UNIT 2 REHABILITATION OF THE MENTALLY ILL PERSONS

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2.0 INTRODUCTION

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

a) Difficulty in learning new skills and employment.

b) Participating in social and recreational activities.

c) Establishing and maintaining relationships.

d) Maintaining housing.

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

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

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

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

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

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

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

g) Active involvement of individuals and primary caregivers.

h) Maintaining continued care.

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

2.1 OBJECTIVES

After studying this unit, you will be able to:

• describe psychosocial rehabilitation and its challenges;

• explain social skill training and its role in psychosocial rehabilitation;

• get an overview of vocational rehabilitation in mental illness;

• acquire knowledge on some landmark development related to rehabilitation of people with mental illness: UNCRPD, PWD Act, RCI Act, National Trust; and

• discuss the role played by the government and NGOs towards rehabilitation of people with mental illness.

2.2 PSYCHO-SOCIAL REHABILITATION

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

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

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

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

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

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

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

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

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

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

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

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

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

2.2.1 The Role of Psychiatrist in Rehabilitation

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

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

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

Self Assessment Questions 1

1) Define ‘Psychiatric Rehabilitation’ or psycho-social rehabilitation.

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2) Discuss the two intervention strategies in psychiatric rehabilitation.

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2.3 CHALLENGES IN PSYCHOSOCIAL/PSYCHIATRIC REHABILITATION

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

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

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

Self Assessment Questions 2
1) List the challenges in psychosocial/psychiatric rehabilitation.

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2.4 SOCIAL SKILL TRAINING

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

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

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

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

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

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

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

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

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

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

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

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

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

### Self Assessment Questions 3

1. Discuss the steps involved in social skills training.

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### 2.5 VOCATIONAL REHABILITATION

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

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

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

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

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

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<td>1) Describe supported employment as a vocational rehabilitation model?</td>
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2.6 UNITED NATIONS CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES (UNCRPD)

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

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

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

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

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

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

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

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

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

**General Principles of the Convention**

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

b) Non-discrimination;

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

e) Equality of opportunity;

f) Accessibility;

g) Equality between men and women;

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

**Equality and non-discrimination**

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

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

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

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

**Participation and inclusion**

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

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

**Mainstreaming of Disability**

Mainstreaming of disability issues according to the Convention are:

- Work of existing human rights treaty bodies.


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


- Poverty Reduction Strategy Papers (PRSP).

- The development activities of international donors and NGOs.

- Census data.
Mental Health Services

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

Conclusion

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

Self Assessment Questions 5

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

2.7 PERSONS WITH DISABILITY ACT (PWD ACT), 1995

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

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

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

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

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

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

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

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

The two terms that need to clearly understand here are:

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

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

### 2.7.1 The Main Provisions of PWD Act

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

I) **Prevention and Early Detection of Disabilities**

1) Surveys, investigations and research.
2) Promote prevention of disabilities.
3) Screening of children and awareness campaigns.

II) **Education**

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

III) **Employment**

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

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

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

VI) **Research and Manpower Development**
Research in the following areas may be sponsored and promoted.
1) Prevention of disability.
2) Rehabilitation including Community Based Rehabilitation (CBR).
3) Development of assistive devices.
4) Job identification.
5) On site modifications of offices and factories.
6) Financial assistance for undertaking research.

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

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

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

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

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

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

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

**Self Assessment Questions 6**

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

2) What is ‘IDEAS’?

**2.8 THE REHABILITATION COUNCIL ACT OF INDIA (RCI ACT)**

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

Handicapped in this Act means a person who is:

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

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

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

Professionals who can apply for RCI accreditation:

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

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

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

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

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

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

Objectives: The basic objectives of the National Trust are:

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

To do any other act which is incidental to the aforesaid objectives.

Main activities/functions

The main activities/functions of National Trust are:

a) To provide financial assistance by way of grant-in-aid to Registered Organisations (ROs) for strengthening infrastructure.

b) To provide training to persons with disabilities, their parents, ROs, Govt. officials, other stakeholders.

c) To provide residential and day care facilities to persons with disabilities.

d) To provide scholarship and financial incentives and support to the persons with disabilities.

e) To constitute Local Level Committees in the districts and to ensure appointment of legal guardians through them.

2.9.1 Services Provided by the National Trust

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

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

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

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

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

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

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

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

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

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

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

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

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

A panel of professionals, retired govt. officers and other experts and volunteers has been prepared for inspection and monitoring of various schemes and programmes of the National Trust. Besides, review survey is also conducted in few key schemes and issues like supported guardianship and Samarth. Committee
of Parents is also constituted to monitor residential centers etc. A system of Management Information System (MIS) is also being developed for real time information dissemination.

### Self Assessment Questions 8

1) What is GHARAUHDA?
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2) What is ARUNIM?
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### 2.10 ROLE OF THE NGOs TOWARDS PSYCHOSOCIAL REHABILITATION IN INDIA

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

#### 2.10.1 Mental Health Non Governmental Organisations (MHNGOs)

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

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

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

### 2.10.2 Rehabilitation Centres

As governmental facilities for Rehabilitation Centers (RCs) is virtually non-existent, so most of these RCs are operated by NGOs. The RCs in India can be grouped as under:
a) Those that provide facilities to patient brought by care givers (eg Richmond fellowship Society)

b) Those that provide shelter and treat the wandering mentally ill (The Banyan in South India, Pingalwara, PrabhAasraetc in North India)

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

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

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

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

Self Assessment Questions 9

1) Discuss the two groups of rehabilitation centres in India.

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Rehabilitation of the Mentally Ill Persons
2.11 LET US SUM UP

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

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

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

2.12 ANSWERS TO SELF ASSESSMENT QUESTIONS

Self Assessment Questions 1

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

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

2) The two interventions strategies are

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

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

Self Assessment Questions 2

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

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

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

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

v) Lack of awareness about mental health.

Self Assessment Questions 3

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

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

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

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

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

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

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

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

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

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

Self Assessment Questions 4

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

Self Assessment Questions 5

1) The principles of the Convention are:

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

ii) Non-discrimination;

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

v) Equality of opportunity;

vi) Accessibility;

vii) Equality between men and women;

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

Self Assessment Questions 6

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

i) Blindness

ii) Low vision

iii) Leprosy-cured person

iv) Hearing impairment

v) Locomotor disability

vi) Mental retardation

vii) Mental illness

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

Self Assessment Questions 7

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

Self Assessment Questions 8

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

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

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

2.13 UNIT END QUESTIONS

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

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

2.14 REFERENCES


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

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


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


2.15  SUGGESTED READINGS


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