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CONFERENCE REPORT

Mental Health Rehabilitation: No Simple Answers

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The recent conference on psychiatric rehabilitation threw light on a host of issues, including the 'rehabilitation needs of the country, cross-cultural perspectives on recovery and rehabilitation, legal issues pertinent to rehabilitation, role of families and communities, learning from other disabilities, geriatric perspectives, community based rehabilitation initiatives in psychiatric rehabilitation, so on and so forth.

The event started with a discussion on rehabilitation needs in India and the cross cultural variations. The unmet rehabilitation needs in India with respect to severe mental illness needs more focus. NGO's play an important role in mental health rehabilitation. It is also necessary to have a supportive legislative framework. Rehabilitation efforts could be outcome or process based focusing on 'recovery'. It is essential to combine rehabilitation and treatment and stressed the need in training in rehabilitation. Rehabilitation goals can only be achieved by coordinated action among all stake holders including caregiver organizations, peer support groups, NGO's and governmental agencies. It is important to develop culturally accepted rehabilitation services and models.

Recovery is viewed differently across cultures and across lifespan of a person. Strategies useful to motivate a person from egocentric culture may not work in a person from sociocentric culture. Rehabilitation needs are also influenced by ethnicity, gender and urban/rural differences. Rehabilitation services have largely been confined to large mental hospitals. General hospital psychiatry units (GHPU's) have difficulties in providing psychosocial services due to resource constraints.

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It is important to empower persons with psychiatric disability and utilize community resources. Focus on symptomatic remission rather than 'recovery' is unlikely to aid rehabilitation. A successful model of delivering palliative care clinic services using motivated volunteers was presented. The model has been tried in mentally ill patients. Each volunteer is assigned a patient with whom they work for empowerment and prevention of symptom relapse.

There are various barriers to volunteering- lack of awareness about needs/opportunities; barriers to initiating-how to start? barriers to continue- lack of support. Volunteering can be encouraged by improving awareness, ensuring openness, using role models, recognizing their valuable work, and having mechanisms in place for networking and cross-volunteering.

Community resources need to be tapped and utilized effectively to ensure community reintegration. Though community reintegration is ideal, we need half way homes and residential facilities for pragmatic reasons.

Rehabilitation needs of geriatric patients is bound to increase as the population ages. Dementia has a significant impact on the individuals and their families. The families face a significant caregiver burden. There is a need to develop home based rehabilitation facilities which have been proved to be successful. As such, long-stay homes, nursing homes and day-care centres for geriatric patients are very few and far in number. There is still a very long way to go.

The role of families in the care of patients with severe mental illness in the Indian setting is pivotal. It is important to involve family members in developing services and empower them. Family resilience, an inherent quality which involves open and honest communication, togetherness, sharing activities, affection, acceptance, and commitment needs to be nurtured through family interventions and social policy. The Role of mental health professionals is to identify

strengths and enhance bonding. Stigma can be major hindrance that not only affects the patients but also the family members and it could be major hindrance in recovery. Programmes should be planned to address stigma. Non adherence to treatment leads to frequent relapses and can be a major setback to recovery. Factors related to non-adherence (including general factors, patient related (intentional/non-intentional) factors, clinician related and illness related factors) can be addressed by a multi-disciplinary approach using various sources. Families play a major role in fighting stigma, developing services. They are often concerned about the question who after me. The need to develop self help groups to tackle the issue is very essential and can have major role developing polices for rehabilitation and after care.

The policies and legislations related to mental health care and rehabilitation are being changed and developed. The suggested changes in the mental health act, in keeping with the notion of protecting the rights of patients with mental illness, were highlighted. It is the need of the hour and it is important for all the key groups involved in rehabilitation to be aware of the policies and legislations. Many case-laws that had direct relevance to psychiatric rehabilitation were discussed.

Development of rehabilitation services for various disabilities has seen an uneven growth. The services for mental illness are far behind other disabilities. This could be due to the fact that the essence of mental disability is different and needs a different approach. We could learn from other disabilities. Cognitive deficits in patients with mental illness interfere in recovery. Developing home based cognitive rehabilitation and tailoring it to the needs of both urban, rural population is essential. A holistic approach to cognitive deficits in Schizophrenia including social interaction/motivation was also stressed upon. The psychiatric care is given by different set ups like mental health institutes, general hospital psychiatry set ups and others. Various challenges are faced in planning rehabilitation services like, lack of resources, focus on medical model than bio-psycho-social model, serial interventions (first treatment then rehabilitation), lack of training, lack of guidelines, need to handle patient care/teaching/research. However it could be less stigmatising if rehabilitation services could be done at general hospital psychiatry units. A single model may not fit all settings. Developing indigenous models and tapping the available community resources is the essential aspect. Innovations are vital to develop good psychosocial rehabilitation services. An innovation would be to utilise recovered patients to be support for patients in the process of recovery.

The main model that needs attention is community based rehabilitation. Few centres have developed CBR models in collaboration with NGOs and have found successes. One notable model is the community intervention programs that are being run by NIMHANS in two rural communities of Karnataka state since the past decade. About 600 patients with schizophrenia are being treated and followed-up in these programs at their own taluks. The interventions provided are pharmacotherapy and psycho-education. All efforts were made to keep the patients under regular follow-up. An important aspect of these programs is the minimal role played by the psychiatrist. Apart from visiting the taluks periodically for follow-ups and diagnosing cases, there is no other role. The entire programs are being co-ordinated by trained social workers in each of the taluks. Ensuring such basic minimum care can be sufficient to a considerable proportion of schizophrenia patients from a public health perspective. A host of good outcomes have been demonstrated in these cohorts including the considerable reduction of disability extending over six years of follow-up, reduction of the family burden, good outcome at the end of four years of follow-up (about 60 % of the patients), satisfactory work functioning of about 2/3rds of the cohort and most recently, the 'real-world functioning of patients has been shown to be satisfactory by ensuring this basic minimum clinical services. Another notable issue with this kind of a model is that there remains a considerable proportion (about one third of the patients in the communities) that requires more elaborate concerted and multidisciplinary approach.

That leaves us with the question whether community based services are the key component of success in rehabilitation. Should this be an end of road for institutionalization and residential care? There is no simple answer for the same!!

Overall learning and future directions

1. There are islands of good-work that is being done in the areas of psychiatric rehabilitation across the country. We need a mechanism to make these techniques and models easily accessible to all stakeholders.
2. In Psychiatry, treatment and rehabilitation go hand in hand. As of now, treatment falls under purview of 'Ministry of Health & family welfare' and the rehabilitation under 'Ministry of Social Justice and empowerment'. Strong co-ordination is essential between various ministries both at the central and state government to ensure recovery of persons with psychiatric disability.
3. Strong orientation of concepts and methods of rehabilitation in mental health training.
4. Need for research into various dimensions of psychiatric rehabilitation.

Information About the Conference

The National Conference on Research and Services on Psychiatric Rehabilitation was held on the 8th and 9th

March 2014, at the Convention Centre, National Institute of Mental Health and Neurosciences (NIMHANS), Bangalore. This was organized by the Psychiatric Rehabilitation Services (PRS), NIMHANS. This multidisciplinary team consists of psychiatrists, clinical psychologists, psychiatric social workers and nurses. Further, various vocational sections are being manned by vocational instructors. The renewed vision of PRS is manifold. Apart from providing state of the art clinical services, PRS NIMHANS has its vision entrenched in training manpower in the field of psychiatric rehabilitation, conducting research and play various advisory roles in matters related to psychiatric rehabilitation for various governmental and non governmental agencies of the state and the centre. As part of this renewed visionary, many innovative efforts are underway. Regular academic activities at the departmental, regional and national levels are being conducted.

The PRS team planned a national activity considering the need to bring together all stake holders in psychiatric rehabilitation, a program having roles for each of the following was devised: academicians, NGOs, activists, end users, students and practitioners. The basic premise was to get an overview of the varieties of the services available and to get glimpses of the research efforts active across the country. In doing so, we hoped to discuss and draw out future directions in psychiatric rehabilitation.

Accordingly, resource persons who participated are eminent personalities from different disciplines of psychiatry, psychology, and psychiatric social work, president of a Self Help Group, NGOs, private sector professionals and representatives from General Hospital Psychiatric Units. The conference was scheduled for one and a half days and included plenary sessions as well as parallel sessions. In addition to the presentations, there was ample scope for debate and discussion with active involvement of the delegates. In total, 207 delegates participated in the conference and the conference was largely well received.

The organizing committee gratefully acknowledges the following faculty members for their whole hearted participation.

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