PSYCHIATRIC REHABILITATION AND THE SOCIAL WORKER

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Rehabilitation has been defined as the restoration of the handicapped to the optimum level of functioning in the emotional, social and occupational spheres that the individual rehabilitee is capable of. The crux of the rehabilitation programmes is individualisation of the programme to suit the special needs taking into account the resources of the individual patient. No two patients of chronic schizophrenia have the same personality or the same home-background or the same degree or type of residual defect or the same degree of motivation for resocialisation or occupational rehabilitation.

The psychiatric social worker has a crucial role to play at every stage of rehabilitation and in the different components constituting the total rehabilitative effort.

Familial and Social Rehabilitation:—

In spite of so much active research in the treatment of schizophrenia the fact has to be accepted that a certain percentage of schizophrenics remain uncurable with varying types and degrees of residual disability. Prolonged hospitalisation is anything but the answer to the management of these cases. The rehabilitation efforts should be set in motion in these cases, the moment it is realised that optimum clinical and social recovery has been attained. The social worker can play an important role at this stage. The patient must be prevented from getting over dependent on the institution, and developing the syndrome of "institutionalism". He should be persuaded to mix socially with other patients and staff members and be kept in active functioning contact with the community outside the institution, most importantly with his own family. The family members should be informed about the unlikelihood of total recovery and made to reconcile themselves to the fact that the patient would probably have to learn to live with a certain degree of residual defect. Their role in rehabilitating the patient in the community should be explained clearly not in general terms but in a concrete manner. The family members are likely to react in a defensive manner and show various types of resistance to the idea of taking back into their homes a sick member who is still not completely cured. These resistances must be systematically analysed and the family members must be made to feel that rehabilitation of the patient is as much their responsibility as of the physician and the institution. Once the family is made to accept its responsibility and persuaded to participate in the reha-

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bilitation programme all possible concrete assistance should be given to them in playing their role satisfactorily. They must not be made to feel that we are washing our hands off the patient and dumping him back into the family. This will not only nullify what little co-operation we are likely to get from the family, but is likely to expose the discharged patient to neglect.

The social worker will have to undertake a good deal of educational work also as part of his professional work. While people are familiar with the handicaps of the chronic patient in the work sphere, they are not as familiar with his handicaps in the emotional and social spheres of functioning. It is more difficult to develop a tolerant attitude to his lapses of commission and omission in the social sphere especially.

Side by side with counselling the family members on their role in the rehabilitation programme, the social worker will have to work directly with the patient also and try to impart to him the optimum social skills which will enable him to live satisfactorily in the community. This has to be done in a graded manner taking into account the resources the patient has still at his command. Group meetings with ex-patients, organising recreational programmes with the active collaboration of volunteers from the community, etc. will help in the acceptance and ultimate assimilation of the patient in the community.

Occupational Rehabilitation :—

This is the most important and the most challenging aspect of rehabilitation effort. The community does not have any respect for an able-bodied young man who does not have a steady job. At the same time, the community, especially the employing community, is not prepared, just at present to consider an individual with residual psychiatric disability for remunerative work, even if his disability is such as not to totally disable him from all work.

We do not have at present any sheltered workshop where a rehabilitee may be allowed to engage himself in at least partially remunerated work. With the prevalent massive unemployment in the country, it is too much to expect the community to show a sympathetic and helpful attitude to employment of the handicapped.

The immediate need of the moment is to rouse the social conscience of the community with respect to its responsibility to the care and vocational rehabilitation of the mentally handicapped. This can best be done by initiating steps for the formation of a Mental Health Association at a local or regional level. The functions of this association will be broadly, care and rehabilitation of the mentally handicapped in the community. It is important to include in the governing body of such an association

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members of the community, like philanthropists, with inclination for social service and contribution in the field of social welfare, officials from the Ministry of Health and municipal corporation, representatives of employing agencies, legislators, leading citizens, psychiatrists and senior psychiatric social Workers. The professional persons in the governing body should try to stay in the background while readily supplying all technical data and the benefit of their professional service for planning and executing various schemes in the field of rehabilitation. The other members must be persuaded to take an active role in all the matters concerned with the rehabilitation effort. This is the only way in which we will be able to get the community to commit itself to participation in the programmes for the care and rehabilitation of the mentally handicapped in the community, and without this active commitment on the part of the comunity no comunity-based programme can ever succeed. The social worker, with the help of psychiatrists can play an active role in this social-conscience 'rousal' programme. At a more individual level, he may try to get placement for the rehabilitee in suitable places of work consistent with his achievements in his educational and occupational spheres and the nature and degree of residual handicaps. The best way of removing the misconception in the minds of the employers that an ex-mental patient can never be employed, is to show him convincingly that an ex-patient can still engage himself in remunerative work, provided a *suitable* job is found for him. Some of the products manufactured by Remploy Factories in U. K. where *only* handicapped persons are employed are of such standard that they are in no way inferior to products manufactured by factories engaging normal people. What are required in the field of rehabilitation work is *faith* in the rehabilitability of the handicapped, and a missionary zeal for helping the disabled. The Social Worker can best play his role by developing this faith and zeal himself and by spreading these in the community as much as he can.

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