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School of Psychiatry and Clinical Neurosciences
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Recovery oriented rehabilitation in Asian Countries : Challenges and opportunities

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Outline of presentation



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- **“Recovery oriented rehabilitation”**
- **Overview of the current status of mental health care and rehabilitation in Asian countries**
- **Challenges and opportunities**
- **What needs to be done?**

Status of psychiatric rehabilitation



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**Mainstream psychiatry
continues to pay
insufficient attention
to psychosocial
interventions and
rehabilitation**

Status of psychiatric rehabilitation



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**For persons with severe mental disorders,
pharmacological treatments
are overemphasized,
all over the world, almost to the
exclusion or neglect of
non-pharmacological
(psychosocial)
interventions and rehabilitation**



Status of psychiatric rehabilitation

**Extensive research on many of
the psychosocial and
rehabilitation interventions
provide
satisfactory evidence for
their benefits**

Assessing the Evidence Base (AEB) series



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Selected interventions include:

- Peer support**
- Permanent supportive housing**
- Supported employment**
- Skill building**
- Patient and family psycho education**

Status of psychiatric rehabilitation



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**Proportion of persons with
severe mental disorders who
use any form of rehabilitation
services in a meaningful
manner is
very low, all over the world
(less than 20%).**

Psychiatric rehabilitation in Asian countries



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**For most, persons with severe mental
disorders:**

**Psychiatric rehabilitation
services are**

- unavailable**
- inaccessible**
- or**
- unaffordable**

Popular notions of psychiatric rehabilitation



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- **“Psychiatric Rehabilitation is primarily a hospital-based practice”**
- **“Psychiatric Rehabilitation begins after all treatments are completed / failed”**
- **“Psychiatric rehabilitation is mainly providing housing and resettlement”**

Popular notions of psychiatric rehabilitation



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- **“Rehabilitation is just development of social and living skills”**
- **“Successful rehabilitation should result in work and gainful employment”**
- **“Rehabilitation should always be community based”**

Popular notions of psychiatric rehabilitation



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What is “best practice” in psychiatric rehabilitation?

**Differences in perceptions
and perspectives, in
different regions of the
world and across time**

Factors which contributed to the development of recovery oriented rehabilitation



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- **“Patient narratives” of lived experiences**
- **“Patients-families” movement**
- **Recovery oriented services**

Recovery: The Lived Experience of Rehabilitation

Patricia E. Deegan

Patricia E. Deegan, Ph.D., is a clinical psychologist who is currently living in a L'Arche community with mentally handicapped adults in Ipswich, Massachusetts.

Abstract: This paper distinguishes between recovery and rehabilitation. Psychiatrically disabled adults do not "get rehabilitated" but rather they recover a new and valued sense of self and of purpose. Through the recovery process they become active and responsible participants in their own rehabilitation project. The experiences of recovery as lived by a psychiatrically disabled man and a psychiatrically disabled woman are discussed. Recommendations for creating rehabilitation environments that facilitate the recovery process are also given.

Recovery from Mental Illness: The Guiding Vision of the Mental Health Service System in the 1990s

Reprinted from *Psychosocial Rehabilitation Journal*,
1993, 16(4), 11–23.

William A. Anthony

■ William A. Anthony, Ph.D., is Executive Director of the Center for Psychiatric Rehabilitation at Boston University.

Recovery from schizophrenia: a challenge for the 21st century

ROBERT PAUL LIBERMAN & ALEX KOPELOWICZ

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Summary

While much professional interest, public advocacy and media attention accompanied the neuroscientific research advances of the Decade of the Brain, much less prominence was accorded to the very considerable progress in psychiatric treatment, rehabilitation and community-based services for persons with schizophrenia. The increasing availability of evidence-based practices and more optimistic views of optimal outcomes possible in schizophrenia are of much practical importance to consumers and practitioners alike. Expectations for substantial improvements in a larger proportion of individuals with schizophrenia than heretofore are emerging on psychiatry's radar screen, especially in symptom control, psychosocial functioning and quality of life. We believe that it is now realistic to set as a goal for professionals and consumers the feasibility of recovery from schizophrenia for half or more of individuals with the first episode of schizophrenia. In this issue of the International Review of Psychiatry, we aim to clarify the rationale for this ambitious clinical objective and stimulate research that will bring it to fruition within a decade. Five domains of advocacy, clinical and empirical work, have converged to bring recovery from schizophrenia to the fore and make it a realistic aim for practitioners and consumers. These include (a) a conceptual framework to guide research and understanding of recovery as a process leading to a defined outcome; (b) new modes of measurement that can permit recovery from schizophrenia to be operationally defined and empirical studies of recovery to proceed; (c) the arrival of a critical mass of evidence-based treatments that can support the progress of consumers to recovery; (d) an emphasis on positive and normative role functioning for treatment and rehabilitation; and (e) empowerment of consumers and their families that has made recovery their personally meaningful goal. The vulnerability-stress-protective factors model of schizophrenia can help researchers to organize data that are heuristic regarding factors that affect recovery or, at the other end of the spectrum, poor outcome. Recovery can be operationally defined by dimensions related to symptom remission and functioning in family, work, friendship, residential and recreational arenas. Considerable evidence-based treatments are available to promote improved functioning of consumers in the domains relevant to recovery. The current state of research on recovery has generated ample hypotheses for planning hypothesis-testing studies and for evaluating quality of care and clinical outcomes that will move the important goal of recovery forward.

RECOVERY – RESHAPING OUR CLINICAL AND SCIENTIFIC RESPONSIBILITIES

Michaela Amering

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SUMMARY

Context: Advocacy for Recovery has been joined by research offering new perspectives on mental health policy, treatment, rehabilitation and anti-discrimination efforts.

Objectives: Chances and challenges of a Recovery model for the mental health field will be presented and discussed.

Key messages: Recovery is currently widely endorsed as a guiding principle of mental health policy. New rules for services, e.g. user involvement and person-centred care, as well as new tools for clinical collaborations, e.g. shared decision making and psychiatric advance directives, are being complemented by new proposals regarding more ethically consistent anti-discrimination and involuntary treatment legislation as well as participatory approaches to evidence-based medicine and policy.

Recovery advocacy has been joined by research on recovery and resilience resulting in new data on the long-term perspectives of people experiencing common as well as severe mental health problems. Definitions of remission and recovery as well as the concept of chronicity are under debate. Research questions regarding recovery as a process as well as an outcome warrant scientific efforts enabling the integration of different perspectives as well as different methodologies.

Conclusions: Consequences and challenges of the Recovery model need to be tackled from different perspectives by clinicians, researchers, policy makers and – essentially - users and carers and their representatives in order to be fully explored and brought to life.

Key words: recovery – evidence base – user involvement - triologue

* * * * *

INTRODUCTION

During the last years important English-speaking countries like USA, UK, Ireland, Australia, New Zealand, and Canada have embraced recovery-orientation as a guiding principle of their mental health

is defined as an outcome and thus differently from the process of being ‘in recovery’ (Davidson & Roe 2007), usually defined around self-determination and a life in the community despite symptoms or illness or disability. Bellack’s suggestion of ‘scientific’ versus consumer models (Silverstein & Bellack 2008) deals with the meas-

Recovery oriented service



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- ‘Recovery’ – now a **significant goal** for mental health policy makers and service providers
- **Rapid increase** in the number of publications, presentations by various stake holders
- Call for **‘transformation’** of mental health services in accordance with recovery oriented care



A national framework for recovery-oriented mental health services

POLICY AND THEORY



Figure 3: The concept of recovery



A Recovery Vision For Rehabilitation

Psychiatric Rehabilitation Policy And Strategic Framework



Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems

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An understanding of recovery as a personal and subjective experience has emerged within mental health systems. This meaning of recovery now underpins mental health policy in many countries. Developing a focus on this type of recovery will involve transformation within mental health systems. Human systems do not easily transform. In this paper, we identify seven mis-uses ("abuses") of the concept of recovery: recovery is the latest model; recovery does not apply to "my" patients; services can make people recover through effective treatment; compulsory detention and treatment aid recovery; a recovery orientation means closing services; recovery is about making people independent and normal; and contributing to society happens only after the person is recovered. We then identify ten empirically-validated interventions which support recovery, by targeting key recovery processes of connectedness, hope, identity, meaning and empowerment (the CHIME framework). The ten interventions are peer support workers, advance directives, wellness recovery action planning, illness management and recovery, REFOCUS, strengths model, recovery colleges or recovery education programs, individual placement and support, supported housing, and mental health dialogues. Finally, three scientific challenges are identified: broadening cultural understandings of recovery, implementing organizational transformation, and promoting citizenship.

Key words: Recovery, mental health services, peer support workers, advance directives, wellness recovery action planning, individual placement and support, supported housing, mental health dialogues, organizational transformation, promoting citizenship

(*World Psychiatry* 2014;13:12–20)

Understanding recovery as a return to symptom-free normality has been challenged in mental health services. People

ABUSE 1. RECOVERY IS THE LATEST MODEL

Controversies in the understanding of 'recovery'



- Two broad ways of understanding recovery:
 - Recovery as an **'outcome'**
(acceptable to **family groups, service providers**)
 - Recovery as a **'process'**
(acceptable to **patients / consumers / survivors / ex-patients**)

Treatment goals and **outcome measures:**



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- **Clinical symptoms**
- **Disability**
- **Social functioning / Global functioning**
- **‘Quality of Life’ (QoL)**
- **Satisfaction with care / services**
- **Social inclusion**

Traditional models of mental health service delivery:



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- Based on the ***medical model***
- Emphasis on ***psychopathology***
- Focus on ***symptom management***
- ***Clinician-driven***

Recovery oriented mental health services



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- Focus on ***functional improvement***
- Goal of ***“wellness”***
- ***Consumer / Care giver-driven***
- Attempts to provide ***hope and empowerment***, reduce ***stigma*** and show ***respect***



Numerous definitions of 'recovery'

**'Recovery': Regaining a role
in society and living with a
chronic illness despite a
certain level of symptoms**

Anthony; 1999, Jacobson; 2001



- **Paths to recovery – multiple**
(Lieberman et al 2008)
- **May proceed along multiple domains:**
 - **Symptoms**
 - **Cognitive abilities**
 - **Independent living**
 - **Employment**
 - **Relationships**

Factors associated with good recovery



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(Kopelowicz et al 2005, Liberman et al 2002, Silverstein and Bellack 2008)

- **Supportive family or other care givers**
- **Absence of substance use**
- **Shorter duration of untreated illness**
- **Good initial response to medications**
- **Adherence to treatment**
- **Good pre morbid history**
- **Access to comprehensive, coordinated and continuous services**

Challenges to effective “recovery oriented rehabilitation”



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- Access to appropriate **accommodation**
- Access to **employment**
- Successful integration in the community and **social inclusion**
- **“Recovery”**



Challenges and opportunities for psychiatric rehabilitation in Asian Countries

Asian countries



- **Considerable heterogeneity between and within various Asian countries**
- **Shared history of colonial past**
- **Continuing wide spread poverty and growing income inequality (GINI coefficient) in many countries**

Asian countries



- Ongoing rapid social change, effects of ‘globalization’ – positive as well as negative
- Variety of paradoxes and contradictions
- Fluctuating status of peace and conflict / violence, within and between countries
- Frequent occurrence of natural and man-made disasters
- **Growing private sector in health and mental health care**

Psychiatric rehabilitation in Asian countries: **Challenges**



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- Mental health services continue to be predominantly **mental hospital-based**
- **Poor priority** and low allocation for health care, in general and mental health services, in particular
- **Double burden** of communicable diseases and non communicable disorders
- **Grossly inadequate financial and human resources** to deal with the growing morbidity

Psychiatric rehabilitation in Asian countries: **Challenges**



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- **Chronic long-stay** in patients in mental hospitals
- **Human rights violation** of various types, both in institutions and in the community
- Draconian forms of **restraint**
- **Unscrupulous interventions** by certain healers
- **Homelessness** and wandering

Psychiatric rehabilitation in Asian countries: **Challenges**



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***“In Asian countries,
the call to close mental
hospitals is neither
realistic nor desirable”***

**Chin-Yuan Lin et al, International
Journal of Mental Health Systems
2009, 3,1**

Psychiatric rehabilitation in Asian countries: **Challenges**



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- No **‘mental health team’ approach**, in most parts of the region
- Absence of any **social security / disability pension / insurance**, in most countries

Psychiatric rehabilitation in Asian countries: **Opportunities**



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- Gradually moving away from large custodial institutions **to general hospitals, primary health care and the community**
- Greater involvement of community and **civil society organizations (NGOs)**
- **Deinstitutionalization and reforms** occurring at vastly varying paces, in different countries and in different regions within countries

Psychiatric rehabilitation in Asian countries: **Opportunities**



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- Large number of patients are cared for by **families, extended families and other care providers**
- **Important role of family / social structures in care**



Psychiatric rehabilitation in Asian countries: Opportunities

**Better outcome (?) in severe
mental disorders such as
schizophrenia, compared to
developed countries**

(WHO, IPSS, DOSMD Studies)



Psychiatric rehabilitation in Asian countries: **Opportunities**

- **Traditional and alternative services** for mental health care are very popular

Is the concept of “recovery” generalizable across cultures and countries?



- “Recovery” in **collectivist** and **individualist** value paradigms
- Assumptions embedded in the concept of “recovery” may be “mono cultural” (Slade et 2012)
- **Need for development of culturally appropriate and applicable “recovery” concepts**

Culture, control and family involvement:



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A comparison of psychosocial rehabilitation in India and the United States (Stanhope 2002)

Do cultural beliefs and practices impact the recovery of people with psychiatric disabilities?

Psychiatric rehabilitation in Asian countries: **Challenges**



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- **Poor coordination** between different sectors (public, private, NGOs, other government agencies)
- **Wide variations in availability of rehabilitation services** across countries and within countries



What needs to be done?

What needs to be done?



- Rehabilitation must **begin concurrently with pharmacological treatment**
- The traditional distinction between “treatment” and “rehabilitation” must cease.
- ***“Pharmacotherapy and rehabilitation are inseparable. They are two sides of the same coin”*** (Lieberman 2006)

What needs to be done?

Consumer and family psycho education



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- **Despite evidence of effectiveness, not adequately offered in routine care**
- **Families want better communication with care providers and more information about the illness**

Consumer and family psycho education



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- **Reduces relapse rates, re-hospitalization**
- **Reduces family burden**
- **Improves patients' and family's functioning and quality of life**
- **No specific approach better than another**
- **Goals: Provide full understanding of the illness, help families to cope with mental illness and train them for appropriate care giving roles**

What needs to be done?

Consumer and family psycho education



- Pragmatic **patient and family educational interventions** at all mental health care settings
- Development of **effective educational modules** in various local language
- User friendly **manuals for families** should be developed and widely disseminated.

What needs to be done?

Consumer and family psycho education



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- **Associations of families** of the mentally ill, in every country / state / region
- **Governmental support** (financial) for formation and sustenance of family groups / associations
- Support from pharmaceutical and other industries, Foundations

What needs to be done?

Peer support:



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**Role and need for “peer”
involvement and “peer
support” services**



What needs to be done?

Involvement of NGOs:

- Strengthening of and **Governmental support for NGOs**
- Recognition that NGOs could deliver some mental health services more **efficiently or more effectively** than the government or the private sector

What needs to be done?

Training:



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Vast proportion of mental health professionals have little or no understanding / training / interest in rehabilitation.

Provide more exposure and training opportunities.



What needs to be done?

Research:

- **Research - “what works for whom and how”**
- **Increased support for research and training in rehabilitation**

What needs to be done?

Legislation:



- **Harmonization of laws and regulations** governing various aspects of rehabilitation
- Better co-ordination and partnerships between **governmental agencies and NGOs**



What needs to be done?

- Individualization of management (assessment, treatment and rehabilitation).
No “One size fits all”
- Each patient must be assessed as an individual for his/her assets, deficits, aspirations and evidence-based intervention should be **carefully selected and suitably adapted** (if necessary) **for each individual**

What needs to be done?

Political action:



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“What credibility and what societal relevance do we have as a profession, if we disseminate the evidence in scientific journals but do not care about the political action required to implement it?”

**“The political mission of psychiatry”
Priebe S, World Psychiatry 14: 1-2, 2015**



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