Psychiatric Rehabilitation in India

T. Murali & Prashant K Tibrewal

Introduction

Interventions that focus directly on functional impairments related to mental illnesses come under the rubric of psychiatric rehabilitation (1). Patients with mental disorders have been increasingly helped by rehabilitation services to achieve functional independence. Rehabilitation is a comprehensive and multi-disciplinary treatment. It involves a wide variety of interventions. These interventions help the patient to integrate into the mainstream of society and improve his/her quality of life (2). Modern psychopharmacology, the assertion of patient rights and the positive results of the effectiveness of psychosocial rehabilitation have all contributed to the recent growth of this discipline (3).

Severe mental disorders figure among the 10 leading causes of disability and burden in the world (4). The treatment of these disorders, especially in the recent era of psychopharmacology has centred on the amelioration of the acute phases of the illness. By their very nature, mental illnesses are chronic and relapsing and require a broad range of services, beyond just pharmacotherapy. Psychosocial intervention uses a combination of learning procedures and environmental supports in a holistic and integrated manner, to provide life-long care for persons with mental illness.

Unfortunately, in our country, a vast majority of patients still do not have access to any form of psychosocial intervention, let alone a well-integrated psychiatric rehabilitation service. In this chapter we have tried to provide a brief overview of the services and concerns related to psychiatric rehabilitation in India.

Psychiatric rehabilitation in India

Psychiatric rehabilitation in India is in a dynamic phase of growth and can best be considered in three different sectors, namely, hospital-based initiatives, initiatives by non-governmental organisations (NGOs) and community and consumer initiatives. While the activities in many of these sectors were started on a largely experimental basis, some of them have

been found to be sustainable and replicable. Organised structured programmes with adequate human resources and budgeting for psychosocial rehabilitation (PSR) are still scarce in government psychiatric hospitals and in the NGO sector. Government initiatives remain largely on paper and have not reached the field. Issues related to norms, guidelines, staff pattern, infrastructure and linkages remain unattended. With this background let us examine the current status of PSR in the three different sectors.

Hospital-based initiatives

These were initially confined largely to the government mental hospitals, re-christened as mental health centres or institutes of mental health. The NHRC report (1999) stated that 63% of the government mental hospitals had some form of rehabilitation services (5). Though rudimentary, they were in existence. These were largely on the lines of occupation therapy. They were mainly ward-based activities, some of which were productive but largely confined to the needs of the hospital. Staff nurses generally carried out a majority of these activities. Formal vocational training and placement were not very common. Hospital work like cleaning, assisting nurses and group D staff was very common in all the hospitals.

Following the recommendations of NHRC in 1999, there were improvements in some of the hospitals. Notable improvements are at the hospitals in Gujarat, Kerala and Madhya Pradesh. These states have NGOs and varying levels of community participation.

There has been a gradual shift from simple occupational activities towards productive and purposeful activities leading to income generation. Patients have started getting incentives for their work. Many of the mental health centres have started attached day care centres and halfway homes in their premises. Different levels of staff are also employed in these facilities. While PSR activities are becoming strengthened at some centres, unfortunately, in a few well-known centres, these activities have actually declined, e.g. at the CIP, Ranchi. This centre was once the Mecca of PSR in India (6).

Day care centres, especially those attached to psychiatric hospitals, tend to be used more by chronic patients with greater disability and those from the lower socio-economic strata (7). Poor work performance is often related to the persistence of residual symptoms of mental illness (8). However, the use of activity therapy, behaviour modification techniques

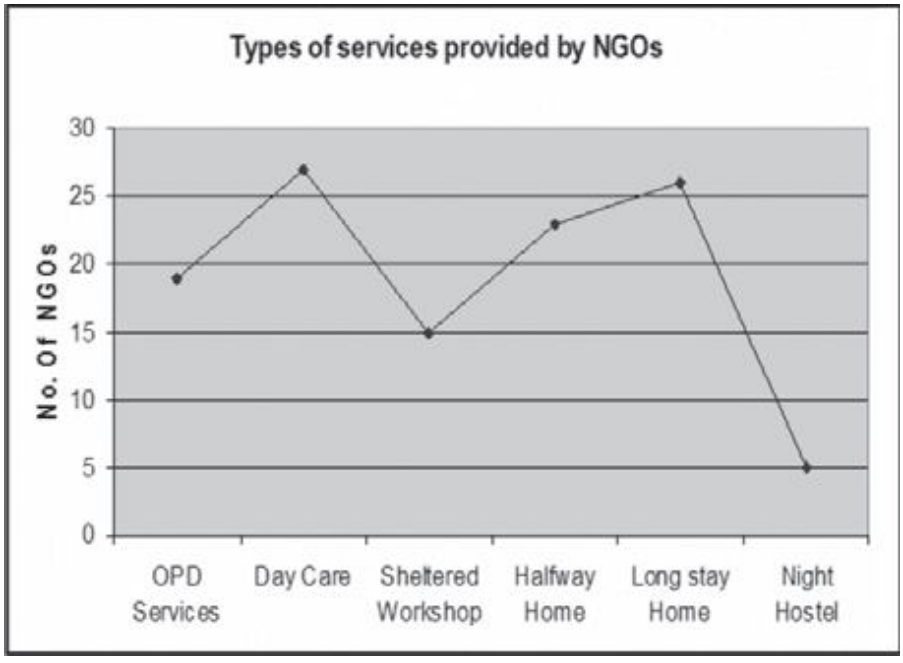
and monetary incentives for work helps to reduce the behavioural problems and improves the social and occupational functioning of the patient (9, 10). Cognitive remediation can be used to improve the quality of life (11).

With a reduction in the duration of hospitalisation at most of the psychiatric hospitals, and a decrease in long-stay patients resident in the hospital, it is important at this stage to extend PSR from just within the hospital to the larger community. The expanded district mental health programme (DMHP) provides an ideal opportunity for this movement.

Non-governmental organisation initiatives

A recent survey of non-governmental organisations provides an interesting scenario of psychosocial rehabilitation efforts in the Indian context. There are different types of organisations involved in a variety of rehabilitation measures for the mentally ill. A major group are the registered societies or trusts. These organisations have reasonable infrastructure, adequately trained professional staff and structured programmes. Their clientele are people who have recovered from the acute illness and who are on maintenance medication. While a majority of the centres have a residential facility, some of them have only a day-care facility as illustrated below.

Figure 1



Residential facilities

Well-known residential facilities, which mostly provide shared accommodation, include the Medico Pastoral Association in Bangalore, the Richmond Fellowship Society with branches across India, the Schizophrenia Research Foundation (SCARF) at Chennai and the Atmashakthi Vidyalaya, Bangalore. These organisations have developed halfway homes with a maximum duration of stay of 1 year, after which the person returns to his/her family. These centres generally accept patients with psychotic illnesses. They offer very well structured programmes for the whole week with an adequate mix of daily living skills, communication, appropriate behaviour, etc. as components. Adequate professional staff, either clinical psychologists, or psychiatric social workers, are employed to supervise the programmes. Among these centres, the Medico Pastoral Association has a unique feature of house parents, who are an elderly couple who function as surrogate parents. Food and medicines are provided in the centres. The charges at these centres range from Rs 3000 to Rs 7000 per month.

These centres have also started long stay facilities as well as day-care facilities in their premises. The long-stay facility is provided after taking a lumpsum from the families. All these facilities provide non-medical aftercare services. However, these organisations are presently required to obtain a license under the Mental Health Act (the same required to run a mental hospital/psychiatric nursing home). This is a misinterpretation of the Mental Health Act as these are not active treatment facilities for the acutely mentally ill. It poses a major hindrance for such organisations and moreover, is a disincentive for newer organisations interested in starting psychosocial rehabilitation. . Their monitoring could be more appropriately done under the Persons With Disabilities (PWD) Act 1995, under the Disability Commissioner.

Day-care facilities

There are over 25 day-care facilities in India spread over Kerala, Karnataka, Tamil Nadu, Goa, Maharashtra, Gujarat, Madhya Pradesh, New Delhi, Assam and Meghalaya. Special educators or vocational instructors primarily manage these day-care centres. They generally cater to persons with psychosis, mental retardation, and mental retardation with epilepsy. They all emphasise on vocational training that is locally relevant. Most centres have productive activities and patients do get a stipend or

remuneration depending on their work performance. Once they are trained, they are assisted to get a placement in the community. Duration of the stay varies according to the individual's disability. There are no formal certificate courses or any specific yardstick to assess employability or competence.

In the district of Malapuram, Kerala, as a part of the DMHP, small community day-care centres have been operational where 10-15 patients are engaged in daytime activity. These day-care centres increase the self-esteem of the patients, gives them some time away from the family. This gives family members an opportunity to attend to their work, making them less pressurised and better able to support the mentally ill family member. Day-care centres can be developed anywhere in the country, they help to reduce stigma, have low professional manpower requirements, and ensure good drug compliance. The difficulties include the need for transportation from home to the centre, and that the family members of the patient need to pack lunch sometimes very early in the morning.

This form of care is popular and can be easily established even in rural areas, as illustrated by Thanal Chavakkadu in Trichur district of Kerala or the day-care centre run by Deshbandhu Club, Silchar, Assam.

Long-stay facilities

Certain families simply cannot accommodate the mentally ill person. Examples include situations when the patient is severely disabled, when there is a very high degree of family pathology, or when there is no immediate family member available to provide care. Cadabams in Bangalore provides this facility, but the costs make it affordable for only a few. Non-governmental organisations and private entrepreneurs must come forward to develop such facilities. Usually they take a lumpsum payment and do not charge any monthly fees. There is a growing demand for such centres and we may see more such centres come up in the private sector, as they may offer more economically viable models of long-term care. A criticism of these centres is that they may become like private asylums.

Home for the homeless

There have also been relatively less visible community initiatives for the mentally ill. Several individuals and families in Kerala have been involved in providing food, clothing, shelter, medicine and occupational therapy free of cost for the destitute mentally ill. These are largely charitable efforts

sustained by the active support of the local community in cash and kind (12).

A novel approach has originated in Kerala. The homeless mentally ill are taken from the streets and provided shelter, clothing and medicine by ordinary families. There are about 60 such centres spread across Kerala; all of them are registered under the orphanage control board. These were started in 1993 and slowly spread across the state. The families, which run these centres are from the low and middle socio-economic strata and are driven by religious faith. A few of these centres are managed very well with adequate infrastructure and good care. The expenditure for running these centres are through donations by the local community and other well wishers. A large number of volunteers are also engaged to care for the patients. These volunteers as well as the care giver's families do not have formal mental health qualification or training. In 2001, a State level workshop of these centres was organised. It was found that some of them do not provide any medication. Hence, a training programme was started and today, a majority of the centres are aware of the principles of care for the mentally ill and they all have visiting psychiatrists providing medication. National Institute of Mental health and Neuro Sciences (NIMHANS), Bangalore, has taken a lead in these programmes. Once the patients are taken to these centres, they are given personal grooming and provided with psychiatric and medical consultation. Once they recover, their families are traced and they are sent back. Those who are not accepted by the families remain at the centre. One such centre has an orchestra and drama troupe comprising recovered persons and has completed more than 300 stage shows. These centres also do a lot of public awareness programmes.

Such centres are also present in Tamil Nadu. Two well-known centres in this state are the Banyan and Udagum Karangal in Chennai. There are a few centres in Karnataka as well. These centres need support from the government for infrastructure and medicines. Models such as the above are worth nurturing and enable healthy community participation. Community involvement in such centres will reduce the stigma associated with mental illness.

Consumer and Community Initiatives

Psychosocial rehabilitation in India has also seen meaningful community participation, primarily from users, family care givers and others who have

taken this as a mission. There are families of the mentally ill who have also taken up psychosocial rehabilitation. Ashadeep in Assam, Aasha in Tamil Nadu are examples of day-care centres started by family care givers. Schizophrenia Awareness Association in Maharashtra is a user initiative. Family Federation of India is a group of different family associations working for the cause of the mentally ill. The World Association of Psychosocial Rehabilitation has provided a significant contribution towards conducting awareness programmes and providing technical assistance for psychosocial rehabilitation. Any interested individual can become a member and work for the cause of the mentally ill.

Psychosocial rehabilitation for non-psychotic disorders

This chapter has catered primarily to issues of psychosocial rehabilitation for persons with mental illness, mainly psychosis. Psychosocial rehabilitation is also a popular and well established therapeutic approach for the long-term treatment of alcohol and drug de-addiction. The Ministry of Social Justice and Empowerment funds NGOs to carry out psychosocial rehabilitation for alcohol and drug dependence. The regional centres identified under this scheme also provide training in rehabilitation of persons with dependence. Many of these agencies have demonstrated the effectiveness of community based and workplace prevention and rehabilitation programmes. The approach and treatment modalities for this group are distinct (13).

Conclusion

Psychosocial rehabilitation is spreading across the country slowly but surely and there is a gradual growth in agencies offering these services across the country. There is a need for a user-friendly rehabilitation policy at both the central and state government levels. The issue of psychosocial rehabilitation and the regulation of different centres offering this service must come under the purview of the PWD Act 1995 rather than under the Mental Health Act. There is a need to develop trained human resources at different levels to provide therapeutic interventions at these centres. Alternate manpower development programmes can be taken up by the Rehabilitation Council of India in association with other mental health professionals' bodies like the Indian Psychiatric Society, Indian Association of Social Psychology, Psychiatric Social Work, World Association of Psychosocial Rehabilitation, etc. The Indian Psychiatric Society has developed a scale for quantification of disability which has been accepted

by the Ministry of Social Justice and Empowerment and is being widely used across the country for certification of disability in mental illness (14). This is a good example of government working in tandem with professional associations. Once these policy changes are implemented and translate into user friendly services, mentally ill persons can have a better life of dignity, individuality and honour.

References

1. Torrey WC, Green RL, Drake RE. Psychiatrists and psychiatric rehabilitation. J Psychiatr Pract 2005 May; 11(3):155-160.
2. Elizur A. Rehabilitation of the disabled mentally III in the community. Isr J Psychiatry Relat Sci 2004;41(4):248-258.
3. Grasset F, Spagnoli D, Orita A, Veillon H, Cucchia AT. Psychosocial rehabilitation at the dawn of the 21st century. I: Principles, population targets, and pathologic causes. Rev Med Suisse Romande 2004 Apr; 124(4):187-191.
4. World Health Report. Mental Health: New Understanding, New Hope. Geneva: World Health Organization, 2001.
5. National Human Rights Commission (NHRC) Quality Assurance in Mental Health. New Delhi: National Human Rights Commission, 1999.
6. Thomas G, Bose S. Value of work in mental disorders. Indian Journal of Psychiatry 1967; 9:73–80.
7. Sharma PSVN, Gopinath PS, Reddy MV. Patients attending a psychiatric day hospital–Analysis of one year's referrals. NIMHANS Journal 1987; 5:39–45.
8. Gopinath PS, Chaturvedi SK, Murali T, Saleem PP. Work performance of schizophrenic day boarders in an occupational therapy centre. Indian Journal of Psychiatry 1985; 27: 207–212.
9. Rao K, Barnabas IP, Gopinath PS. Behaviour modification. Letter to the Editor. Hospital and Community Psychiatry 1988;39:1311.
10. Rao K, Barnabas IP, Gopinath PS. Behaviour modification in a rehabilitation setting. Journal of Personality and Clinical Studies 1989; 5: 23–27.
11. George RM, Chaturvedi SK, Murali T, Gopinath PS, Rao S. Cognitive deficits in relation to quality of life in chronic schizophrenics. NIMHANS Journal 1996; 14:1–5.
12. Murali T. From the secretary's desk. World Association for Psychosocial Rehabilitation (Indian chapter). Bulletin 2002; 6:5.
13. United Nations Drug Control Programme. Community based drug rehabilitation and workplace prevention. Murthy P (ed). UNDCP/MSJE/ILO. Available at: http://www.unodc.org/pdf/india/publications/Partnerships_808_Report/section_1.pdf
14. Indian Psychiatric Society. Indian Disability Evaluation and Assessment Scale (IDEAS) 2002.