Recovery Oriented Services: Obstacle is the Path

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There are numerous hurdles and obstacles in the path of development of recovery oriented services, also known as rehabilitation, popularly. These hurdles are in various aspects of the mental health care and aftercare. One of the most important rehabilitation needs in mental health is the need to work, and have a job. This provides self-esteem and identity, a sense of self worth and social status. The need to earn is faced with difficulty in finding and holding on to a job in open employment. There are also needs for vocational training and income generating activities, and to be wanted by the family and the society.

The obstacles are at various levels—policy level, community level, family level, individual's situation, professional's level, financial obstacles, educational, employment related, social or societal ones, legal and maybe many more.

Stigma, which actually cuts across all the above, is the main obstacle to mental health care and better quality of life, of people with mental illness. There is no formal anti stigma campaign at any level, in many societies. "We know what obstacles stand in the way of recovery and rehabilitation. Amongst these obstacles undoubtedly the most serious and difficult is the stigmatization of mental illness and of all those in contact with it—the sufferers, their families, the medications used for treatment, the institutions in which treatment is provided, staff in mental health institutions and even the sites on which they are located." Norman Sartorius wrote in his book *Reducing the Stigma of Mental illnesses*, 2005.

Stigma is the Main Obstacle

Stigma gets in the way of getting a job and keeping a job. People with mental illnesses are amongst the most stigmatized, discriminated and socially rejected. Employment is perhaps not so much of a challenge for persons with other physical difficulties, as for those with a mental illness. The stigma of mental illness is often experienced as more painful, long lasting, and difficult to overcome than the illness itself. Stigma is pervasive and debilitating, and a major barrier to recovery.

Self-stigma occurs when an individual who has a mental illness believes the negative views that others hold. This adds on further to the discrimination by the society and employers. Due to self stigma, the individual hesitates to make adequate attempts.

Professionals as Obstacles

Interestingly, mental health professionals who try to fight stigma and discrimination, and try to make a success of the recovery oriented services, become obstacles themselves, unintentionally. This begins with the beliefs they hold and the attitudes they have, not towards the mentally ill person, but towards rehabilitation. Professionals are not clear about the concept of Rehabilitation! They wonder if rehabilitation is an intervention, a therapy or therapeutic method, an approach, an outcome, a philosophy, a model, a lifestyle/ life skills programme, a goal, a catchphrase, a bandwagon or anything else.

There is stigma attached to the term 'rehabilitation'. Professionals harbor certain myths about rehabilitation! For them, rehabilitation means mainly working, employment, and earning. Though this may be an important part,

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rehabilitation goes beyond the need to work and earn. Many other dimensions need to be addressed. Another view professionals hold is that rehabilitation is for the patients only, and make it patient-centric. There is hardly any attention to the caregivers and relatives. No amounts of efforts and interventions on patients are likely to be successful without involving the family, relatives and caregivers. Many professionals believe that rehabilitation does not 'work' and is not effective. This also stems from their viewpoint that they cannot explain or understand how rehabilitation works, despite there being good evidence that rehabilitation improves the overall recovery, outcome and quality of life? For those who feel that it works, consider that rehabilitation takes too long a time to work.

Some professionals feel that rehabilitation is an alternative for medical care, or for those patients who do not respond to medical care. In fact, rehabilitation complements medical care, for those who do or do not respond to medical care. It is felt that since rehabilitation involves multiple disciplines, it would need many persons, which would be difficult in a resource poor country. Rehabilitation may need many aspects of care, not necessarily multiple specialists. For many professionals, leisure and recreation is not rehabilitation [no fun allowed, as a therapy cannot be enjoyed!]. For others, rehabilitation is all about getting disability benefits!

Some professional obstacles emerge from clinical practice, for example, when to start rehabilitation, and invariably, a commonly held belief is that rehabilitation should start after remission of symptoms; in case of patients admitted in the hospital, after their discharge; In most mental health institutions, discharging to home itself is considered as rehabilitation. For some admitting in a long stay institution is rehabilitation!

Preferably, rehabilitation should start right from the time of first contact and assessment, and a beginning should be made, simultaneously with medical treatment. The focus should vary with course of illness, remission and recovery. At times, a palliative care model could be used in order to reduce distress for continual or residual symptoms.

Another view of the professionals, which appears as a hurdle is their opinion that, rehabilitation has to be provided for chronic disorders, after many months or years of illness or for those who are not responding or partially responding, for those with remitting and relapsing disorders, for severe mental disorders, psychoses, alcoholism and substance use disorders. It should be recognized that rehabilitation can also be provided for other mental health problems, like obsessive compulsive disorders, somatoform disorders, and other common mental disorders. Importantly, the professionals should be aware that rehabilitation can also be provided while the person is symptomatic.

Pharmacotherapy as an Obstacle

Side effects of psychotropic medications may interfere with occupational functioning, social interactions, motivation, and may reduce working capacity. Use of a minimum, safe, and effective dose of medications is advisable. Users and consumers should participate in the treatment planning for full understanding and involvement. Some mental health services do employ persons with a past history of severe mental illnesses as case manager aides, in the pharmacy and as counselors. Some side effects like extra pyramidal and metabolic effects can appear as physical stigmata, and aggravate stigma. Medications can also impair the quality of life (QOL) and cognitive functions of the person. Pharmacotherapy should not delay plans for rehabilitation.

Training Obstacles

Training in Psychosocial Rehabilitation globally is rather inadequate. There are bare minimum or no training for professionals in psychiatric rehabilitation in many countries. Training of non-medical professionals, such as clinical psychologists, rehabilitation psychologists, psychiatric social workers, psychiatric nurses and occupational therapists, are also needed. Rehabilitation specialists should be identified.

The Path from the Obstacles

Education is an important way to remove the myths and misconceptions of the professionals about rehabilitation. There should be specialized courses like Masters in Disability Studies, and Psychosocial or mental Health Rehabilitation. Fellowships, short-term courses for rehabilitation workers, volunteers and family care providers should be encouraged. Training of health workers and lay volunteers in psychosocial rehabilitation is needed. Needless to say, committed, motivated professionals to train those needing training, and conducting motivation and inspiring training programmes would go a long way in overcoming the obstacles.

It is necessary to provide for more funding support for empirical research in psychiatric rehabilitation. The effectiveness of alternative models of community-based care in disability reduction and improving the quality of life have to be examined. Indigenous measures of outcome, QOL, and work performance are needed.

Professional resistance, especially from psychiatrists, and other mental health professionals, is mainly due to their training or lack of. Manpower shortage in mental

health in general, and psychosocial rehabilitation in particular needs to be addressed. Paucity of resources prevents the growth of psychosocial rehabilitation. There are not sufficient funds for research or services. High staff burnout amongst professionals is due to frustration, demoralization, challenges, slow recovery, demanding families. Professionals may find a lack of glamour working in rehabilitation!

Rehabilitation should become a public health issue and the recovery model should be a social endeavour. Social neuroscience and behavioural neuroscience models to explain recovery oriented practices and services need to be studied.

This second issue of the journal has addressed some of the above issues. Tirthalli and Chethan discuss the need of continued clinical care, rehabilitation as a treatment, and also stress the importance of dynamic nature of psychiatric disability and the role of insight. Thus, they emphasise the distinctive nature of disability due to psychiatric conditions. Sadath et al. report how carers' poor understanding

and high stigma cause significant delays in seeking psychiatric treatment. Kumar et al. observe psychopathology as a significant predictor of disability and conclude that a small proportion of patients with first episode schizophrenia remain disabled if they are adherent to medications. Tse and colleagues describe an interesting nationwide Gamble Free Day health promotion project in New Zealand consisting of an action group, song-writing competition, and discount restaurant dining, and recruitment and training of volunteers specifically for the campaign. This one and another on psychosocial treatment of opioid addiction by Kufner et al., highlight the role of rehabilitation in addictive disorders. The first letter to editor by Hans Oh has been included in response to the paper published in the first issue of this journal, and an interesting exposition on what recovery means in terms of psychiatric care. The second issue of the journal thus has a variety of interesting articles from different parts of the world.