety. Other reported beneficial effects are reduction of distress, improvements in resilience, mood and metabolic regulation (Büssing et al., 2012; Harder, Parlour & Jenkins, 2012).

Naturopathy is an art and science of healthy living and a drug less system, It has its own concept of health and disease and also principle of treatment. In today's age, Naturopathy is Recognized and well accepted as an independent System of medicine. Naturopathy advocates aiding human system to remove the cause of disease i.e. toxins by expelling the unwanted and unused matters from human body for curing diseases. Nature is the greatest healer. The human body itself has the healing power to prevent itself from disease and regain health if unhealthy.

In Naturopathy, it is not the disease but the entire body of the patient which is caused and is renewed. Naturopathy cures patients suffering from chronic ailments in comparatively less time than any other form of medicine. Naturopathy treats all the aspects like physical, mental, social and spiritual at the same time. Naturopathy treats the body as a whole. According to Naturopathy, "Food is only the Medicine", no external medications are used.

CHAPTER 5

PSYCHOSOCIAL REHABILITATION

Introduction:

The main focus of rehabilitation is the functioning of people in their normal environments, improving their personal and social skills, giving support for them to undertake the different roles of social and community life and, in short, to improve the quality of life of the persons affected and of their families, as well as support for their social participation in the community in the most active, normalized and independent way possible in each case. In other words, the aim of psychosocial rehabilitation is to help people with severe and persistent mental illnesses develop intellectual, social and emotional skills that they need to live, learn and work in the community with the least possible professional support.

Concept of Recovery

The recovery concept has been defined as “the process where people are capable of living, working, learning and participating fully in their community”.

Practices aimed at recovery recognize that people with mental illness have the same wishes and needs for work, accommodation, relationships and leisure as any other person who does not suffer from a mental illness. Mental illness represents important changes that break with life expectations both on a personal level and in the environment, especially the family environment. The recovery concept shows the need to renew these life expectations, overcoming these changes through the different techniques that the services must provide.

Reintegration into society is a result that can be reached through the use of therapeutic mental health services, such as community psychiatry and rehabilitation, among others, as well as a political and community initiative, to promote solidarity and openness with respect to individuals who suffer from several mental illnesses.

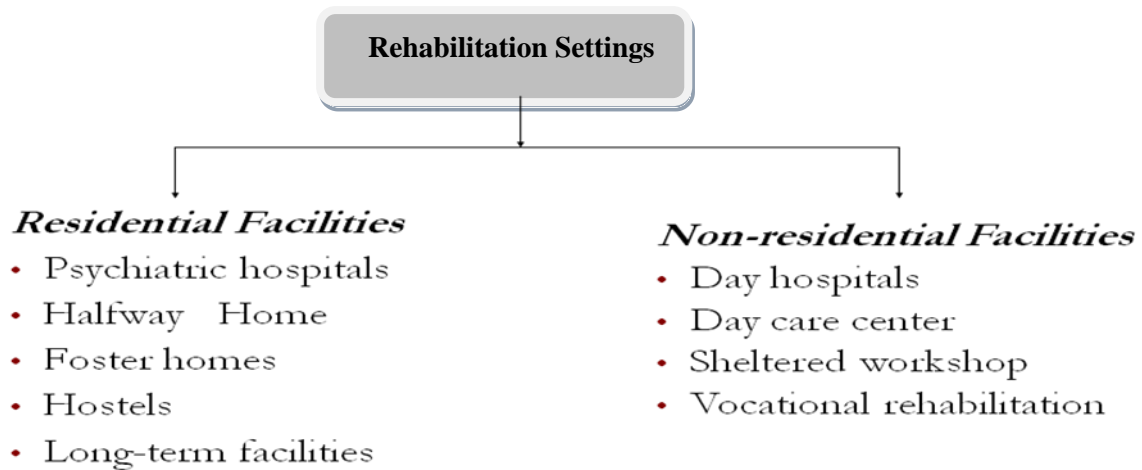
The Social Worker has a significant role to play in ensuring maximum recovery of persons with severe mental illnesses. The role of the Social worker is to assist individuals to overcome or compensate for the psychosocial and social integration difficulties that these people undergo, giving them support in their daily lives in the community in the most independent and decent manner, as well as in undertaking and handling the different roles and demands represented by living, working and mixing in different community environments.

Psychosocial Rehabilitation

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

Goals of Psychiatric Rehabilitation	Strategies
<ul style="list-style-type: none"> • Activities of daily living • Behaviour of daily living • Opportunities • Identification of community resources • Independent • Empowerment of the client • Recovery • Quality of life • Community advocacy • Increase Coping skills • Increase social support • Satisfaction of basic needs • To increase Interpersonal skills • Improvement of his social network • Diminishing the impact of psychiatric symptoms 	<ul style="list-style-type: none"> • Psycho education • Independent living skill training • Basic living skills training • Communication Skills Training • Social skills training • Vocational training • Activity scheduling • Supportive counseling • Art therapy • Play therapy • Dance therapy • Biblio Therapy • Drama Therapy • Horticulture Therapy • Recreational Therapy • Behavioral intervention

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



The Social Workers need to also facilitate the vocational rehabilitation programmes available in the community to persons recovering from mental disorders.

There is a need to appropriately plan Vocational training in the form of Sheltered Workshops, Psychosocial Programmes and Sheltered Employment. It is also necessary to prepare and refer recovering mentally ill persons to Pre-vocational training classes that include-

- Teaching work skills
- Job search skills
- Transitional employment
- Trial employment
- Part time employment
- Volunteer placement before competitive work

The Social worker working in this set up has multiple roles to play.

<ul style="list-style-type: none"> • Working with family • Working with groups • Working with individual • Community Organization • Home/ office/ school visits • Family Guidance and counseling services • Training volunteers, various Professionals • Referrals • Advocacy 	<ul style="list-style-type: none"> • Teamwork • Networking • Supervision • Coordinator • Consultation • Skills training • Correspondence • Resource mobilizing • Interagency collaboration • Community liaison and consultation • Researches in Psychiatric Rehabilitation
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A comprehensive rehabilitation planning that is well coordinated, multi-disciplinary in nature, and makes the optimum use of community resources helps in the comprehensive recovery of those recovering from severe mental disorders.

Factors contributing to successful rehabilitation

- Right diagnosis
- Appropriate treatment
- Periodical clinical evaluation
- Regular follow-up
- Continuity of care
- Activity scheduling
- Vocational training
- Job placement
- Psycho-social therapeutic intervention
- Self-help group services
- Family welfare services
- Alternative home care services
- Day care services
- Family support
- Community support
- Government support
- Institutional care services
- Community based rehabilitation services
- Eradication of stigma, discrimination.

Ways to maximize Maintenance

- Techniques of Relapse prevention
- Identifying high risk situations
- Coping with negative emotional states
- Coping with interpersonal conflicts
- Coping with social pressure
- Coping skills training
- Preparation for high risk situations
- Life style interventions

- Family psycho-education incorporating all of the above plus medication/ maintenance techniques

Stepped Care Intervention

Several decades of research have documented the high prevalence of common mental disorders in general medical settings. Evidence suggests that community-dwelling people with common mental disorders frequently present in general medical settings, such as primary care clinics, during the course of an illness episode, although relatively few receive specialty mental health care.

About half of the care for common mental disorders is delivered in general medical settings; representing an important—perhaps the single most important—point of contact between patients with mental disorders and the health care system.

Mental health problems have long been recognized in every society. Communities had their own mechanisms of handling these problems, which is being replaced by modern science.

In this evolving health care scenario non-communicable diseases pose a major problem due to lack of skilled healthcare, manpower, inadequate information and the inability of the system to meet this challenge all over the world.

However, the expansion of healthcare infrastructure in both the public and private sector along with technology progress in medicine has brought about improvement in the health of people.

Stepped care is a model of healthcare delivery with two fundamental features. First, the recommended treatment within a stepped care model should be the least restrictive of those currently available, but still likely to provide significant health gain. Second, the stepped care model is self-correcting.

The definition of 'least restrictive' may refer to the impact on patients in terms of cost and personal inconvenience (Sobell & Sobell, 2000), but in the context of publicly funded healthcare systems where specialist therapist time is a key limiting factor, 'least restrictive' is often interpreted as referring to the amount of specialist therapist time required (i.e. treatment intensity). In stepped care, more intensive treatments are generally reserved for people who do not benefit from simpler first-line treatments, or for those who can be accurately predicted not to benefit from such treatments (Newman, 2000). In this way, stepped care has the potential for deriving the greatest benefit from available therapeutic resources.

A stepped care recovery model seeks to treat service users at the lowest appropriate service tier in the first instance, only 'stepping up' to intensive/specialist services as clinically required. The level of

professional input is augmented gradually, until satisfactory health status is achieved. This offers clinical and financial advantages that can benefit service users.

Stepped care usually begins with relatively low-intensity interventions, such as antidepressant medications prescribed by a primary care provider and care management provided by telephone or in the primary care clinic. Under the supervision of a consulting psychiatrist or other appropriate mental health specialist, patients who are not helped by such initial treatments are shifted to progressively more intensive treatment approaches, including referral to specialty mental health care as needed.

Effective treatment programs recognize that usual primary care is better suited to address acute, time-limited medical problems rather than chronic illnesses that require ongoing monitoring and management.

Stepped Care

- Identification
- Treatment
- Monitoring

Who will do it?

- Involving- GP's, PHC Worker, AYUSH, welfare Sector
- Community Health Worker
- ASHA Worker
- Community Social Worker
- NGOs/ Voluntary Worker/ Liaisoning with Civil Society/ Stakeholders/ Lions / Rotary Club etc.

Focus will be on

Prevention: aims to reduce the incidence of disease or dysfunction in a population through modifying stressful environments and strengthening the ability of the individual to cope. Prevention involves the promotion and maintenance of good health through education, attention to adequate standards for basic needs and specific protection against known risks. In mental health settings, preventive activities include public and client education regarding emotional self-care and healthy relationships, building community knowledge and skills (community development), social action, and advocacy for social justice.

Treatment: aims to reduce the prevalence (number of existing cases) of a disorder or dysfunction and includes early diagnosis, intervention and treatment. In mental health settings, treatment activities are focused on individuals experiencing acute psychiatric symptoms, emotional trauma, relationship problems, stress, distress or crisis and include assessment, risk management, individual, couple, family and group counseling, intervention or therapy and advocacy. Social work uses relationship as the basis of all interventions.

Rehabilitation: aims at reducing the after effects of disorder or dysfunction, and involves the provision of services for re-training and rehabilitation to ensure maximum use of remaining capacities by the individual. In mental health settings, rehabilitation activities focus on clients who are disabled by mental illness and may include individual, couple, family, and group interventions to build knowledge and skills, provision of specialized residential, vocational and leisure resources, and advocacy to ensure the development of needed services and to change community attitudes.

Mental health settings usually include services in three broad levels of health care application: prevention, treatment and rehabilitation. It is recognized that individual social workers may practice exclusively within one setting or cross the boundaries of all three in response to diverse client, family and community needs.

A mental health social worker can and should deliver the following professional services:

- **Direct Services** to individuals, couples, families and groups in the form of counselling, crisis intervention, therapy, advocacy, coordination of resources, etc.
- **Case Management** - coordinating inter-disciplinary services to a specified client, group or population.
- **Community Development** - working with communities to facilitate the identification of mental health issues and development of mental health resources from a community needs perspective.
- **Supervision** - clinical supervision/consultation of other community health workers, other social workers involved in mental health service delivery.
- **Program Management/Administration** - overseeing a mental health program and/or service delivery system; organizational development
- **Program, Policy and Resource Development** - analysis, planning, establishing standards
- **Research and Evaluation**

Stepped care in Mental Health

Who is responsible for care?	What is the focus?	What do they do?
Inpatient care - Crisis Team	Risk to life, severe self neglect	Medications, combined Rx,
Mental health specialists	Atypical, acute manifestations	Medication & psychosocial intervsn
Primary care team and Social worker	moderate to severe symptoms	Rx, counselling, psy.social intervention
PHC team and Social Worker	Mild M.H. Problems	Counselling, supportive therapy
GP / Nurse/ health worker/MPWs	Identification	Assessment

A balanced approach, including both community and hospital services are necessary in all areas regardless of their level of resources. Areas with low levels of resources may focus on improving primary care, with specialist back-up. Areas with medium resources may additionally provide out-patient clinics, community mental health teams (CMHTs), acute in-patient care, community residential care and forms of employment and occupation. High-resource areas may provide all the above, together with more specialized services such as specialized out-patient clinics and CMHTs, assertive community treatment teams, early intervention teams, alternatives to acute in-patient care, alternative types of community residential care and alternative occupation and rehabilitation.

Benefits of Stepped Care Model

The stepped care model helps in

- easy availability of mental health services in the community,
- easy accessibility and
- a better utilization of these mental health services by the persons in need of these services.

- Reduction of stigma associated with mental disorders.
- Reduction of patient overload at tertiary care centres
- Better acceptability of mental health services in the community
- Easy monitoring and follow up of clients.

Referral and Directory of Mental Health Services

The Social Worker working in the Primary Health Centre and Community Mental Health Centre has to identify persons in the community, requiring mental health care and treatment in their regular community and home visits that they carry out. The persons requiring these services should be referred to the appropriate services that are easily available, accessible and affordable. Wherever the family shies away from accessing the mental health services in a tertiary mental health centre due to fear of stigma, it should be taken note of and as much as possible, mental health care that is integrated into the general health care should be considered. The social worker should also be able to observe and identify families who approach faith healer or God-men and spend most of their earnings with the hope of curing their mentally ill family members. Such families need to be guided and counselled that pharmacological treatment is very essential to treat severe mental disorders. They can also be supported in their resorting to spiritual forms of healing.

The Social Worker can also prepare a Directory of Mental Health Services and Welfare and Disability benefits and where and how they can be accessed by the community.

The Directory may have details like Particulars of the service, Address, location, Contact Person, Telephone Number.

Services like-

- Mental Health Specialists in the village, Block, District and State level
- Tertiary care mental health centres
- Alcohol Anonymous Groups,
- Psychologists/ Psychological services available
- Child and Family counselling services
- Child and Adolescent Guidance Centres
- Marriage and Family counselling services
- IQ testing centres
- Disability Certification Centres
- Lions Club, Rotary Club etc. organising community mental health camps
- List of NGOS working in the field of Disability and Welfare
- Government run Homes for children with Mental Retardation

- Special Schools
- Government and NGO run Homes for girls and women in distress
- Legal services
- Local area Magistrate
- Private Psychiatric Clinics/ Psychiatrists
- Day Care centres
- Half Way Homes
- Residential Care Homes
- Occupational Therapy and Physiotherapy services
- Speech Therapy services
- Local Lok Kalyan Samitis
- Any other related to mental health, disability and welfare

Such a Directory would ease difficulties faced by those unaware of such services and help in accessing information and availing appropriate services.

Legislative Measures for protecting the rights of persons with mental disorders-

The Social worker should also be well informed of the legislative measures in respect of persons with mental disorders. Mental health legislation is essential for protecting the rights and dignity of persons with mental disorders, and for developing accessible and effective mental health services. Effective mental health legislation can provide a legal framework to integrate mental health services into the community and to overcome stigma, discrimination and exclusion of mentally-ill persons. Legislation can also create enforceable standards for high quality medical care, improve access to care, and protect civil, political, social and economic rights of mentally-ill individuals, including a right of access to education, housing, employment and social security.

The Legislative measure to protect the interests of persons with mental disorders is the Mental Health Act, 1987.

Mental Health Act, 1987

An Act to consolidate and amend the law relating to the treatment and care of mentally ill persons, to make better provision with respect to their property and affairs and for matters connected therewith or incidental thereto.

This Act discusses issues of licensing and supervising of psychiatric hospitals, providing custody of mentally ill persons, regulating the procedures of admission and discharge of mentally ill persons under different circumstances, safeguarding the rights of detained persons, protecting citizens from being detained unnecessarily, providing free legal aid to poor mentally ill.

The Government of India has enacted the following legislations for empowering the Persons with Disabilities and notified Rules & Regulations under the provisions of the Acts:

Persons with Disability (Equal Opportunities, Protection of Rights and Full participation) Act, 1995.

The Act has been enacted under Article 253 of the Constitution read with item No. 13 of the Union List. It gives effect to the proclamation on the full participation and equality of the persons with disabilities in the Asian & Pacific Region and provides for their education, employment, creation of barrier free environment, social security, etc. The implementation of the Act requires a multi-sectoral collaborative approach by the appropriate governments, including various Central Ministries/Departments, States/Union Territories, local bodies.

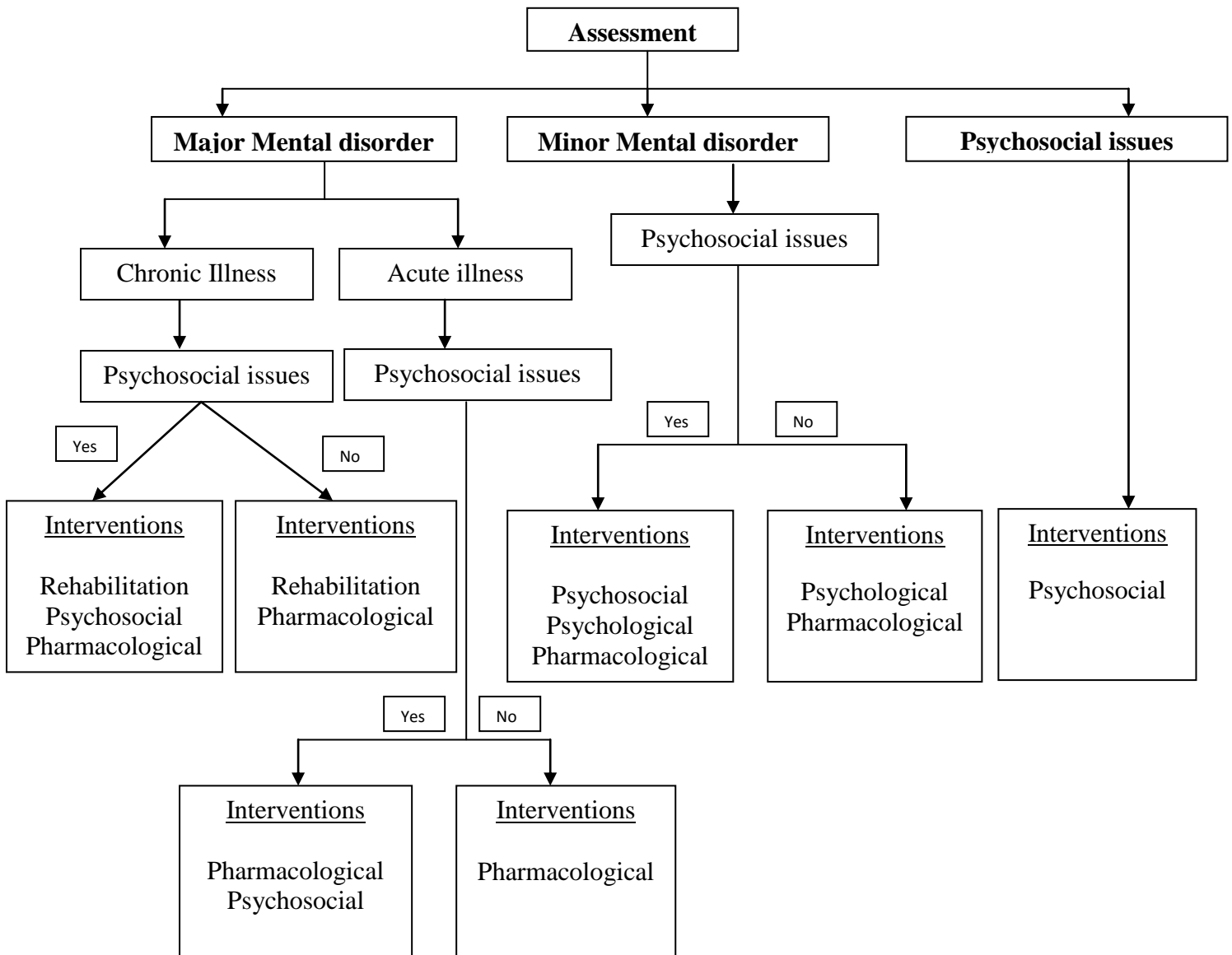
National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disability Act, 1999

The Act provides for constitution of the Board of the National Trust, Local Level Committees, Accountability and Monitoring of the Trust. It has provisions for legal guardianship of the four categories of the persons with disabilities and for creation of enabling environment for their as much independent living as possible.

Rehabilitation Council of India Act, 1992

The Act provides for constitution of the Rehabilitation Council of India for regulating the training of rehabilitation professionals, maintenance of a Central Rehabilitation Register, recognized rehabilitation qualifications, minimum standards of educations etc.

CHART FOR ASSESSMENT AND INTERVENTIONS



Conclusion:

Many of the roles that social workers perform are common to all mental health disciplines. Specific to the domain of social work are roles of building partnerships among professionals, caregivers and families; collaborating with the community, usually with the goal of creating supportive environments for clients; advocating for adequate service, treatment models and resources; challenging and changing social policy to address issues of poverty, employment, housing and social justice; and supporting the development of preventive programs. Prevention occurs on many levels and includes a focus on early intervention, individual and public education, advocacy and improving access to services, resources and information.

At the micro and mezzo levels social workers are primarily concerned with "the social well-being of individual clients and their families equally valued with the importance of their physical, mental and spiritual well-being." (CASW National Scope of Practice Statement, p. 1) At the macro level "social workers generally demonstrate a greater capacity to look beyond the illness and treatment issues, to consider the broader human, social and political issues in mental health.

The primary focus of social workers should be on the emotional well being and mental health of individuals that emphasizes the importance of social and psychological determinants of health in the community.

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