PSYCHOSOCIAL REHABILITATION IN INDIA

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Rehabilitation

Historically, the term has described a range of responses to disability, from interventions to improve body function to more comprehensive measures designed to promote inclusion. The International Classification of Functioning, Disability and Health (ICF) provides a framework that can be used for all aspects of rehabilitation. For some people with disabilities, rehabilitation is essential to being able to participate in education, the labour market, and civic life.

Rehabilitation is always voluntary, and some individuals may require support with decision-making about rehabilitation choices. In all cases rehabilitation should help to empower a person with a disability and his or her family.

Rehabilitation measures and outcomes

Rehabilitation measures target body functions and structures, activities and participation, environmental factors, and personal factors. They contribute to a person achieving and maintaining optimal functioning in interaction with their environment, using the following broad outcomes:

- Prevention of the loss of function
- Slowing the rate of loss of function
- Improvement or restoration of function
- Compensation for lost function
- Maintenance of current function

Psychosocial Rehabilitation and mental illness:

Mental illness is a term that describes a wide range of mental and emotional conditions. Mental illnesses causing disability are prolonged and chronic in nature. Now they are known as severe mental illnesses, which require psychosocial rehabilitation, include chronic schizophrenia, long standing bipolar illness, persisting depression, delusional disorder and dementia.

Disability arising out of severe mental illness is also known as psychiatric disability. This disability is defined as a substantial limitation in a major life activity (Liberman, 1998). World Health

Organisation (WHO) defines this disability as an inability to participate or perform at a socially desirable level in such activities as self care, social relationship, work and situationally appropriate behaviour.

Psychosocial rehabilitation aims to provide the optimal level of functioning of individuals and societies, and minimization of disabilities and handicaps, stressing individual's choices on how to live successfully in the community (Rangnathan, 1999)

Psychosocial rehabilitation is a process that facilitates the opportunity for the individuals who are impaired, disabled, or handicapped by a mental disorder to reach their optimal level of independent functioning (Rangnathan, 1999).

Goals:

1. Recovery from mental illness: It is a basic prerequisite of psychosocial rehabilitation in terms of symptom management. Compliance with medication plays an important role with the support of family and treating psychiatrist. Noncompliance of medication retards the process of psychosocial rehabilitation.

2. Integration in the family and community: It is a prominent goal to be achieved with all the efforts of psychosocial rehabilitation. Integration of person with severe mental illness in the family and community is the key determinant in the success of psychosocial rehabilitation.

3. Better quality of life: It needs to be ensured at par with members of the family and community through psychosocial rehabilitation services being rendered to the person with severe mental illness.

Values:

A rehabilitation professional actively involved in psychosocial rehabilitation follows certain values which facilitate achievement of goals in integrating the person with severe mental illness in the family and in ensuring her or his better quality of life. These values are:

1. Self determination,

2. Dignity and worth of every individual,

3. Capacity of every individual to learn and grow, and

4. Culture sensitivity.

Guiding principles: Following are the important guiding principles of psychosocial rehabilitation.

1. Individualization of services: Psychosocial rehabilitation services should be planned to suit individual needs of the person suffering from severe mental illness according to his or her demographic characteristics like age, gender, education, locale, socio-economic status and cultural background, the nature of illness and function level in day to day work. Individual programme planning of psychosocial rehabilitation services for two persons with same diagnosis may differ in their individual rehabilitation needs of psychosocial rehabilitation services**.**

2. Maximum involvement and due importance to be given to preferences and choices of person with severe mental illness: In order to ensure maximum involvement, due importance should be given to choice and preferences of person with severe mental illness. Anything cannot be imposed on her or him in the name of psychosocial services.

3. Normalized and community based services: Scope for community based psychosocial rehabilitation services is wider, as this is known to be the door step service delivery with an intention to reach the unreached. Such services are not only in demand, rather are known to be the need of the day, especially for greater reach in the rural areas for wider coverage of severely mentally ill population.

4. Strength focus: Severity of mental illness is likely to cause many losses. What has been lost due to severe mental illness should not be the primary concern. Remaining positive potentials in terms of cognition, emotion, motor activity level and social interaction of person with severe mental illness should be the focus of overall rehabilitation process.

5. Situational assessment: Remaining positive potential has a situational dimension. Psychosocial milieu of the person like family setup, work place, person's social living conditions, etc may also need to be thoroughly understood to ensure favourable situational support.

6. Treatment, rehabilitation, and integration through holistic approach: Treatment, rehabilitation and integration into the community are linked being integral part of each other. They should not be dealt with in isolation. Psychosocial rehabilitation for the management of severe mental illness should be a holistic approach.

7. Ongoing, accessible, and coordinated services: psychosocial rehabilitation services should be coordinated in such a manner that they are not disrupted in between. They should be available with easy access as per the requirement of the persons with severe mental illness as continued care.

8. Training of skill and vocation focus: Severe mental illness undermines the individual's behaviour, performance, cognition and social interaction. Certain skill deficits are apparent in the major categories of severe mental illnesses. They are the focus of intervention in psychosocial rehabilitation. There is continuum of skill training in the process of rehabilitation. That is activities of daily living skills, social skills and lastly followed by vocational skills. Through acquisition of these skills vocational focus should be kept in mind to place the person in a remunerative job. This generates a feeling in the individual that she or he is also a productive member of the society.

9. Environmental modification support: At times modification in the environment facilitates the process of rehabilitation. Provision of support to such environmental modification should be available so that the same is flexibly used.

10. Partnership with the family: The person with severe mental illness in the family is not the only sufferer rather the whole family is greatly affected due to severity of illness. This adds to the burden of caring on regular basis. Hence the family needs to be involved as part of the process of psychosocial rehabilitation.

11. Evaluative assessment with outcome focus: Evaluation of progress to ascertain the outcome of rehabilitation is necessary. Usually progress is disrupted due to relapse, which also makes evaluative assessment of outcome essential.

Need for Psychosocial Rehabilitation

By their very nature, mental illnesses are chronic and relapsing and require a broad range of services, beyond just pharmacotherapy. No treatment of mental disorder can be considered as complete or adequate without giving due consideration to rehabilitation or aftercare services (Channabasavanna, 1987). The need for psychosocial rehabilitation arises out of the increasing percentage of mental disorders across the globe.

Severe mental disorders (SMI) figure among the 10 leading causes of disability and burden in the world (who, 2001). An estimate based on extrapolation from household surveys and which excluded homeless people and residents of institutions such as nursing homes, prisons, and long-term care facilities, stated that nearly 4.8 million people suffer worldwide from severe and persistent mental illnesses and 10 million people suffer from serious mental illnesses (IAPRS, 1997).

A worldwide estimate of the current and future impact of severe mental illnesses has increased dramatically. A new internationally used statistic called the DALY, the "disability adjusted life year," is a measure of a year of healthy life lost to a particular disease, either through premature death or disability. The most significant result from measuring disease by DALYs is the new prominence it gives to the negative impact of severe mental illnesses. For example, major depression, typically not mentioned in international health rankings, is currently the fourth leading contributor to DALYs, and is projected to be ranked as the second leading contributor by the year 2020 (Knox, 1996; Karel, 1996).

Evidence Based Psychosocial Rehabilitation

The empirical base of the psychiatric rehabilitation process draws its evidence base from several lines of research. it is the person's self-determined goals and the presence of the skills and supports necessary to reach those goals, rather than the person's diagnosis and symptomatology, that relates most strongly to rehabilitation outcomes (Anthony & Farkas, 2009).

• Psychosocial rehabilitation in general and skills training in particular, for both consumers and family members, are intended to promote a range of outcomes (IAPSRS, 1995). These interventions have demonstrated success in symptom reduction, community adjustment, relapse prevention, medication compliance, and reduced use of the hospital and other restrictive settings (Dobson et al, 1995, Smith et al, 1996, Moller et al, 1997 & Conners et al, 1998).

• Cognitive skill remediation has shown promising results in helping patients relearn basic information processing abilities such as attention, concentration, and memory (Cassidy et al, 1996, Corrigen et al, 1996 & Medalia et al, 1998), which are critical to the acquisition of other skills and, in some approaches, are taught together with other skills in an integrated program (Brenner et al, 1994). Cognitive skill remediation has also shown success in directly reducing psychotic symptoms (Corrigan et al, 1996).

• McFarlane and associates, 1992, showed that patients who participated in an intensive case management program that had a vocational and rehabilitation orientation and provided family psycho-education, had significant improvement in community adaptation compared with patients who received intensive case management alone.

Ethical issues

The four guiding ethical principles of medical practice, also referred to psychosocial rehabilitation practice are the following:

• Respect for autonomy of the client: it involves providing the client the freedom of choice treatment and course of illness after hearing the benefits, risks and costs of all reasonable options.

• Non malfeasance: a Hippocratian code of ethic is an essential rule, preventing the risks of treatment and iatrogenic harm. This principle is often violated with the intention of "good" treatment effect outweighing the "bad" effect.

• Beneficence: providing the form of treatment to the client that would benefit him and would result in meaningful outcome.

• Justice: related to the equal distribution of health care resources, especially to those persons who are in greater need.

Other ethical issues include: • It is unethical if there is a breach of confidentiality e.g. reporting patient's "diagnosis" of treatment details to a possible employer and when therapeutic work procedures are videotaped or recorded for education or research purposes, without a previous written informed consent, by the rehabilitation service clients.

• Another important ethical issue is when the rehabilitation staffs challenge the client's system of cultural values and beliefs, when in the rehabilitation process.

• Another ethical issue arises when the client is not compliant with the programme's principles and regulations and when aggressive behaviour of a client is directed towards other members and staff, or a sexual misconduct causes problems to others in the programme. It is the staff and the other members of the programme, who will try to "treat" this problematic behaviour and prevent harmful consequences within the limits of Therapeutic Community principles.

• Ethical code violation exists when there is no service internal policy, securing human rights of clients attending the programme.

Legal issues

The following document the so called psychosocial rehabilitation malpractice. They arise when there is: • Incorrect psychosocial rehabilitation diagnosis of a client, leading to improper service placement.

• Improper work supervision, exposing the client to possible work risks.

• Failure of staff to monitor psychiatric care or prevent adverse psychotropic drug side effects due to lack of intercommunication between mental health care agencies involved in the treatment and rehabilitation of the client.

• Building a psychosocial rehabilitation service programme, with inadequate organization procedures, leading to misdiagnosis, activities with no clear boundaries, improper placement and supervision, are liable for malpractice claims.

• Employment of service personnel with inadequate specialized training could jeopardize the successful rehabilitation outcome and is liable for malpractice claims. However, there is no evidence of malpractice when the client's poor rehabilitation outcome is not related to negligent rehabilitation procedures.

Psychosocial Rehabilitation Versus Pharmacotherapy

The debate over psychosocial rehabilitation versus pharmacotherapy is still a controversial subject. Pharmacotherapy is important, there is no doubt about that but in addition to the medical field, rehabilitation has shown significance in treatment. Psychosocial rehabilitation is a holistic approach that places the person, not the illness, at the centre of all interventions (Baron, 2000). Psychosocial Rehabilitation is a healthy alternative or combination to pharmacotherapy. Pharmacotherapy and psychosocial rehabilitation are inseparable; they are two sides of the same coin (Kopelowicz & Liberman, 2003).

Pharmacotherapy: It focuses on the removal of disease symptoms by diagnosis and prescription of drugs. Focuses on symptom relief and stabilisation of current condition. It suggests short-term treatment by medication Does not prescribe community integration for treatment.

Psychosocial rehabilitation: It focuses on the person with the mental illness as opposed to the diagnosis of the mental illness.Focuses on recovery process. long-term treatment focusing on increasing social status,occupational roles, and independence within the community. Facilitates for potential supports within the community as an alternative to hospitalization.

Current status of psychosocial rehabilitation in India

• Rehabilitation in India is still in its infancy. Although, a rehabilitation sub program aimed at treating and maintaining psychiatric patients in the community, was envisaged in the National Mental Health Program. It could not be implemented due to variety of a reason (Srinivasa Murthy, 2004). At the governmental level, policy makers have been unable to devote serious attention to the development of rehabilitation services for the chronic mentally ill primarily due to economic constraints. The current status of rehabilitation services of our country as assessed by the national Human Right Commission project report on Quality Assurance in mental health (1999), is as follows:

Structure • Number of psychiatrist, social workers, occupational therapists and even psychiatric nurses in developing countries can be totally unacceptable by standards elsewhere in the developed world. For instance, India and Australia have roughly same number of qualified psychiatrists while the population of India is about more than 1000 million, while Australia has about 20 million people, Indonesia until recently had 1 occupational therapist for 190 million people.

• About 36% of government mental hospitals have a separate facility for vocational training.

• There are neglected sheltered workshops in the government hospitals.

• Occupational therapy section is present in 63.9% of hospital. However, untrained personnel in an ad hoc carried out these activities. Further in 61% of the centers it was noticed that only a selected number of patients were attending these activities. • Awareness among staff in psychiatric hospitals regarding the principals of rehabilitation is poor.

Day care centres • Such facilities have started to develop in some hospitals while 7 (19.44%) of the hospital provide day services. The centers providing day care are NIMHANS, Bengaluru, Mental Health Centre, Thiruvananthapuram , KIMH, and Chennai.

• 41.66% of centers reported regular production even though only 36.1% has separate vocational facilities.

Rehabilitation wards • About 8.33 of government psychiatric hospitals have rehabilitation wards

• There is an interesting experiment being carried at NIMHANS where the nursing staff has been entirely withdrawn from a chronic ward and the patients are entirely in charge of the ward.

Halfway homes • The half way homes concept has taken root in a few states like Karnatka, Tamil nadu and Kerala. Such facilities are usually managed by NGO'S. 87.8% of the mental health centers don't have these types of community care facilities in their vicinity.

• There are no separate facilities for occupational therapy and rehabilitation for children in 95% of the hospitals.

Programs • In 53.65% of the hospitals there are no organized programs for rehabilitation. • Combined programs for male and female are present in 5.55%. • Separate rehabilitation programs for males and females are present in 33.33%. • Programs only for males in 2.77% and only for female's in2.77%. • Most hospitals cater predominantly to psychotics. • 19.44% of the centres ensures employment placement outside the hospital i.e. NIMHANS. • 25% of mental health centres paid incentives to the patients.

Volunteers and community participation • Only 25 (67.6%) of mental health centres involve volunteers. • The family's role as a partner in care is not utilized in 95% of the mental hospitals.

Major Rehabilitation centres in India

Some of the major voluntary/ non-governmental organisations/ autonomous organisations in India working in psychiatric and other disability rehabilitation fields are:

- National Institute of Mental Health and Neurosciences (NIMHANS), Bangalore, Karnataka
- Deepsikha Institute, Ranchi, Jharkhand
- Sevak, Kolkata, West Bengal
- Child in need institute (CINI), Kolkata, West Bengal
- Samarpan Care Awareness and Rehabilitation Centre, Indore, Madhya Pradesh
- Ashadeep, Guwahati, Assam (working for psychosocial rehabilitation for mentally ill)

- Antara, Centre for Rehabilitation of Mentally Ill and Substance addicted person, Kolkata, West Bengal
- CAIM, Deaddiction and Rehabilitation Centre, Bangalore.
- St. Joseph Rehabilitation Centre and Relief Services, Kolkata, West Bengal; treatment centre for chemically dependent and mentally disturbed.
- Thakur Hari Prashad Institute of Research and Rehabilitation, for Mentally Handicapped, Andhra Pradesh
- V.D. Indian Society for Mentally Retarded, Malad (W), Mumbai, Maharashtra
- Schizophrenia Research Foundation (SCARF), Chennai, Tamil Nadu.
- Nav bharat jagriti Kendra, Ranchi and Hazaribagh, Jharkhand
- The Association for the Welfare Of Persons With A Mental Handicap In Maharashtra (A.W.M.H. Male)
- National Institute For Empowerment Of Persons With Multiple Disabilities (NIEPMD), Chennai, Tamil Nadu
- Central Institute of Psychiatry (CIP)
- Ranchi Institute of Neuro-Psychiatry and Allied Sciences (RINPAS) and psychosocial rehabilitation.

Future Direction

• Psychosocial Rehabilitation services should be accessible, equitable and affordable.

• Government should downsize large psychiatric hospitals. More open ward treatment facilities must be created.

• Human resources for psychosocial rehabilitation must be systematically enhanced through both short-term and long-term strategies.

• There should be a national data base of services and human resources available for psychosocial rehabilitation in the country and this should be periodically updated.

• Psychosocial rehabilitation must be converged with the social, education, labour and legal sectors. Translational research must be encouraged in all areas.

• Law review and reform needs to occur periodically. They must emphasise community care, rehabilitation and aftercare.

• Limitations imposed on mentally ill receiving rehabilitation in the area of insurance should be rectified.

• The rehabilitation of vulnerable groups like children, elderly, and women who are subject to domestic violence should receive priority attention.

• There is a need to design outcome studies regarding the effectiveness of rehabilitation program and also it is needed to recognize the interaction between drugs and environmental therapy effects especially in case of ward managements.

• Patients and family members will become more effective as advocates for needed services and partners in treatment, planning and implementation. It is necessary to encourage NGO to start half way homes. The family's participation and involvement through regular contact with the half way home staff should be encouraged to make community adjustment easier.

• There is an urgent need for more day care centers that can provide the much-needed respite for the family as well as make the individual patient feel less stigmatized and more valued.

Conclusion

Psychosocial Rehabilitation exhibits principles of hope, change and recovery for Persons with severe and persistent mental illness. Effective mental health service providers should facilitate change through the recovery-oriented theory. Recovery is individualized and person centred, placing the person at the core of all interventions with the goal of rehabilitating and re-integrating the individual to active community life. For successful rehabilitation, co-operation and collaboration of health care personnel, patients and their family members, opinion leaders, policy makers and various agencies are indispensable. Then only we can hopefully address the rehabilitation of psychiatric patients in a more meaningful manner and make them more meaningful citizens of our country.

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