MADRAS SCHOOL OF SOCIAL WORK

In collaboration with

Schizophrenia Research Foundation (SCARF India)

VALUE ADDED (CERTIFICATE) COURSE ON

Online Certificate course on Psycho-social Rehabilitation

Date: February 2020

COURSE COORDINATOR

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MADRAS SCHOOL OF SOCIAL WORK

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P.G Department of Social Work (SF)

In Collaboration with

SCARF INDIA

Certificate Course on Psychosocial Rehabilitation

Course Coordinator

J. DAMEN QUEN

ORGANIZER`S NOTE:

Madras School of Social Work in partnership with SCARF organized an online certificate course on Psycho-social rehabilitation with special focus on recovery. Schizophrenia Research Foundation (SCARF India) is a NGO with a track record of working in the field of mental health for over 30 years delivering care and treatment with a particular focus on rehabilitation, conducting research, raising awareness and training people (students of social work, psychology, doctors, nurses, etc.). One of the main missions of SCARF is to rehabilitate patients with severe mental illnesses. This could be achieved only with staff with special interest and skills in rehabilitation. With increasing recognition of mental illness as treatable and families willing to ask for help, it is only rational to have more staff with the right rehabilitation-oriented skills and knowledge to provide interventions.

OBJECTIVE OF THE COURSE:

- To familiarize the participants in the concepts of recovery and psycho-social rehabilitation.
- To provide a comprehensive knowledge on components of rehabilitation.
- To understand the theoretical bases and learn skills of delivering psycho-social rehabilitation.
- To train the participants in assessing needs, delivering intervention and access progress in the area of rehabilitation.

- To Create an interest for participants in the field of rehabilitation.

- To Enhance skills related to providing rehabilitation and delivering psycho-social interventions

STRUCTURE OF THE COURSE:

The course was designed to provide an understanding on Psycho-social Rehabilitation. It is a 30 hours course with 4 mandatory assignments distributed over the 4 weeks of the course. The course is structured to provide a progressive learning on the theoretical & practical understanding on Psycho-social Rehabilitation. The resource persons are part of the experienced multi-disciplinary team at SCARF who have been providing Psycho-social Rehabilitation to their clients enabling a holistic treatment and management of their mental health disorder.

MSSW SCARF PSR Certificate course

Date	AM	PM	Resource persons	Venue
1/2/2020	1. Introduction to rehabilitation and functioning 2. Recovery concepts 3. PSR general principles 4. Needs	PSR Assessments Rehab oriented history taking	Dr R Padmavati Ms Jainey Joseph	MSSW
15/2/2020	Components of rehabilitation ADL SST	Assessment and intervention practice of ADL and SST	Dr. Lakshmi Ms. Sonia morning Dr Lakshmi Ms. Sonia Ms. Omega afternoon	MSSW
22/2/2020	Cognition Motivation	Practical session	Ms. Subashini Gopal Ms. Sangeetha	MSSW
14/3/2020	Vocational rehabilitation	Practical session	Dr Lakshmi	MSSW

			Ms. Kiruthika morning Ms. Jainey Joseph afternoon	
21/3/2020	Psychoeducation Family interventions	Practical session Resource mobilisation Psychoeducation Family interventions	Dr R Padmavati Ms. Rabiya Mr. Rao Ms. Jainey afternoon	SCARF
March 2020	Field visit to SCARF to observe PSR in batches- dates to be finalised			

INTRODUCTION TO REHABILITATION, FUNCTIONING, NEEDS AND RECOVERY

Definition of Rehabilitation

A whole systems approach to recovery from mental illness that maximizes an individual's quality of life and social inclusion by encouraging their skills, promoting independence and autonomy in order to give them hope for the future and leads to successful community living through appropriate support (Killaspy et al 2005)

A simple definition of a psychiatric rehabilitation service is a recovery-oriented service for people with disabilities associated with longer-term mental health problems. Currently, there seems to be a difficulty within UK mental health services in having an open discourse about disability. It is almost as if experiencing some form of disability is such a bad thing that its effects (and how to minimise them) cannot be talked about. Physical illnesses can result in marked impairment in physical and psychological functioning and consequent disability, for example, inability to work. Disability may be short-term (e.g. flu) or long-lasting (e.g. Parkinson's disease). Severe mental illness also results in short- or longer-term disability. Personal reactions to the illness may compound the problem. Also social stigma can affect the person and their family when they are dealing with the illness.

Psychiatric rehabilitation services address, very directly, the disabilities of people who have not made a rapid recovery and may experience continuingdifficulties in personal functioning and relating to others. For instance, they may have cognitive impairments that make it hard to plan ahead; symptoms which make it hard to communicate clearly, or be vulnerable to exploitation by others, or their behaviours may be challenging to others.

Professionals working within psychiatric rehabilitation require skills in assessing the extent and the causes of these difficulties. The task is to work collaboratively with the person who is using the service to address these problems in a manner that includes and recognises that person's own wishes and ambitions.

The purpose of rehabilitation services is treatment and care of people with severe and complex mental health problems who are disabled and often distressed. The aim is to promote personal recovery, 'whilst accepting and accounting for continuing difficulty and disability' (Roberts et al, 2006).

What makes rehabilitation services unique is the length of time they expect to work alongside individual service users. They will support people as they gain or regain confidence and skills in everyday activities, a process which can take months or even years. Maintaining expectations of recovery over long periods of time can be difficult for staff and service users alike. A major aspect of the purpose of rehabilitation services is the continuous promotion of therapeutic optimism.

People receiving rehabilitation services are likely to share the same aspirations as all their fellow citizens for independent living, recreation, employment, social and sexual relationships, material goods, having their religious and cultural needs met and income. This is only partly true: there is, in fact, abundant evidence that these aspirations are eroded over time for people who live impoverished existences, whatever the cause of this impoverishment, in a process described over 40 years ago as institutionalisation. Severe mental illness can also impair conation (conation is the desire to engage in voluntary purposive activity) which may in at its most extreme result in very marked self-neglect. In addition mental illness is associated with a high level of social stigma, which may be of particular significance to patients from some black and minority ethnic groups.

Traditionally the client group for psychiatric rehabilitation was defined by referral to and acceptance by a designated rehabilitation service, often operating in a residential setting. People would only receive specialist rehabilitation after a very lengthy psychiatric career, by which time a range of "secondary handicaps" would generally have accumulated (these are the emotional, cognitive, reduced desire, social and functional effects of being a patient, particularly in a hospital setting). Relating a need for rehabilitation to contact with a particular local service is clearly not a needs-based approach.

Wykes and Holloway (2000) made an attempt to describe the potential client group for psychiatric rehabilitation thus:

"People defined as having mental health difficulties and fulfilling the following criteria:

• They have active symptoms (e.g. hallucinations, delusions, high levels of anxiety or depression, negative symptoms of psychosis)
• Reductions in social functioning (e.g. breakdown of social relationships, reductions in the capacity for economic support) as a result of a persistent mental illness."

This broad definition underlines the fact that a large proportion of individuals in contact with specialist mental health services require rehabilitative inputs. People with severe mental illnesses such as schizophrenia experience pre-morbid social difficulties and disadvantages, active symptoms of illness and impairments in cognition and conation, social stigma and the secondary handicaps consequent on the illness experience. As a result of these problems the opportunities and outcomes for people with severe enduring mental illness in terms of employment, income and social and intimate relationships are very much worse than the general population. In addition to symptoms and impairments in social functioning, severe mental illness is characterised by a relapsing and remitting course and a range of risk issues. These include risks of suicide, self-neglect and harm to others, all of which are very much commoner.

Section 1.1: Functioning

Psychosocial functioning reflects a person's ability to perform the activities of daily living and to engage in relationships with other people in ways that are gratifying to him and others, and that meets the demands of the community in which the individual lives.

Functioning is complex and people function both in diverse domains (e.g., marital functioning, parental roles, paid work and homemaking) and across widely differing levels (e.g., ranging from basic needs to complex multitasking).

A four factor structure is provided to functioning: Well Being, Basic Functioning, Self-Mastery, and Interpersonal/Social Relationships.

- The *Well Being* factor has the most subjective-experience quality and covered domains that reflected personal satisfaction with one's functioning versus a sense of demoralization rooted in the lack of a strong sense of self and internal strength.
- *Basic Functioning* predominantly taps behaviors for basic living (e.g., self-care, mobility, and basic communication skills).

- *Self-Mastery* captures functional capacity related to the ability (vs.failure) to exercise self-control (e.g., impulsivity, instability, and irresponsibility)

- *Social/Interpersonal* factor captures various aspects of the capacity to form positive relationships, such as social concordance and empathy.

Mental illnesses like Schizophrenia affect the functioning of the patients in different aspects and to differing severity. There is consensus amongst all mental health professionals that psychosocial functioning is an important component of mental illnesses and they have to be assessed carefully.

Section 1.2: Needs

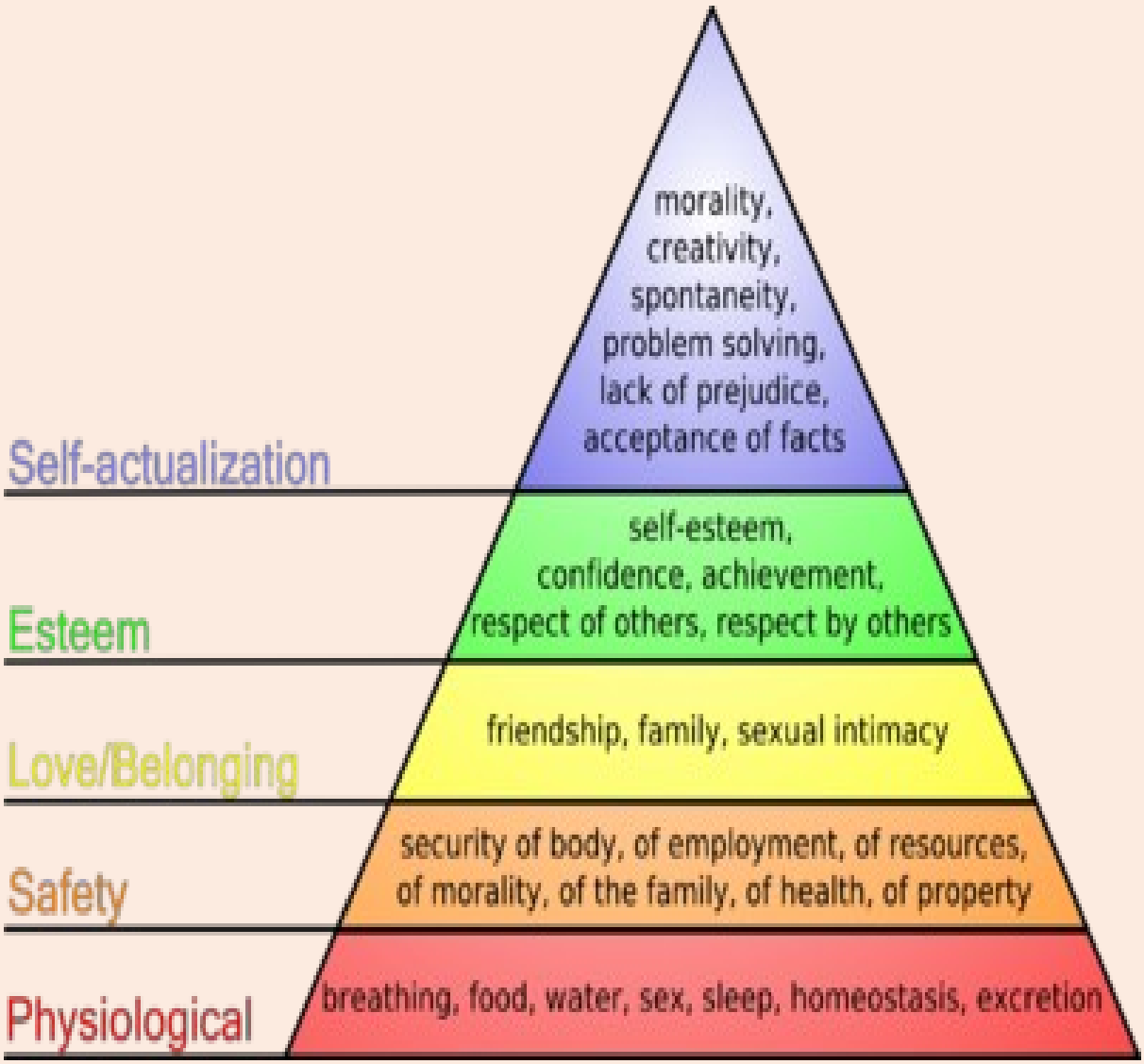
Definition of needs

- Needs (Verb) - to have to have something, or to want something very much

- Needs have been defined as “the requirements of individuals to enable them to achieve, maintain or restore an acceptable level of social independence or quality of life.”
- It is important to understand the needs of persons with mental illness to provide adequate mental health care services
- Reducing symptoms and meeting patient's needs is an essential component of the treatment
- In the last decades, the rising awareness of human rights and democratic sensibility in society at large has contributed to the empowerment of users of mental health services.
- Patients and carers both started to get involved in the identification of their individual needs.

Meeting needs are important because the numbers of unmet needs are related to reduced health, poor quality of life, and ongoing health-related expenses

Maslow’s Hierarchy of Needs



Importance of understanding needs

- Evaluating Needs- Holistic and quality care for persons with mental illness
- Problems lead to Actions which leads to Evaluation
- Planning and development of health care services
- Outcome criterion – Unmet needs
- Look beyond symptom reduction – Other needs
- Ensuring a better quality of life for people having mental disorders is most important

Perspectives on needs

- Perceived needs are defined

  - by what people think about their needs
  - allows for a responsive service delivery
  - interviews, focussed groups, town meetings
  - each standard changes with each respondent
- Expressed needs are defined
  - by the number of people who have sought help
  - focuses on circumstances where feelings are translated into action.
  - a major weakness of expressed needs assumes that all people with needs seek help.
- Relative needs are concerned with equity and must consider differences in population and social pathology

Assessing needs

- Camberwell Assessment of Needs (CAN)
- Is a valid and reliable instrument for assessing the needs of people having severe mental illness (SMI).
- Rehabilitation Needs Assessment Scale (Nagaswami et al, 1985)

Unmet needs

- % of individuals who require treatment in a country or in a defined community but do not receive it due to various reasons are said to have unmet needs

Reasons for unmet needs

- Non availability of services
- Difficult to access services
- Stigma
- Non availability of adequate medication

- Lack of trained professional

Section 1.3: What is Recovery?

The concept of recovery emerged from the 'user movement' but also owes a historical debt to the 'moral treatment' pioneered in the 18th century by the Tukes at the York Retreat (Tuke, 1813). Then as now, valuing hope and optimism was at a premium. Low expectations of service users can easily become self-fulfilling prophecy. The importance of good physical as well as mental health, respect and the right to a life that is not defined by illness or diagnosis are values that underlie all effective rehabilitation practice. Engagement often begins by constructing a detailed narrative base for understanding a person's past and how it impinges on the present. The service user and the multidisciplinary team can then collaborate to develop a personal formulation.

The meaning for recovery can be different for different people. For many people recovery is about regaining control of their identity and life, having hope for their life and living a life that has meaning for them whether that be through work, relationships, community engagement or some or all of these. So recovery is more than just "freedom from symptoms", " being cured" or "being normal again". It is about gaining new meaning and purpose in life,being able to live a self- directed/determined and autonomous life,in spite of difficulties a person is facing in life currently.

Recovery is a journey but does not necessarily have an endpoint. People tend to see recovery as a lifelong journey of growing and learning, gaining resilience, managing setbacks and celebrating successes.

Key components of Recovery

1) Inclusion

This is important for recovery as people need to be able to access the same opportunities as any other person and be included in the community.

2) Relationships

These include friends, partners, family members, mental health and other practitioners, and peers including peer supporters and groups in the community. All of these relationships have an important role in supporting people in recovery.

3) Hope

This is universally seen as key to recovery and without it people can give up their recovery journey.

4) Belief

Believing that a change in one's situation is possible is central to the
recovery approach and can be fostered by hope- inspiring relationships.

5) Identity

Redefining or rebuilding identity is a central component of recovery
because people often lose their sense of 'self' when they are given a diagnosis.

6) Meaning and purpose

This can vary for everyone but it is important that recovery supports people to rebuild and find meaning in their lives.

7) Dreams and aspirations

The recovery approach helps empower and support people to develop and achieve their dreams and aspirations in life.

8) Control and choice

Recovery focuses on respecting a person's right to exercise their legal capacity to make their own choices and on providing supports to do so whenever this is seen as helpful by the person.

9) Managing ups and downs

Recovery enables people to develop skills that are required to manage negative moments in life and any associated triggers.

10) Positive risk-taking

This is essential for recovery as it allows individuals to learn and grow from their experiences and it is important that people are supported while embarking on positive risk-taking.

Barriers to recovery

- Lack of a sense of identity, self-respect, hope.
- Mistreatment, neglect, abuse or trauma.
- Poverty.
- Lack of educational, income-generating, social and other opportunities.

- Being excluded from family, friends, social/support networks and one's community.
- Feelings of isolation and lack of support.
- Experiencing stigma and discrimination.
- Staff or families' lack of belief in people's ability to get better and claim and reclaim their lives.
- Not knowing or being informed of one's rights.
- Not being allowed or trusted to make decisions for yourself any longer.
- Feeling that one's opinion is not respected by others (mental health and other practitioners, families, others).
- Others defining what they see as recovery or success (e.g. others around us having low expectations or excessively high expectations about our recovery).
- Lack of available/accessible/affordable/acceptable mental health and social services and/or alternatives.
- Being denied, or facing barriers to, treatment or recovery approaches they believe could be helpful, such as counselling or psychotherapy.
- Lack of access to information, treatment and support options, psychosocial alternatives to medication.
- Pathologizing normal grieving processes which can lead to unnecessary and harmful treatment. This also leads people to think they are "not normal", interferes with normal healing processes and discourages people from feeling emotions because they are seen as "symptoms of a disorder".
- Negative effects of medication.
- Negative attitudes from mental health and other practitioners.
- Loss of trust in the mental health system and the people working in the service.
- Overprotection by family opposing discharge from the service.
- Being told that you have a lifelong illness that you won't recover from.
- Lack of contact with other people who have gone through similar experiences or who have been through a recovery process.

Many of these problems can be addressed through good communication and by building a trusting relationship between those people going through recovery and their families, peers, other supporters and mental health and other practitioners. Building a trusting relationship requires a personal connection which cannot be forced. When this does not seem possible, efforts should not be stopped, but it is advisable to seek other persons who may be able to

connect to the patient more easily. Efforts should always be made to ensure good communication, understanding and respect for the will and preference of the person who is going through recovery.

The Recovery approach in mental health

- In this approach, recovery is understood to be about helping people regain or stay in control of their lives, and having meaning and purpose in life.
- In the recovery approach, recovery may or may not involve treating or managing symptoms.
- Recovery is different for everyone. It is a deeply personal process; its significance and what it constitutes will vary from person to person.

For some people:

- Recovery is an ongoing journey.
- It may mean developing or strengthening relationships.
- It may involve (re)gaining independence, finding a job or going back into education.
- Recovery might mean participating more actively in community life and activities.
- Recovery might also mean an absence of what are considered as symptoms (but not always).
- It involves redefining what people's experience means to them (e.g. identifying themselves as trauma survivors).
- It involves creating safe places to acknowledge trauma and explore ways of healing.
- Recovery is based on hope and optimism for the future

- Hope is a core principle of recovery that mental health and other practitioners, family members and other supporters should promote.
- Although different people may define hope differently, the essence of hope in recovery is the affirmation that it is possible to live a meaningful life in the presence or absence of "symptoms".
- Central to the concept of recovery is a belief that one's situation or circumstances can change and/or that one will be able to manage and overcome the situation. This can be fostered by hope-inspiring relationships.
- In the recovery approach, symptoms, illness or disability do not mark the end of dreams, aspirations and possibilities. Therefore, dreams and aspirations need to be encouraged and valued.

- Connectedness is key to recovery
- People need to be included in their community on an equal basis with all other people.
- Recovery may involve reconnecting with family and friends or developing new meaningful relationships. It may also involve connecting with peer support groups or other groups in the community.
- Meaning and purpose are important aspects of recovery
- Recovery supports people in rebuilding their lives and gaining or regaining meaning and purpose according to their own choices and preferences.
- Recovery is also about empowering people to achieve their dreams and goals in life.
- Recovery also means exploring your identity
- The recovery approach can help people to accept who they are or strengthen their sense of self and self-worth, as well as to help them to overcome self-stigma that can put one's sense of identity at risk.
- Recovery is based on respect for people and their unique identities and self-determination, as people themselves are the experts on their own lives.
- Recovery supports empowerment
- Recovery promotes a positive outlook that empowers people and enables them to regain control.
- Having control and choice is central to a person's recovery and is intrinsically tied to legal capacity.
- Recovery involves taking risks
- Risk-taking can be an important part of embarking on one's recovery journey.
- It is natural to take risks in life and either succeed or fail as a result. This is a learning process that is essential for living. Without taking risks we cannot progress or build a life for ourselves, and this can lead to stagnation.
- It requires courage and creativity to support positive risk-taking to help people move forward and achieve goals.
- Recovery is holistic
- Recovery in action is not just treating or managing symptoms. Recovery is an approach that looks at the whole person, extending to include social, emotional, physical and other aspects of life.
- This may involve addressing social adversities (e.g. poverty, unemployment, discrimination) that have a negative impact on people's mental health.

- Recovery involves healing from trauma.
- Trauma-informed services recognize that many people have experienced trauma in their lives (e.g. childhood trauma, trauma due to abuses in service settings, etc.) and this experience negatively affects their mental well-being and quality of life.
- Services should provide care in a way that is sensitive to this issue and avoid traumatizing or re-traumatizing people. This means that services must refrain from practices of violence or coercion, such as seclusion, restraints and forced treatment, which are inherently traumatizing, hinder recovery and lead to re-traumatization.
- Recovery means being seen as a person and not just as a condition/disability.
- Recovery is about being seen as a whole person, focusing on one's abilities and strengths and using support when needed to achieve one's goals and aspirations in life. What some people may see as a deficit may in fact be an important strength for the person concerned.
- Recovery and human rights are strongly linked
- The recovery approach respects people's choices and supports them in living fulfilling lives.
- Respecting all human rights is essential to implementing a recovery approach. In turn, adopting a recovery approach helps to uphold human rights.
- It is natural to take risks in life and either succeed or fail as a result. This is a learning process that is essential for living. Without taking risks we cannot progress or build a life for ourselves, and this can lead to stagnation.
- It requires courage and creativity to support positive risk-taking to help people move forward and achieve goals.

Recovery plans

A recovery plan is a document that it is written and implemented by a person to guide them along their recovery journey, regain or stay in control of their life, and find meaning and purpose in life.

A recovery plan can be a useful tool to:

- Support a person to work out a direction and steps for moving forward in life.
- Help a person get the support of important people in their life, if they wish to do so (such as family, friends, peers, health practitioners and others).

- It is important to note that a recovery plan is a potential tool for people to use in their recovery, and not an end in itself.
- Recovery means being seen as a person and not just as a condition/disability
- Recovery is about being seen as a whole person, focusing on one's abilities and strengths and using support when needed to achieve one's goals and aspirations in life. What some people may see as a deficit may in fact be an important strength for the person concerned.

What does a recovery plan look like?

- A recovery plan outlines the person's own goals in life. Depending on the person, it may include: reconnecting with friends, going back to school, managing difficult situations, etc.
- The plan outlines how the person will work to achieve these goals.
- The plan is driven by the person concerned and reflects their choices, will and preferences for support and care.
- It may include a personal plan for dealing with distress, for which the person can list possible actions that can be taken to prevent the situation getting worse.
- A recovery plan may also include an advance directive about care and treatment.

How can people promote their recovery?

- Develop practices that make them feel better and identify strategies that promote and maintain well-being.
- Seek out cultural and spiritual practices for growth and self-knowledge.
- Reject disempowering labels and narratives that limit one's potential.
- Seek out relationships with those who can act as peers and equals who value one another's knowledge and autonomy, whether or not the person has had the same type of lived experience.
- Do not blame self for having been abused or for having been discriminated against.
- Be clear with others that recovery is possible and that they are at the centre of their recovery and that they drive all the decisions about their own life.
- Develop their own plan based on strategies that they find helpful along their recovery journey.
- Listen to others' experiences and share your own story.

- Explore opportunities to be more active and engaged in the community.

How can family and others support recovery?

- Make sure that services and supporters respect the opinions, decisions and choices of the individual on their treatment, care and other areas of life rather than making decisions on their behalf.
- Acknowledge that differences of opinion can arise but that, ultimately, the individual's decisions should be respected. Support their right to make their own choices, and to establish their own identity and understanding of what they are experiencing.
- Find out more about the support options and strategies that the individual finds it helpful to maintain to improve wellness.
- Support individuals to be actively engaged in their local community.
- Include the individual in family life and decisions on an equal basis with other family members.
- Support the individual to ensure that they are being treated fairly and without discrimination by health services and local agencies.

How can services support recovery?

- Make sure that services and supporters respect the opinions, decisions and choices of the individual on their treatment, care and other areas of life rather than making decisions on their behalf. (For more information on this topic, see the module on *Legal capacity and the right to decide* and the module on *Supported decision-making and advance planning*).
- Acknowledge that differences of opinion can arise but that, ultimately, the individual's decisions should be respected. Support their right to make their own choices, and to establish their own identity and understanding of what they are experiencing.
- Find out more about the support options and strategies that the individual finds it helpful to maintain to improve wellness.
- Support individuals to be actively engaged in their local community.
- Include the individual in family life and decisions on an equal basis with other family members.

- Support the individual to ensure that they are being treated fairly and without discrimination by health services and local agencies.
- Create a relaxed and welcoming environment where people feel free to consult with their mental health or other practitioners when they wish to do so.
- Encourage people to discuss their concerns, express their opinions and take ownership of how they want to live their life.
- Encourage people to identify their personal goals for recovery and, if useful, to draw up and follow a recovery plan on their own or with the assistance of a trusted person.
- Demonstrate compassion and kindness.
- Support people's wishes to access spiritual, religious and cultural resources and experiences if requested (e.g. prayer room, religious scriptures, traditional cultural healing).
- Help people to access uplifting and therapeutic experiences – such as art, music, nature, sport, journal writing, self-help – in line with their personal preferences.
- Ensure that people are informed about the different support options available to them.
- Ensure that staff are trained about people's rights and are familiar with international human rights standards.
- Ensure that staff have the skills to provide counselling, information, education and support to individuals and their families and care partners.
- Promote self-reflection and critical evaluation among staff about how staff might be helping or hindering recovery for different people (e.g. discrimination, gender-sensitive services, how to best address diverse people's needs and contexts, etc.).
- Be open to learning from and being changed by people with psychosocial, intellectual or cognitive disabilities or any other person using the services
- Recognize people as experts by experience.
- Involve people with psychosocial, intellectual or cognitive disabilities at all levels of the service, including service reform, management and governance.
- Welcome the involvement of family, care partners, friends and other supporters in the planning and delivery of the service.
- Adopt a trauma-informed approach to recovery which recognizes and addresses trauma that has been experienced by some people

Chapter 2

Psychosocial Interventions

Medications have proven to be crucial in relieving symptoms of mental illnesses—hallucinations, delusions, and incoherence — but are not consistent in relieving the

behavioral symptoms of the disorder. Even when patients are relatively free of symptoms, many still have extraordinary difficulty with communication, motivation, self-care, and establishing and maintaining relationships with others.

It is with these psychological, social and occupational problems that psychosocial treatments may help most. Psychosocial rehabilitation is a series of psychosocial and social intervention strategies which complement the pharmacological management and whose aim is to improve personal, social and occupational functioning of persons with mental illnesses

Rehabilitation Assessment

Assessment is the cornerstone of all intervention for persons with psychiatric disabilities. Understanding an individual's needs is the first step toward identifying the areas that are most important to address, and in evaluating the success of rehabilitation efforts. Therefore, assessment is involved in all aspects of rehabilitation, and skill in assessing individual's needs is a prerequisite to effective work with people with psychiatric disabilities.

Functions of Assessment

Assessment serves four broad, overlapping functions in psychiatric rehabilitation:

(1) Identification of treatment and rehabilitation needs

(2) Assessment of the strengths and weaknesses of the individual, his or her family (or broader social network), and the environments

(3) Developing a rehabilitation plan

(4) Monitoring progress and altering the rehabilitation plan as needed.

Identification of Rehabilitation Needs

Different dimensions of personal life experience that can be influenced by psychiatric disability span a broad range, including symptoms of the illness, mood state e.g.: depression, anxiety, happiness), enjoyment of life, involvement in work or school, satisfaction with close

relationship, self-care skills, substances abuse, health, and aggression. Adequate functioning across these different life areas is considered important to an individual's quality of life.

Identifying psychosocial needs involves posing the question, what needs to be changed in order to reduce the impact of the psychiatric disability on the individual's life and his or her adjustment in the community?

Other assessments:

Assessment are conducted to evaluate

- The effect of specific symptoms or abilities on functioning. For example, examining the frequency and nature of specific psychotic symptoms may provide valuable information about an individual's anxiety or depression, because psychotic symptoms are often associated with these negative moods
- Assessing independent living skills provides information about activities of daily living
- Social skills assessment may be conducted to pinpoint specific skills that need to be taught in order to improve aspects of a person's social functioning
- Cognitive assessment may also be conducted to determine whether cognitive impairments contribute to functional, social or vocational problems

Monitoring Progress towards Goals

The final function of assessment is to monitor progress in achieving rehabilitation goals and to modify the plan as needed to address stubborn problems or emergent needs. Regular monitoring of goals, and modifying rehabilitation plans as needed, reinforces the importance of those goals as the basis for the therapeutic relationship. Without ongoing monitoring of progress, it is impossible to know whether and individual is benefiting from rehabilitation.

For practitioners, this lack of information can either be *demoralizing* (e.g., they may believe they are not helping the individual) or *misleading* (e.g., they believe they are helping the person when, in fact, they are not).

For people with a psychiatric disability, the failure to monitor progress towards goals implies that the treatment team does not view these goals as important. This can lead individuals to devalue the importance of their own goals or can make them pessimistic about their ability to achieve their goals.

Specific Domains of Assessment

In this section we discuss the wide range of domains important to rehabilitation assessment and treatment planning.

Diagnosis

Psychiatric diagnosis often has important treatment indications for individuals with psychiatric disabilities. The most important implication is that diagnosis is strongly related to a determination of which medications are most likely to reduce symptoms and prevent relapses. Knowing an individual's diagnosis can help clinician's select the most promising pharmacological interventions.

Symptomatology

Evaluating symptom severity is important because it is often related to distress, which can interfere with functioning as well as enjoyment of life. In addition, the assessment of symptoms provides and important outcomes by which to measure the success of psychiatric treatment and rehabilitation efforts. By definition, individuals with psychiatric disabilities usually experience such disabilities over long periods of time. Although treatment and rehabilitation efforts usually do not eliminate psychiatric disabilities altogether, they may be successful at reducing the severity of symptoms and the suffering associated with them. Therefore, it is important to be able to assess symptoms severity in order to determine whether a patient needs help in managing a particular symptoms and whether interventions are successful in reducing its severity.

Independent Living and Self-Care Skills

Like difficulties in social relationships and role functioning, difficulty in caring for oneself and living independently is a major problem for many individuals with psychiatric disabilities and often requires extensive supports from treatment providers and family members. As with these other areas, impaired self-care skills are incorporated into the diagnostic criteria of some disorders such as schizophrenia. For these reasons, improving self-care and independent living skills is an important priority of many rehabilitation programs.

Social functioning

Problems of social functioning are a core feature of mental illness and are included as part of the diagnostic criteria for some disorders, such as schizophrenia. Problems in the quality and

extent of social relationships often predate the onset of psychiatric illnesses and continue to hamper the enjoyment of life for many patients. Because the enjoyment of close personal relationships is an important part of living for most people, improving social relationships is a common goal of psychiatric rehabilitation.

In addition to improving quality of life, better social functioning can also serve as a protective factor for improving the course of the psychiatric illness. Good social functioning and associated social support may be beneficial for several reasons to live, and motivation to take care of them-selves. Second, social support can buffer the negative effects of stress, making individuals less vulnerable to stress-included relapses. Third, having close relationship with other people can provide opportunities for reality resting, which may be especially beneficial for individuals with psychotic symptoms? People with better social functioning and greater levels of social support experience a more benign course of their mental illness. Thus, improving social support is an important goal for rehabilitation, and the assessment of social functioning is critical to evaluating the success of the efforts to achieve such improvement.

Role functioning

Role functioning refers to the extent to which an individual is able to meet the expectations of socially defined roles, such as worker, student, parent, or spouse. Role functioning is often included as a dimension of social functioning, and it is strongly related to the quality of social relationships and use of leisure time. However, practically, it is useful to distinguish role functioning from the quality of social relationships, as impairment in this area of functioning is critical to the definition of disability.

Substance abuse

Drug and alcohol abuse is one of the most common co-morbid disorders among people with psychotic disabilities, with about 50% of individuals with a psychiatric disability experiencing problems related to their substance use at some point in their lives. Substance abuse has a wide range of effects, including relapses and re-hospitalizations, legal, economic, and family problems, and increased vulnerability to infectious diseases

Medication Adherence and Side Effects

Medication is probably the most powerful treatment tool for psychiatric disabilities, having a significant impact on reducing symptoms and preventing relapses in 70-90% of patients. However, medication adherence is a common problem, with more than half of all consumers

being non adherent to medication at some point in their illness. Medication non-adherence is an important contributor to relapse and re-hospitalization, as evidenced by numerous studies. Therefore, improving medication adherence is common goal for psychiatric rehabilitation.

Cognitive Functioning

Impairment in cognitive functioning is common in persons with psychiatric disabilities. For example, cognitive impairment is pervasive in schizophrenia, with many individuals experiencing at least some deficits in their cognitive functioning following the onset of their disorder. Further, in the absence of intervention, impairment in cognitive functioning tends to be quite stable over the course of psychiatric illness and is strongly related to various domains of functioning, such as independent living, social relationships and work.

Integrating Assessment into Rehabilitation

Assessment plays a critical role in the identification of treatment and other needs, and in rehabilitation planning. In addition, ongoing assessment is needed to determine whether rehabilitation efforts are achieving their intended aims. It is helpful to divide the role of assessment into treatment and rehabilitation planning, and monitoring the effects of rehabilitation interventions.

Treatment and Rehabilitation Planning

The assessment of treatment and rehabilitation needs can be hierarchically organized in terms of the immediacy with which needs must be attended to: immediate needs, clinical needs, and rehabilitation needs.

Immediate needs:

Crisis issues are so pressing that they must be attended to immediately in order to protect the person or others. Urgent needs typically involve general health or psychiatric issues. For example, if an individual has a chronic medical condition for which he or she is not receiving treatment, attending to these treatment needs is utmost importance. Similarly, if a person is seriously injured, such as in an accident or from an attack, attending to the treatment of these injuries is critical. Details of these are available in the booklet given along with this document.

Clinical Needs

Clinical needs involve the direct manifestation of clinical conditions that are responsible for a person's psychiatric disability. The severity of specific psychiatric symptoms, relapses, and medication side effects are all clinical needs for which pharmacological management is most important. Although some degree of persistence in clinical symptoms is common in people with psychiatric disabilities, insufficiently treated symptoms or persistent side effects can interfere with the effectiveness of rehabilitation and the goal of improving functional outcomes. For example, if an individual is experiencing the early signs of a relapse, or has actually experienced a symptom exacerbation, getting immediate treatment for these signs and symptoms is important in order to minimize the effects of a relapse on other areas of functioning. For individuals who have unstable and persistent symptoms, it is often unclear as to whether optimal pharmacological treatment is being provided. However, people are most likely to benefit from rehabilitation if their symptoms and side effects are routinely monitored and pharmacological treatment is provided.

Rehabilitation Needs

The first step lies in prioritizing rehabilitation goals. A wide range of such goals are possible, such as greater self-care and independent living skills, improving family relationship, family psycho-education, improving skills for self management of an illness, pursuing work or educational goals, etc. Many of these goals can be pursued simultaneously, and the best strategy is to focus first on those goals that the consumer is most motivated to work towards and that are closest to his or her personal recovery goals.

Integrating Assessment into Monitoring

Just as assessment is the key to effective treatment and rehabilitation planning, it is also crucial for evaluating the success of those efforts. This is most effectively accomplished by incorporating formal, ongoing, collaborative assessment into the monitoring of rehabilitation efforts. Ongoing assessment involves identifying monitoring can occur almost continuously with some rehabilitation goals, but more formal monitoring should also be conducted every 1-3 months.

Outcomes can be monitored varies significantly from one domain to another. Some domains are quite easy to monitor, such as employment involvement in school. Other may require specific assessment probes. These probes can be conducted by selecting key outcomes related to the domain of interest. For example, the effectiveness of treatment for substance abuse in a

person with a psychiatric disability can be monitored by periodically assessing the person's use of substance.

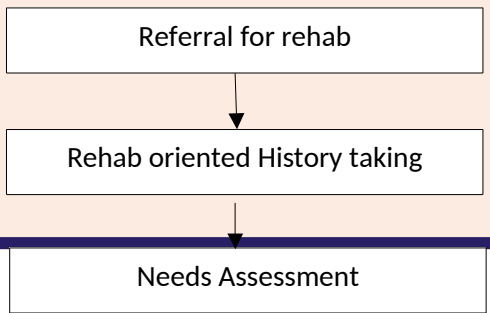
Sustained lack of progress toward targeted rehabilitation goals should signal the provider to reconsider the rehabilitation plan, again in collaboration with the consumer. Lack of progress can be addressed a variety of ways; breaking down the goal into smaller and more manageable steps, altering the goal to make it more attainable, establishing a different goal that the consumer is more motivated to work toward, or trying a different rehabilitation approach. The rate of change to b e expected depends on the consumer's specific strengths, the nature of the desired goal, and the rehabilitation approach used.

Interventions

The interventions delivered will depend on the needs identified during assessment. The various interventions (see independent chapters for more details about the interventions) delivered based on the needs are

- Improving ADL
- Social Skills training
- Improving motivation and cognition
- Vocational rehabilitation
- Psychoeducation
- Family interventions

Process of Rehabilitation



CHAPTER 3 : ACTIVITIES OF DAILY LIVING

Activities of daily living (ADL) are those activities usually performed in the course of a normal day in the individual's life such as brushing, bathing, grooming, eating, work, transportation, homemaking and leisure, etc.

ADL is categorized into 2 components namely Basic ADL (ADL) and Instrumental ADL (IADL)

1. Basic Activities of Daily Living (ADL) includes self-care tasks such as personal hygiene and grooming, toilet hygiene, bathing, dressing, self-feeding, functional mobility (transferring).

2. Instrumental Activities of Daily Living (IADL) are those activities necessary for individuals to be independent in the community such as Housekeeping, Food Preparation, Laundry, Shopping, Ability to Use Telephone and other forms of communication, Mode of Transportation, Responsibility for Own Medications, Ability to Handle Finances, Moving within the community.

Why is ADL important?

The issues with self care and personal space eventually affect their social involvement. Interaction with family members, friends, colleagues, and relatives decreases. Interaction becomes minimal or stops completely. In order to deal with such difficulty which is major and severe problem, brining improvement in ADL functioning is emphasized among patients. Thus, improvement in ADL activities can improve quality of life for clients and help to alleviate caregiver

burden, enhances clients independence, improves social involvement, Improvement in ADL can prevent institutionalization and stigma.

Reasons for poor ADL?

- Symptom severity
- Lack of initiation
- Lack of routine
- Lack of volition, interest or drive
- Lack of motivation
- Cognition dysfunction
- Lack of opportunity to experience or learn the ADL

Assessments

The following assessments are used assess ADL functioning

- History and clinical examination
- Independent Living Skills Survey (includes questionnaire in informant and self-report version)
- Katz Index of Independence in ADL scale (Brief self care assessment completed by healthcare provider)

Interventional strategies to ADL:

The following interventional strategies help in working with the individuals to bring improvement in ADL functioning:

1. Graded tasks and Activity scheduling and it is important for all individuals to have a regular and realistic routine in their day o day life, poor ADL may lead to a poor routine. motivational interview can be used by the therapist to help the individuals choose and select activity tasks that the client can perform on a regular basis, these tasks are individualized and tailor made, the therapist can start by scheduling some enjoyable activities for the client, that the client is able to achieve and perform , and slowly move to graded tasks that are more productive in nature for client, some tasks can be extended to allow family members to engage along with the client while performing the task.

Tasks can rage from bathing everyday to watch TV programs, going to the church or temples. Attending social functions, performing domestic chores etc.

2. Remedial and compensatory strategies

Remediation involves addressing the underlying deficits that lead to difficulties with daily living skills.

For example, a person may have difficulty learning new skills as he/ she has poor concentration. A remediation approach would mean to firs address the deficit of improving concentration and allow them to first engage in gradual tasks to improve concentration.

Compensation involves adapting a skill deficit to still find a way that the task can be accomplished. It usually involves making changes to the way the task is done or to the environment it is done in.

For example, a person does not do grocery shopping cause she feels anxious to go to public places, a way of compensating would be to help her learn to order groceries online or by phone.

The aim is to maximize or optimize the skills, while learning new ways of doing things to minimize the problems

3. Reminders strategies

Reminder strategies help in prospective memory (remembering to remember) such making use of notebooks, to do lists, diaries, calendars and daily planner, Alarm or reminder functions on mobile phones, written and/or picture instructions.

4. Skills training by Coaching, modelling and role plays

- *Modelling*

Is a method where the therapists will model the specific skill that the client can see exactly what is needed to done before attempting to do it

- *Role playing*

  After the therapist has modelled the skill, client will be asked to role play. This practice is a very important aspect. Until the skill is

practised, it is hard to use it outside the safety and confinement that therapy sessions provide.

Areas where skill training is required: Cooking, medication management, cleaning, budgeting, public transportation training, banking training and shopping strategies.

5. Cognitive - behavioural strategies- use errorless learning strategies

Errorless learning (EL) is a principle used to teach new information or skills to people with cognitive impairment.

Task are broken into components, the components are learned through repetition; training happens from simple to complex gradation.

Errorless Learning approach will *improve* the execution of complex daily tasks in *persons* with executive deficits.

Eg: cooking, cleaning home

6. Positive reinforcement

Positive reinforcement involves the addition of a reinforcing stimulus following a behaviour that makes it more likely that the behaviour will occur again in the future. Eg: praising verbally on completion of tasks, token economy

Patients, family members and practitioners collaborate to identify individualised target behaviours, goals and rewards. The purpose of rewards is to reinforce the healthy behaviour.

Steps involved in intervention

Step 1: Determine areas to be addressed in ADL

It is important to assess the daily activity schedule of clients, It is helpful if clients are made to objectively record their current activity level for a week. This may be useful for several reasons. First, it provides a baseline measurement to compare your progress when you have increased your activity level later in treatment. Second, an examination of your current level of activity may enable you to realize that you are less active than you originally thought. Seeing evidence of this reality may provide motivation for you to increase your activity level.

To monitor your already occurring activity level, we ask that you keep a detailed record (hour by hour) of all activities that you engage in, including those that seem insignificant, such as sleeping or watching television.

Step 2: Identify potential activities to be addressed

It is important to determine the activities you would like to target. In determining these activities, you might want to consider activities related to the following life areas (adapted from Hayes, Strosahl, & Wilson, 1999):

1. Family Relationships (e.g., what type of brother/sister, son/daughter, father/mother do you want to be? What qualities are important in your relationship with those in your family?)

2. Social Relationships (e.g., what would an ideal friendship be like to you? What areas could be improved in your relationships with your friends?)

3. Intimate Relationships (e.g., what would your role be in an intimate relationship? Are you currently involved in this type of relationship, or would you like to be?)

4. Education/Training (e.g., would you like to pursue further education or receive specialized training? What would you like to learn more about?)

5. Employment/Career (e.g., what type of work would you like to do? What kind of worker would you like to be?)

6. Hobbies/Recreation (e.g., Are there any special interests you would like to pursue, or new activities you would like to experience?)

7. Volunteer Work/Charity/ Political Activities (e.g., what contribution would you like to make to the larger community?)

8. Physical/Health Issues (e.g., Do you wish to improve your diet, sleep, exercise, etc.?)

9. Spirituality (e.g., what, if anything, does spirituality mean to you? Are you satisfied with this area of your life?)

10. Psychological/Emotional Issues (e.g., what are your goals for this treatment?)

Step 3: Rank order or Prepare a list of activities based on the hierarchy or priority:

Rating the tasks from simple to complex will help patient's initiation; client can also prioritize the important tasks to that of less priority. for instance : Activity identification ranking sheet Instruction: Compile your desired activities and rate the difficulty of each from 1= least difficult to 10= most difficult.

Activity	Rank

Step 4: Plan how to work these activities

In collaboration with patient and caregiver make a plan to implement these activities in every day routine. Strengthen the behavioural change with reinforcement. It is important to reward the client for achieving his/her weekly goals. Scheduling rewards at the end of each week gives them something to look forward to and provides motivation for completing the Activity log where the list of the activities are listed out in order of the day.

Step 5: Monitoring progress and boosters

Progress of daily activities could be monitored with the help of activity chart. It's very crucial to facilitate maintenance of new changes in the behaviour (daily activity) by appreciation, regular tangible rewards and describing clients about how the change in daily activities will contribute or lead to achieving their life goals.

Successful ADL performance requires:

- Social support
- Interaction of skill, knowledge and experience
- Underlying abilities (cognition, emotional and social)
- Environmental resources

CHAPTER 5: **Social Skills Training**

SOCIAL FUNCTIOING

Human beings are sociable creatures, although sometimes some might have difficulty communicating and interacting with others, Individuals with disability can have several factors that can influence they social functioning including symptoms, motivation, Information processing deficits, medication side effects etc. Some clients have limited social skills deficits and may need to improve their skills in only a few areas. Whereas others are more severely affected and require extensive training in many skills over long periods of time to improve their social functioning.

SOCIAL DYSFUNCTION occurs when the individual does not know how to use social skills in his or her repertoire when they are called for, or are unable to perform social skills appropriately or when appropriate behaviour is undermined by socially inappropriate behaviour. Individuals with social dysfunction have deficits in areas of social cognition or social competence

Social cognition refers to those mental operations underlying social interactions, including perception, interpretation and response generation to the intentions, dispositions and behaviours of others (Green et al*., 2008).*

Social competence refers to the aspects of communication including verbal and non-verbal communication skills that allow successful

execution of interpersonal interactions and an individual's ability to solve everyday problems and achieve affiliation goals

Although social skills training is provided following a standardized structure of modelling, role play, feedback and home work, the content and format of the programme is flexible and can be tailored to respond to the specific needs of individual.

Definition of SOCIAL SKILLS

- Involves giving, receiving and interpreting messages
- Include verbal and nonverbal behaviour communication.
- Influenced by culture and the immediate social group
- Social skills refer to any skill or ability to facilitate interactions, recognize and reciprocate emotional cues from others, and communicate with others in various social situations

- The Albert Ellis Institute in New York.

The components of socials skills

- Expressive behaviours-

  Verbal behaviors- what we say, the form , structure, content and amount of words we emit, Paralinguistic behaviors- characteristics of the voice during speech including volume, pace, intonation, pitch. (Check for fast-soft-slow-speech / disfluencies-lengthy pauses / Monotonous/ high pitched- volume increases/flatted tone/ slow or rapid pace etc)

  Nonverbal behaviors – reflects or mood and feeling, eye contact, posture, facial expression- smiling / frowning /grimacing/ glowering etc:, proximics- maintaining appropriate distance while interacting, (Check for balled first/ pursed lips/ forward lean/ distance maintenance etc)

- *Receptive Behaviors* – attention to and interpretation of relevant cues – eg: raised tone of a person when he is angry, when a person is sad they want to be alone, accurate perception of the social situation, emotional recognition.
- *Interactive Behaviors* - response timing, use of social reinforcements, turn taking.
- *Situational factors* - social intelligence knowledge of social norms and demands of the specific situation.

The assessment of social skills begins with general questions about the client's activities and moving or more specific probes concerning his or her social functioning. There are various standardized assessments to measure social skills. Assessments help in identifying specific social deficits in social skills and factors or circumstances under which the deficit is evident. These assessments will help in fixing target specific behaviors to modify.

Social Skills Training

- Social skills training is a systematic approach to teaching interpersonal skills based on social learning theory.
- Social skills training programs can be described as all those treatment approaches that aim to address deficiencies in social cognition and social competence (Smith, Bellack, & Liberman, 1996)

Steps of social skills training in group

Step 1: Establishing a rationale

To motivate group members to learn a new skill, a rationale for its importance must first be established. There are two strategies for establishing the rationale for learning a new skill: The leader can elicit the rationale from group members, or the leader can provide reasons for the importance of the skill. With most groups, a combination of both strategies is most effective.

The reasons for learning a new skill can be elicited from group members by asking leading questions about the importance of the skill. When eliciting the rationale from group, it may be helpful to ask questions regarding the disadvantages of not using a specific skill.

Step 2: Discussing the steps of the skill

When the rationale for learning the skill has been established, the leader introduces and discusses each step of the skill. The steps of the skill should be written down and posted in a prominent location in the room so that all participants can see them. It is also helpful for group members to have hand outs of the steps of the skills.

The leader briefly discusses each step of the skill, eliciting from group members the importance of each step or directly explaining it. When discussing a step, the leader points to the step on the poster or board.

Step 3: Modeling the skill in a role play

Discussion of the steps of the skill is immediately followed by the leaders modeling the skill in a role play. This demonstration is intended to help participants see how the different components of the

skill fit together into an overall performance that is socially effective. It is best if the leaders plan in advance of the session the role play scenario they will model in the group. The role play situations should be selected that have high relevance to the participants.

If the group is conducted by two leaders, then both of them should participate in the role play, with one of them demonstrating the skill and other taking the role of the partner. When the group is conducted by a single leader. He or she should enlist a group member to play the role of the partner in the role play. In the latter case, a participant should be selected who is co-operative and likely to respond appropriately to the leader during the role play.

Immediately after the demonstration of role play, the leader reviews the different steps of the skills with group members, eliciting a response, for each step as to whether it was performed. After reviewing the different steps, group members are asked to provide an overall evaluation of whether the leader was an effective communicator during the interaction.

Step 4: Engaging a group member in a role play

The modeling of a specific skill is always followed immediately by a role play rehearsal of the same skill by a group member. The role play is then set up with a group member and a leader. Instructions are given to the group member and the role play is conducted.

When a skill is introduced for the first time, it is preferable for participants to practice the skill using the same role play situation that was modeled by the leader.

When engaging clients in a role plays, the leaders begin with an individual who is likely to be co-operative and more skilled. This will enable more skilled group members to serve as role models for less skilled group members who practice the skill in role plays later in the group.

Step 5: Positive feedback

Role play rehearsals by group members are always followed by positive feedback about what specifically the person did well. Something genuinely positive must be found in even the poorest role-play performance.

Positive feed backs can be provided both by the leaders eliciting it from the other group participants and by providing it directly to the participants. To elicit positive feedback from the group, it can be helpful to inquire, “what did you like about the way …….did that skill just now? And “Which step of the skill did you see……doing well?”

Leaders must be vigilant to ensure that all feedback given at this stage is positive, negative or corrective feedback is immediately cut off. The goal at this stage of feedback is to reinforce the group member’s effort in the role play and to provide some specific feedback about what was done well.

Group members soon learn that positive feedback always precedes corrective feedback and this rapidly becomes acceptable as a group norm. Positive feedback should be as behaviorally specific as possible.

Step 6: Providing corrective feedback

Corrective feedback should be brief, noncritical, to the point and as behaviorally specific as possible. The aim is to identify the most critical aspect of the role play interaction that needs to be changed in order to enhance overall performance. Corrective feedback should not be an exhaustive list of all the problems in the group member's performance. Rather it should focus on most crucial components of the skill.

Using phrases such as "your role play would be even better……" can be helpful in suggesting modifications in a role play. Similarly, constructive feedback can be obtained from other group members by asking questions such as "Are there ways that……could improve his/ her skill in the role play".

Step 7; Engaging group member in another role play of the same situation.

Identifying specific components of a social skill that were deficient in a role play leads naturally to making suggestions for improving performance in a subsequent role play. In this step the participant is engaged in a role play with same situation and is requested to make

one or two small changes based on the corrective feedback that has just been given.

This ensures that the instructions given to the participants about how to improve his or her performance in the next role play are clear and within the realm of the person's capability.

Step 8: Assigning and review of home work

At the end of the session the leader gives the group members a home work assignment to practice the skill before the next skills training session. When home work is assigned, it is important to that participants understand the rationale behind an assignment. This can be explained in a straightforward manner, such as by saying "Now you had an opportunity to practice this skill in some role plays here in the group, it's important for you to try the skill on your own in situations you naturally encounter in your everyday life. It's very helpful for me to know which steps you are having success with and which ones is a problem for you".

Except for the first social skills training session, all sessions begin with a review of the home work assignment given at the end of previous session. The review of home work begins with the leader asking group members about specific situations when they tried using the particular skill. During the home work review leaders assess both whether group members are able to identify appropriate situations in which they can use the skill, as well as the member's ability to use the skill effectively.

An individual group member is then instructed either to show what happened in the situation (if the person tried to use the skill) or to try practicing how he or she might have used the skill (if the person forgot to use the skill). The leader then encourages the participant to describe the situation in order to determine if it is suitable for using the skill. It is preferable make participants perform a role play rather than allowing them to completely recite the whole situation.

Tailoring Skills for Individual Needs

Goals related to Specific social skills deficits

Problems in social functioning	**Possible goals for skills training**
No friends, socially isolated	To start conversations on a regular basis (eg. daily)
Lack of interest in leisure activities	To participate in at least one form recreation
Speaks in a monotone	To vary voice tone and expression
Make frequent demands	To make positive requests to others
Becomes physically aggressive when angry	To express anger appropriately (i.e. verbally)

Choosing appropriate skills to teach:

As much as possible, it is important for the leader to choose the curriculum for a social skills group based on the needs and goals of its

members. However almost all clients who are entering skills training group will benefit from learning certain basic skills that can serve as a core curriculum to which other skills can be added. The four basic skills are expressing positive feelings, making requests, listening to others and expressing unpleasant feelings.

Matching individual goals with social skills

Goal	Skills
Make a friend	Expressing positive feelings Giving compliments Accepting compliments Starting a conversation with a new person Maintaining conversation by asking questions Maintaining conversation by giving factual information Listening to others Ending conversations
Talk to physician about reducing medication	Asking questions about health-related concerns Listening to others Making compliments Making requests Disagreeing with another's

	opinion without arguing.
Improve assertiveness	Making requests Making compliments Asking for information Refusing requests Expressing unpleasant feelings Expressing angry feelings Making apologies Leaving stressful situations

Chapter : COGNITIVE RETRAINING

What is cognition?

"the characteristics of serious mental illness like schizophrenia involve a range of ***cognitive*** *and emotional dysfunctions that include perception,* ***inferential thinking****,* ***language*** *and communication, behavioral monitoring, affect,* ***fluency****, and production of thoughtand speech, hedonic capacity, volition and drive, and* ***attention."***

Impairments in attention, memory processing speed and problem solving ability are the most common cognitive deficits found in persons with schizophrenia, bipolar disorder, major depression, and alcohol and substance use disorder. The

severity varies depending on various factors like diagnosis, course of illness and social environmental factors.

In schizophrenia the deficit is observed even at the prodrome stage and throughout the course of the illness. It is independent of the patients psychopathology. Even when the patients are symptomatically stable cognitive deficits are observed which leads to impaired functioning. When compared to healthy individuals patients with schizophrenia score one to two standard deviations below the mean scores.

Medication does not have a major impact on cognitive deficits in schizophrenia. In the affective disorders medication can significantly reduce attention problems if the deficits are state related. Impairments in these domains have been associated with functional outcome in psychiatric patients. In schizophrenia impaired cognition results poor socio occupational functioning.

Let's look at the various cognitive domains in detail and the problems associated with those deficits:

Attention and Concentration:

- *Attention* is the ability to focus on something such as looking up a number in a phone book without getting distracted by other unrelated things such as a sound of a bus or auto passing on the street outside.
- *Concentration* is the ability to sustain attention long enough to complete a particular task or all the tasks
- Problems with attention are the core of many cognitive difficulties experienced by people with schizophrenia. Being unable to pay attention leads to problem in social situations (such as not tracking the

conversation), task oriented situations (such as work) and taking care of their personal hygiene.

Memory and Learning:

- The ability to learn new information, store it and retrieve it when needed is important for an individual in all aspects of one's life. People with schizophrenia often have difficulties with memory, which can make it harder for them to learn new things.
- Eg: forget appointments with doctors, people's name, and previous conversation.

Executive Functioning:

- The term executive function encompasses a broad range of complex cognitive skills that are critical to many aspects of daily living:
    - the ability to plan,
    - to solve problems,
    - to grasp concepts and
    - to reason logically.

In the recent times social cognition has also been included as part of the cognitive domains and they are put together as **SMART** which included **Speed of processing, Memory, Attention, Reasoning & Problem Solving and Tact or Social Cognition.**

How do we assess cognition?

Structured cognitive assessments are used to assess various domains of cognitions. The scores obtained will be compared with the normative scores and interpreted. We often hear from our clients about certain difficulties and challenges they face in their day to day life. For example:

"Food is either overcooked or burnt"

"I just become blank and confused and not able to take decisions"

"I always end up searching for my belongings"

All these statements indicate their problems with attention memory and problem solving skills. Hence it is important to understand their subjective experience of cognitive deficits in their day to day life a tool named **Subjective scale to identify cognition in schizophrenia (SSTICS)** is used. SSTICS detects some everyday cognitive failures that are recognized by patients which will help in planning intervention.

How does these deficits impact functioning?

Attention deficits affect an individual to acquire new skills. Theattention problems make it difficult for them to process the information given in groups, and they may not be able to sustain attention for a longer period.

Cognitive deficits make it difficult to succeed at work (McGurk & Meltzer, 2o01). If the ability to pay attention and remember information is worse, then patients are at a distinct disadvantage when compared to others. Most jobs require people to multitask and prioritize information. For example, a cashier must be able to ring up the items, answer questions, remember information about sales, and deal with coupons. It can be very difficult to perform well at work if they have trouble attending to and remembering information.

Cognitive deficits make it difficult to manage independent living (Velligan, Bow-Thomas, Mahurin, Miller, & Halgunseth, 20oo). Many clients with attention and memory problems struggle with things like remembering their keys, remembering where they put important items, and remembering appointments. People with problem-solving deficits have trouble organizing their living space so that they can find things. Many have trouble maintaining a budget, nd it difficult to negotiate.

How do we manage these deficits?

- Cognitive Remediation or Retraining is defined as "A behavioral training-based intervention that aims to improve various cognitive domains like Memory, Attention, Problem solving skills, Planning and Execution."is an intervention targeting cognitive deficit" using scientific principles of **learning** with the ultimate goal of improving **functional outcomes**. Itseffectiveness is enhanced when provide in a context (formal or informal) that provides support and opportunity for extending everyday functioning."

There were many cognitive training modules developed in the west using diverse methods like Computerized vs Non Computerized, Drill and Practice vs Compensatory techniques etc., Research shows that CT cannot be a stand-alone treatment and it has to be delivered along with Psycho social Interventions for better functional outcome in persons with serious mental illnesses. Computer assisted cognitive interventions shows improvement and significant difference is observed between the pre and post tests, but it fails to get transferred to the real-life situations. It has been found that interventions that incorporate drill and practice exercises and strategy coaching is more effective when compared to other interventions.

There are **two models two approaches**. They are:

Compensatory Approach:changes in the environment in order to influence and facilitate the cognitive functions. It aims to:

- Not to ***get things right***
- To develop a more systematic approach to activities,
- Focus more on strategy use
- Strengths
- Compensating for cognitive difficulties
- To facilitate
- Self-awareness and self knowledge
- Self-confidence
- Self-efficacy

CogSMART is a strategic CR program developed by Dr. Elizabeth Twamley at UCSD. It was developed to be "brief, practical, low-tech, engaging to clients, and portable enough to be delivered in the community" (Twamley et al., 2012).

Restorative Approach: to correct a specific deficit or trying to repair the specific underlying compromised function. It aims at

- improving, strengthening, or normalizing specific impaired cognitive functions.
- "exercise-like" aspect
- for example, a series of computer tasks that require detection of targets on the screen at an increasing pace.

- Real world transferability – If the cognitive abilities are restored

Specific strategies in cognitive remediation program to enhance the learning process

Learning tasks required by a job and performing those tasks at an acceptable level are basic to all occupations and requirements for continued employment. Persons with Schizophrenia have cognitive deficits in particular with Attention, Memory and Executive function. Cognitive Remediation (CR) is intended for individuals who are experiencing problems in specific areas of cognition. From a psychiatric rehabilitation perspective, CR focuses on skills and supports to improve the success and satisfaction people experience in their day to day life.

The use of techniques like shaping, errorless learning, prompting, modelling and frequent positive feedback are very important and to be used while delivering cognitive remediation. In this article I would focus on Errorless learning and shaping.

Errorless learning refers to the careful titration of difficulty level so that the client learns without resorting to trial and error and has a positive experience with increasing challenge. It is very important that we have to choose a level that is believed to be easy enough to guarantee success, and then the level of difficulty is slowly increased. Each level is broken down in to smaller steps and practiced until there are no errors. The therapist demonstrates each step in a particular level and the client performs each step. Cumulative training of all the steps should be practiced. This would help in high level of performance proficiency and resistance to forgetting. For example: Let us consider a client who is a housewife has responsibilities to take care of the household chores. Task of making a simple breakfast will be broken down in to simple steps and taught to the client. Each step (Making Tea) will be practised till the client learns it completely without errors and will be positively reinforced. Each step

will be rehearsed cumulatively ie when learning the 2nd step in a task client will be asked to perform the second step along with the previously learnt first step.

Shaping: The process of establishing a behavior that is not learned or performed by an individual at present is referred to as Shaping. Shaping can also be defined as the procedure that involves reinforcing behaviors that are closer to the target behavior, also known as successive approximations. The concept was first developed and used by B.F Skinner, who is known for his theories that involve learning behaviors through reinforcement.Shaping has been found effective in cognitive remediation programs. Shaping can be used to improve behaviours like Attendance, Punctuality, and Sustaining in the Remediation Program. On a weekly basis we can reward clients on their desirable behaviours with positive reinforcement. For example: Mr.Arecruited for a Cognitive Remediation Program is hesitant to attend the sessions regularly. The target behaviour for shaping in this client is making him attend the sessions regularly. Initially the client will be rewarded for the days he attends the session irrespective of whether he gets involved in the activities or not. Once the target is achieved then we move on to the next target of getting involved Mr.A in the sessions. Even if he gets involved for a brief period he will be rewarded until the desired target is reached.

Using these techniques is more effective, enhances the learning process and produces more reliable and durable performance in clients.

Purpose:

The purpose of cognitive retraining is the reduction of cognitive problems associated with brain injury, other disabilities or disorders, and/or aging. The overall purpose of the therapy is to decrease the everyday problems faced by individuals with cognitive difficulties, thereby improving the quality of their lives.

Who benefits from the retraining?

✓ Therapy must be tailored to each individual's needs and abilities.

✓ Persons who have made some progress in their recovery.

✓ A person's moods and emotions have an effect on their cognitive skills. Example – A person, who is depressed, may need psychotherapy and/or medication before he or she can engage in and benefit from cognitive retraining.

Cognitive retraining involves -

✓ Repetitive practice that targets the skills of interest.

✓ In fact, repetition is essential for the newly retrained skills to become automatic.

✓ Regular feedback is another important element of cognitive retraining,

✓ Reinforcement and Rewards

✓ Begins with simpler skills and proceeds to more complicated skills.

✓ Manual retraining activities and computer based tasks.

✓ Success of the retraining – when an individual is able to apply the acquired skills in the real life situation.

Attention and concentration retraining:

This type of cognitive retraining aims to improve several abilities, including focusing attention; dividing attention; maintaining attention while reducing the effects of boredom and fatigue and resisting distraction. Attention has

been considered the foundation of other more complicated cognitive skills, and therefore an important skill for cognitive retraining.

Manual retraining tasks – Some of the manual tasks generally practised for improving attention and concentration are listed below:

- Letter cancellation task,
- Sorting beads,
- Drawing traditional kolams with dots.

General strategies adopted in improving attention and concentration:

- ✓ Breaking the task in to parts.
- ✓ Scheduling frequent breaks in between the tasks.
- ✓ Introducing lighter tasks during the break.
- ✓ Removing the distractions and slowly introduce distractions during the later stage of the therapy.
- ✓ Shaping attention span.
- ✓ Reinforcement and rewards.

Learning and Memory retraining

Memory retraining involves teaching the patient several strategies that can be used to recall certain types of information. For example, rhymes may be used as a memory aid. A series of numbers, such as a phone number with an area code, may be broken down into smaller groups. A person may be taught to go through each letter of the alphabet until he or she remembers someone's name.

General Strategies adopted in improving memory:

✓ Use of memory aids such as keeping a calendar, making things to do list etc.,

✓ Developing a daily routine, creating an orderly environment which in turn minimizes memory problems.

✓ Rehearsing - rehearse information in a manner that will ensure that it transfers to long term memory so that it can be retrieved at a later time

✓ Repeated practice

✓ Associated learning

Retraining activities to improve executive function:

Executive skills retraining refers to teaching individuals how to monitor themselves, control their thinking and actions, think in advance, set goals, manage time, act in socially acceptable ways, and transfer skills to new situations. These are higher-level cognitive skills. Charts and videotapes may be used to monitor behavior, and a variety of questions, tasks, and games may be used in retraining these skills.

Some of the retraining tasks used to improve executive function are listed below.

◆ Card sorting:Care giver should sit with the patient and make him sort cards according to the number, colour and pattern. This improves the patient's ability to shift concepts. Initially this can be done by giving two different concepts say colour and design; slowly the complexity can be increased by introducing more concepts.

Example: Plastic beads or tokens with different colours, size, shapes, numbers and designs printed on it can be used. Initially colour and shape can be mixed and progressively the other concepts can be introduced one by one depending upon the patient's improvement.

Role of Family: Family plays a major role in the treatment and rehabilitation process of schizophrenia. Cognitive deficits can be improved by means of cognitive retraining done by a trained therapist at a rehabilitation setup either on a one to one basis or in a group. After every session the patients will be given homework assignments. A family member would be trained to monitor the retraining activities carried out by the patient at home. She/he acts as a Co-therapist. A monitoring chart will be provided by the therapist and the family member should fill the chart after monitoring patient's activities at home.

Role of Motivation: Motivation plays a significant role in cognitive remediation program. The activities for the remediation should be carefully chosen keeping in mind the choice and interest of the individual and also whether the activity chosen will be of use to the individual in their day to day life.

As in any kind of intervention setting goals is equally important in CRT program. The therapist helps the individual to to formulate their goals. This promotes autonomy in the person and facilitates engagement in sessions, increases the motivation, gives them a clear focus.

Conclusion: Cognitive retraining may be considered successful if performance on a behaviour related to a particular cognitive skill has improved. It is ultimately successful if it helps the dysfunctional person improve his or her functioning and meet his or her needs in real-life situations and settings. So retraining may be continued until the patient's skills are improved, transferred to, and maintained in real world activities.

CASE VIGNETTE 1:

Mr. A 31 years old Married male, post graduate in IT, employed in a BPO as a team leader, living with spouse and daughter. He is diagnosed with Schizophrenia, 4 years of duration, adherent to medications, currently asymptomatic.

Referred by the Psychiatrist for Rehabilitation

Detail history reveals client has **difficulty at work place,unable to meet the targets**, frequent complaints from his boss that **he has become very slow**, **doesn't respond to the customer queries** through email on time. Even at home he **keeps searching** for his belongings (Watch, key, id card etc.,) This happens almost every day, he **forgets to buy** the entire grocery items told by his wife, misses two-three things. While conversing with friends after few seconds **become lost** and had to be shaken by the friend to get him back to the topic.

Duration: Past 6 months slowly increased in frequency and intensity.

CASE VIGNETTE 2:

Ms. R 35 year old married female, House wife, educated up to 12 th std, stays in a joint family with in laws, spouse and children. She has the responsibility to take care of the entire household chores. She had **trouble focusing** on the tasks involved in **preparing meals** and often got **distracted** resulting in problems such as burned food, dishes prepared without salt, **forgets to turn off the gas stove** etc., this resulted in frequent arguments with her mother in law and she was much upset and stressed about working in the kitchen. She is compliant to her medications and her psychotic symptoms were under control. She

approached her Doctor regarding this issue and she was referred to the rehab therapist for further management.

Chapter: Motivation

Self determination theory provides an approach to personality and motivation,that examines how the interplay of socio contextual conditions and innate psychological needs fosters constructive development, well being, happiness and optimal functioning. Self determination refers to the development of the self. According to this theory self development occurs when people are motivated intrinsically, self regulated and when their basic psychological needs are met.

Hence Motivation is essential for good outcome of treatment in patients with severe mental illness. Impairment in motivation affects both treatment adherence and participation in psychosocial interventions

Rewards are known to initiate and sustain a particular behavior, that is - if an individual attains a goal, it would further motivate that person to engage in the behavior, again. Rewards are of two types. One can be extrinsically motivated through reward like Money, Gifts or even a verbal appreciation. Feeling happy and satisfied about engaging or completing a task are examples of intrinsic motivation. .Extrinsic and intrinsic motivation can be present at the same time. People work for monetary extrinsic rewards and at the same time experience satisfaction (intrinsic reward) when the work involved is interesting. In a

clinical context, an individual can feel better (symptomatically) after taking medication and this results in good adherence (Intrinsic motivation-IM). The same individual is able to work efficiently which in turn yields more incentives (Extrinsic motivation-EM). The balance between EM and IM varies from time to time and also it depends on the individual. If the rewards are not tangible, the individual might become amotivated.

Most of the skill-based treatments of psychosocial interventions are based on the learning capacity of the particular person. Research evidences state that "In both healthy controls and persons with schizophrenia IM is specifically and positively associated with more learning, greater persistence of learning and greater engagement in learning activities." (Medalia et al.,2009). When an individual engages in an activity with fullest involvement and volition, his/her needs are met which inturn gives a sense of autonomy and competency. This can be achieved only when the person is intrinsically motivated which in turn enhances the learning capacity. A person is said to be intrinsically motivated when the activity is associated with enjoyment, and relevant to personal goals and values. Hence individuals are intrinsically motivated in a learning task when they involve in the task out of their personal interest, enjoyment and satisfaction which is not always achieved with external rewards. Also, when they are given the preferences to choose what they want IM is consistent and sustains for a longer time rather than EM which is short lived. This doesn't

mean that EM has no role to play in treatment outcomes but when IM is greater, learning outcomes are better.

Understanding the role of IM in learning and treatment outcomes is very important. As individuals with schizophrenia has low IM, it is essential that skill-based interventions should be carefully planned keeping in mind the choice, interest and usefulness of the tasks which keeps them intrinsically motivated.

How do we improve motivation?

Motivation plays a major role throughout the delivery of psycho social interventions. Psycho social Interventions are tailor made based on the needs of the individual, hence when the interventions are designed the therapist has to carefully choose activities keeping in mind the three most important components which would aid in enhancing the motivation of the individual. They are Choice, Interest and Usefulness. The individual undergoing psychosocial interventions should be allowed to make a choice from various activities targeting a particular skill, it must be useful in the individual's day to day life and it should be interesting. When these three components are taken care it in turn motivates clients intrinsically and results in better outcome.

For example: As part of Social Skills Training introducing role plays to teach assertiveness: If the client is provided with a scenario of bargaining to an auto driver, the client might not find it useful as he never travels by auto, since it is

not useful he might not find it interesting. Also by not giving the opportunity to make a choice from a list of activities the client's autonomy is ignored. So in this scenario provide different role play situations based on the needs of the client, allow them to make a choice.

Choice: While selecting activity for improving attention, it is important to choose different variety of tasks. The client must be allowed to choose what he/ she likes among the different activities given. The activities chosen must have connection with their day to day life. For example activities like, "Remembering a grocery list", "Steps involved in withdrawing money from an ATM" "Planning a meal" "Sustaining attention in a conversation" etc., These real life scenarios can be combined with other computer or manual based tasks like memory games, letter cancellation tasks, connecting dots, drawing traditional kolams etc.,

Interest:The activities given must also match the interest of the client. Some clients might be interested to learn using an ATM card to withdraw money and play memory games but might not find the traditional kolams or letter cancellation interesting.

Usefulness: The activities must have relevance and usefulness in the client's day to day life. So it is very important to select activities like "Remembering a grocery list", "Withdrawing money using a ATM card, the steps involved in such a activity, how to remember these steps etc., because the client will get the

opportunity to practise these in a real life scenario and find it useful. At the same time activity useful for an individual like “Remembering a grocery list” might not be useful to another individual as he/she would never get the opportunity to practise such an activity in their daily life.

At the same time we should not ignore extrinsic motivation. Rewards would motivate clients during the initial period of interventions. They can be of gifts, tokens that can be exchanged or verbal appraisals, monetary benefits like incentives etc.

Motivational Interviewing:

Motivational interviewing is a technique in which you become a helper in the change process and express acceptance of your client. It is a way to interact with substance-using clients, not merely as an adjunct to other therapeutic approaches, and a style of counseling that can help resolve the ambivalence that prevents clients from realizing personal goals. Motivational interviewing builds on Carl Rogers' optimistic and humanistic theories about people's capabilities for exercising free choice and changing through a process of self-actualization. The therapeutic relationship for both Rogerian and motivational interviewers is a democratic partnership. Your role in motivational interviewing is directive, with a goal of eliciting self-motivational statements and behavioral change from the client in addition to creating client discrepancy to enhance motivation for positive change (Davidson, 1994; Miller and Rollnick, 1991). Essentially, motivational interviewing activates the capability for beneficial change that everyone possesses (Rollnick and Miller, 1995). Although some people can continue change on their own, others require more formal treatment and support

over the long journey of recovery. Even for clients with low readiness, motivational interviewing serves as a vital prelude to later therapeutic work

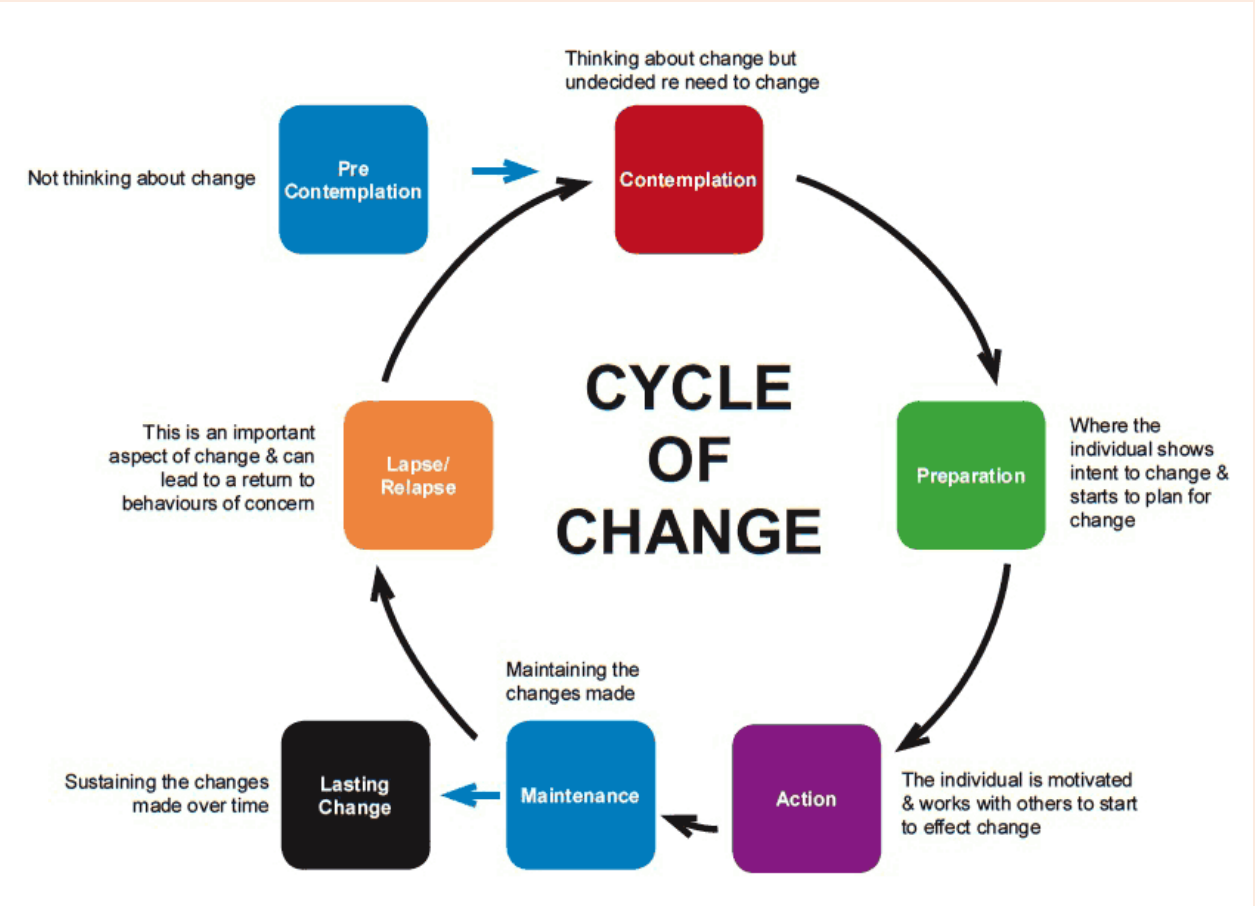
- **Stage I – Precontemplation**: In the earliest possible stage, the person may be experiencing some negative ramifications as a result of their behavior but they do not view these issues as being serious enough for them to consider changing their behavior. In the precontemplation stage, individuals have little interest or motivation to change.
- **Stage II – Contemplation**: In this stage, the person may realize that their behavior is leading to problems however, they remain ambivalent about actually changing. The person may have been considering making a change or may even desire to change, but the person has not actually made a commitment to change. In this stage, individuals are often open to the suggestion that they need to change their behavior, but they have not made any efforts toward actually changing their behavior.
- **Stage III – Preparation**: During this stage, the person may actually have weighed out the positive and negative aspects of their behavior and concluded that the negative aspects outweigh any benefits they are getting. The person has made a commitment to change and understands that they are responsible for changing. They may have developed a plan or tried to conceptualize how they might make changes, but they have not yet taken any formal action.
- **Stage IV – Action**: In this stage, the person is actually involved in an effort to change their behavior. Any effort to change their behavior qualifies as being part of the stage. In this stage, the person understands that they have to change their behavior and they are also the one who must make the changes even if they require assistance from others.
- **Stage V – Maintenance:** In this stage, the person has developed a level of efficiency that allows them to change their behavior and may have firmly established new behavioral patterns. These individuals are still working on

change, but they have become proficient at whatever actions they need to make in order to change the behavior. Often, sources suggest that in order for an individual to actually qualify to be in the maintenance stage, their changes must have been in place for six months.

- **Stage VI – Termination**: In the termination stage, the person has adopted all of the changes they need to make and is able to overcome any new obstacles. They may not actually quit or terminate their participation in a formal treatment program, such as therapy or 12-Step groups, but they have been able to overcome the issues they faced regarding changing their behavior, have maintained their new behavior, and are moving forward.

It is important to understand that this model does not represent a linear process, such that an individual starts at Stage I and progresses to the final stage. The MI model assumes that different individuals start the process at different points along the stages; individuals can experience setbacks and drop back one or more stages and need to start over; and even individuals in the final stage of the model may still need to make changes and adjustments.

The model can be used by therapists who can attempt to ascertain where a particular individual stands regarding their understanding of their need to change their behavior, what stage of change they may be in, and then therapy can be individualized to suit the particular situation. Thus, an individual who is forced into therapy in the precontemplation stage would require a different approach than an individual who is already in the action stage.



How do we handle challenges during MI?

The therapist practices motivational interviewing with five general principles in mind:

1. Express empathy through reflective listening.
2. Develop discrepancy between clients' goals or values and their current behavior.
3. Avoid argument and direct confrontation.
4. Adjust to client resistance rather than opposing it directly.
5. Support self-efficacy and optimism.

Setting Goals: SMART goals are important which help the individual to take ownership in their life and improve their self efficacy

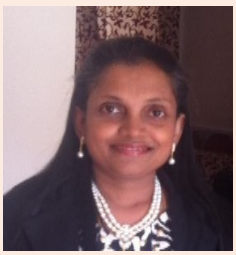
- Specific: A clear and well-defined goal that is capable of answering questions as to what the outcome of the goal is.
- Measurable: A goal with a specific criteria which measures your progress towards accomplishing the goal
- Achievable: The goal must be attainable, you must be capable of achieving it.
- Realistic: A goal that is applicable to your life purpose and your resources.
- Time -bounded: A goal which is clearly defining the timeline, including the

As a practitioner of motivational interviewing, your goal isn't to heal, but to help. It isn't to solve your patients' problems, but to help them solve their own problems.

PROFILE OF THE TEAM:

Dr.Padmavati Ramachandran
Director,
SCARFIndia.

- Completed Postgraduate Psychiatry degree at the University of Bombay.
- Over 29 years of experience with the Schizophrenia Research Foundation, (SCARF) Chennai, India.
- Involved with research in several areas like epidemiological studies, drug trials, untreated schizophrenia, culture and psychoses, especially Stigma, metabolic disorders and physical comorbidities in mental illness.
- Closely involved in SCARF's community mental health programs and the telepsychiatry project.
- Key interest in socio-cultural aspects of Mental illnesses and psychosocial rehabilitation.
- Established the Department of Psychosocial Rehabilitation at SCARF which provides a needs-based psychosocial intervention program for persons accessing SCARF Clinical services for treatment and rehabilitation.
- Published in a large number of peer reviewed national and international journals.
- Reviewer of many national and international psychiatric journals.
- Associate editor for the International Journal of Mental Health Systems. Serves on several Institutional Review Boards.
- Teaches postgraduate students of psychiatry and is a guide for postgraduate dissertations.



Dr. Lakshmi Venkatraman,
Consultant Psychiatrist,
SCARFIndia.

- Trained in Psychiatry at IMH, Chennai and UK
- 10 years of work experience in UK as a psychiatrist
- Consultant Psychiatrist at SCARF since July 2013
- Special interest in Psychosocial Rehabilitation and Eating disorders
- Edits the quarterly Psychosocial rehabilitation newsletter of SCARF
- Co-authored a chapter on social aspects of schizophrenia in Social Psychiatry: Principles and Clinical perspectives.
- Conduct training events for different health professionals in mental health
- Contributed and developed training material and information leaflets in psychiatry

MADRAS SCHOOL OF SOCIAL WORK (AUTONOMOUS)
32, Casa Major Road, Egmore, Chennai-600008
Value Added Certificate Course Candidate Attendance Report , As On 07-08-2020

Subject Code:MSS/18CC/02 **Subject Name:PSYCHOSOCIAL REHABILITATION**

S.NO	REGISTRATION NO	STUDENT NAME	DEPARTMENT NAME	1/2/2020	15/2/2020	22/2/2020	14/3/2020	21/3/2020
1	1915782091020	UDAYA G	M.S.W. SF COMMUNITY DEVELOPMENT	Present	Present	Present	Present	Present
2	1915782091021	AGNES RAPHEAL	M.S.W. SF MEDICAL & PSYCHIATRIC SOCIAL WORK	Present	Present	Present	Present	Present
3	1915782091022	DHARSHINI J	M.S.W. SF MEDICAL & PSYCHIATRIC SOCIAL WORK	Present	Present	Present	Present	Present
4	1915782091023	KIRTHIGA N	M.S.W. SF MEDICAL & PSYCHIATRIC SOCIAL WORK	Present	Present	Present	Present	Present
5	1915782091025	MANNA MARIAM SUNIL	M.S.W. SF MEDICAL & PSYCHIATRIC SOCIAL WORK	Present	Present	Present	Present	Present
6	1915782091026	SHALINI D	M.S.W. SF MEDICAL & PSYCHIATRIC SOCIAL WORK	Present	Present	Present	Present	Present
7	1915782091027	SHUBHDA RANA	M.S.W. SF MEDICAL & PSYCHIATRIC SOCIAL WORK	Present	Present	Present	Present	Present
8	1915782091028	IRENE PRISCILLA J	M.S.W. SF COMMUNITY DEVELOPMENT	Present	Present	Present	Present	Present
9	1915782091041	VAISHNAVI J	M.S.W. SF COMMUNITY DEVELOPMENT	Present	Present	Present	Present	Present
10	1915782091042	MOHAMMEDTHARICK F	M.S.W. SF MEDICAL & PSYCHIATRIC SOCIAL WORK	Present	Present	Present	Present	Present
11	1915782091043	SAJAN THRIKKUKARAN	M.S.W. SF MEDICAL & PSYCHIATRIC SOCIAL WORK	Present	Present	Present	Present	Present
12	1815782051013	MONICA R	M.SC. COUNSELLING PSYCHOLOGY	Present	Present	Present	Present	Present

13	1815782091027	JOHN ITTY JACOB	M.S.W. SF COMMUNITY DEVELOPMENT	Present	Present	Present	Present	Present
14	1815782091032	BHARATH KUMAR V	M.S.W. SF MEDICAL & PSYCHIATRIC SOCIAL WORK	Present	Present	Present	Present	Present
15	1815782091033	ILFANA ILLIYAS	M.S.W. SF MEDICAL & PSYCHIATRIC SOCIAL WORK	Present	Present	Present	Present	Present
16	1815782091034	KASTHURI RENGAN S	M.S.W. SF MEDICAL & PSYCHIATRIC SOCIAL WORK	Present	Present	Present	Present	Present
17	1815782091035	MARITA K PAUL	M.S.W. SF MEDICAL & PSYCHIATRIC SOCIAL WORK	Present	Present	Present	Present	Present
18	1815782091037	SREELAKSHMI R	M.S.W. SF MEDICAL & PSYCHIATRIC SOCIAL WORK	Present	Present	Present	Present	Present
19	1915782091014	CHINGBIAKLIAN SUANTAK	M.S.W. SF COMMUNITY DEVELOPMENT	Present	Present	Present	Present	Present
20	1815782091041	ABHIMANYU S G	M.S.W SF MEDICAL & PSYCHIATRY SOCIAL WORK	Present	Present	Present	Present	Present
21	1815782091006	BLESSY R	M.S.W HUMAN RESOURCE MANAGEMENT	Present	Present	Present	Present	Present
22	1815782021041	M M THILEAPAN	HUMAN RESOURCE DEVELOPMENT	Present	Present	Present	Present	Present
23	1815782021026	SADHANA KANNAN	HUMAN RESOURCE DEVELOPMENT	Present	Present	Present	Present	Present
24	1815782091023	YAMUNA C	M.S.W HUMAN RESOURCE MANAGEMENT	Present	Present	Present	Present	Present
25	1815782091011	JINI THOMAS	M.S.W HUMAN RESOURCE MANAGEMENT	Present	Present	Present	Present	Present
26	1915782091036	SRILAKSHMI ANANTHANARAYAN	M.S.W HUMAN RESOURCE MANAGEMENT	Present	Present	Present	Present	Present
27	1815782091019	RIA JOSE	M.S.W HUMAN RESOURCE MANAGEMENT	Present	Present	Present	Present	Present
28	1915782091013	SHARUMATHI M	M.S.W HUMAN RESOURCE MANAGEMENT	Present	Present	Present	Present	Present

MADRAS SCHOOL OF SOCIAL WORK

(An Autonomous Institution Affiliated to the University of Madras)

P.G. DEPARTMENT OF SOCIAL WORK (SHIFT-II)

CERTIFICATE OF COMPLETION

This certificate is awarded to

Ms. KIRTHIGA. N

on completion of the value added Certificate course on PSYCHO-SOCIAL REHABILITATION by SCARF India in collaboration with Madras School of Social Work.

DR. S. RAJA SAMUEL
Principal,
Madras School of Social Work.

DR. R. PADMAVATI
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