Efficacy of psychosocial rehabilitation program: The RFS experience

Rupasri Chowdur, Ramaprasad Dharitri, S. Kalyanasundaram, Suryanarayana Rao N.
The Richmond Fellowship Post-Graduate College for Psychosocial Rehabilitation, Ashok Nagar, Banashankari I Stage, Bangalore – 560 050, India

ABSTRACT

Background: People with severe and persistent mental illness need help in most aspects of their lives, as the disability associated with these diseases can be debilitating. Psychosocial rehabilitation interventions aim to help them relearn skills that would reduce disabilities so that they can be reintegrated into society.

Objective: To study the efficacy of the rehabilitation program at the Richmond Fellowship Society (RFS) ‘ASHA’ half-way home.

Subjects: Fifty-four clients diagnosed with either schizophrenia or affective disorder who stayed at the half-way home for more than 6 months.

Materials and Methods: A retrospective evaluative approach was followed. An evaluation checklist was developed for the purpose and this was used to assess the level of functioning of the clients. A paired sample t-test was used to score changes in client progress between admission and discharge.

Results: Significant improvement ($P \leq 0.05$ level) was noticed on all the parameters from baseline to discharge.

Conclusion: The psychosocial rehabilitation program at the RFS half-way home has a beneficial effect.

Key words: Half-way home, psychosocial rehabilitation

INTRODUCTION

People with severe and persistent mental illness need help in most aspects of their lives, as the disability due to chronic mental illness can be debilitating. Persons with psychiatric disability experience problems in their living, working, learning, and social environments. They have needs related to psychiatric treatment compliance, enhancing the skills of daily living, socialization, vocational training, and meaningful employment. Psychosocial rehabilitation interventions aim to help them learn or relearn skills that would improve their long-term capabilities so that they can reintegrate into society.

While outcome research in psychosocial rehabilitation is a relatively new initiative in mental health research, there is growing evidence that it has a positive impact on the lives of people with serious and persistent mental illness. After reviewing 35 studies Dion and Anthony [1] reported that psychosocial rehabilitation interventions have a positive impact on skill development, employment, and the amount of time spent in the community. Participation in psychosocial rehabilitation has been found to increase the level of independent living. [2]

Many outcome researches have documented a positive impact of psychosocial rehabilitation efforts on the level of functioning of persons with severe and persistent mental illness like schizophrenia and affective disorder. [3-5]
Training programs have an impact on psychiatrically disabled persons’ skills in a variety of areas, including personal hygiene, activities of daily living, physical fitness, use of public transport, interpersonal skills, self-control skills, family relations, money management, and job seeking and job adjustment skills.\[^{6,7}\]

The present study is an evaluative study of rehabilitation outcome carried out at the half-way home run by the Richmond Fellowship Society (India) at Bangalore.

**MATERIALS AND METHODS**

**Objective**

To study the efficacy of the psychosocial rehabilitation program offered at the RFS half-way home.

**Methodology**

A retrospective approach was adopted. Case files of 54 clients with a diagnosis of either schizophrenia or bipolar affective disorder, who fulfilled the inclusion criteria of a minimum of 6 months of stay at the half-way home and more than 2 years of illness, were reviewed.

**About the facility and program**

RFS ‘ASHA’ is a half-way home that offers psychosocial rehabilitation facilities for persons between the ages of 18–50 years who have schizophrenia or bipolar affective disorder. Admission is voluntary. RFS follows the therapeutic community approach, with its principles of democratization, permissiveness, reality confrontation, and communalism. The center offers a structured program and varied therapeutic interventions. The ‘residents’ are required to follow a structured routine. Clients, on admission to the rehabilitation center, have recovered from the acute phase of the illness and are free from active symptoms. They generally present with negative symptoms, poor skills of daily living, poor social skills, inadequate medical compliance, inappropriate social behavior, and inability to follow a structured routine; their families report difficulty in managing them at home.

The interventions include skills training in the activities of daily living (ADL), social skills training, individual counseling, group therapy, community meetings, art work, planned recreation, physical exercises (yoga), training in managing money and budgeting, medical compliance strategies, inculcation of a work habit, family therapy, and psychoeducation. Skills training is carried out using the learning principles of shaping, chaining, modeling, role plays, demonstrations, and instructions in groups as well as at the individual level when required. Social skills training are in the areas of communication skills, anger management, assertiveness skills, coping with stress, conflict resolution, etc. In the community meetings, we address day-to-day issues and hassles, leadership issues, assigning of responsibility, interpersonal conflicts in the community, etc. Staff members closely monitor the progress of each resident. Individual creative talent and skills are encouraged. A structured routine is followed at the center. Training in the skills of ADL and self-care is a part of this. Social skills training, group therapy, community meetings, and the skills of budgeting and money management are conducted once a week in 60-75 minute sessions. Individual counseling sessions are conducted once a week or once in 2 weeks, depending on the requirement, with each session lasting 30–40 minutes. Group therapy sessions focus on motivation enhancement, interpersonal and family relationship, emotional issues and concerns, and planning for the future. Educational programs are held on various topics: e.g., mental illness, importance of health and hygiene, nutrition, dental care, etc. Some of the common issues addressed in the individual sessions are personal concerns, issues about family, future plans, vocational guidance, emotional issues (especially hostility), social behavior, habits and beliefs, medical compliance, and other issues brought up in the group sessions but which the residents are unwilling to share and discuss in the group.

In addition, we lay stress on psychoeducation and developing medication compliance among the residents. All residents are encouraged to attend the vocational training center run by the same organization. The staff members also help residents to take up suitable part-time employment or voluntary work.

Family intervention is an integral part of the rehabilitation program offered at the center. The family of each resident is expected to attend the family therapy session once in 3 months and stay within the premises at least for 2–3 days. During this period they participate in the activities of the community and interact with the members. They observe and learn from staff members and notice the improvement achieved by the resident. The therapy sessions for the family members consist of psycho-education, identifying problem areas and stressors and addressing them, developing skills for problem-solving and coping with the stress of caring, crisis management, dealing with unrealistic expectations, planning for the future of the resident in collaboration with the resident, and addressing interpersonal and emotional issues. Family education and counseling sessions are held once in three months. These sessions comprise psycho-education, coping with stress and dealing with the behavior of the client, communication skills, planning for the client’s future, and any other issue the family brings up. This facilitates the reintegration of the residents back into the families with greater comfort and ease.

**Tools**

*Socio-demographic information form*

Evaluation checklist: An assessment checklist of questions was prepared. Each item was required to be rated on a
5-point scale. The checklist was circulated amongst the RFS professional staff for consensus on the items included. Some modification and additional items were suggested. Incorporating these suggestions, a final tool for evaluation was prepared. Before the start of the study, an inter-rater reliability exercise was conducted by involving the staff working in the three different centers of the Fellowship (viz., half-way home, long-stay home, and the day-care center). This was done by asking seven professionals to score five case files each independently, using the information available about the client’s functioning at the time of admission and at the time of discharge. The results indicated an alpha score of 0.95, suggesting high inter-rater reliability. The checklist covered 10 domains: self-care, following a routine, interpersonal relations, participation in community activities and leisure activities, communication, vocational activities, family relationship, general behavior, money management, and getting around.

After the inter-rater reliability was adequately established, the final scoring of the case files for the retrospective study was undertaken.

Data collection
Sociodemographic details were gathered from the files. The case files were evaluated on the evaluation checklist (mentioned above) using the information documented in the files at the time of admission and at the time of discharge. Thus, each subject had two sets of scores. A paired sample t-test was done to assess the changes in the residents between admission and discharge. Raters participating in the reliability exercise were blind to the pre- and post-rating status of the client. The raters were postgraduates in social work or psychology, with a minimum of 4 months of experience working with mentally ill persons in the day-care center. The final scoring was done by the investigator who was completely unaware of the client status and identity.

RESULTS

The sociodemographic profile revealed that the majority in the group fell within the age range of 24–31 years. Male residents outnumbered (74%) female residents (26%). Most of the subjects were graduates (60%). While 78% of the sample was unmarried, 18% were either separated or divorced, 2% were currently married, and 2% were widowed. The average duration of illness was 10 years, and the average duration of stay at the half-way home was 11 months. Most of them were diagnosed as having schizophrenia (89%) and 7% and 4% were diagnosed as having schizoaffective disorder and bipolar affective disorder, respectively.

Table 1 shows comparison of scores in the 10 areas evaluated at the time of admission and at the time of discharge. On all parameters, a statistically significant (P<.05) improvement could be demonstrated. This suggests that the psychosocial rehabilitation program has a beneficial impact on the level of functioning of persons with chronic and persistent mental illness.

DISCUSSION

Living in a supportive community offering planned therapeutic programs appears to facilitate the recovery of persons with chronic and persistent mental illness. The therapeutic community process, by itself, functions as the agent of change and progress. Several training programs have been found to have an impact on psychiatrically disabled persons’ skills in a variety of areas, including personal hygiene, cooking, use of public transportation, use of recreational facilities, physical fitness, interpersonal skills, self-control skills, job interview skills, family relationships, money management, job seeking, and work adjustment.[6–10]

Though the study reveals an overall positive impact on different areas of functioning, it does not reveal the specific effects of various components of the rehabilitation program and the interaction of those components with client characteristics and phase of illness. As Barton[11] has stated, outcome research has not yet sufficiently developed to determine these effects. Since all these components interact with each other and/or complement one another, it would be difficult to say how each of the items would

| Table 1: Comparison of scores in the areas of psychosocial rehabilitation at admission and discharge |
|---------------------------------------------------|----------|-----------------|--------------|-------|--------|
| Paired samples | Areas                             | Mean difference | Std. Error of Mean | t (Paired) | df    | P value |
|----------------|-----------------------------------|-----------------|-------------------|----------|-------|---------|
| Pair 1         | Communication                     | 1.5             | 0.24              | 6.35     | 53    | 0.001   | Sig     |
| Pair 2         | Family relations                  | 1.5             | 0.19              | 7.8      | 53    | 0.001   | Sig     |
| Pair 3         | General behaviour                 | 1.4             | 0.12              | 11.80    | 53    | 0.001   | Sig     |
| Pair 4         | Interpersonal relations           | 4.6             | 0.29              | 16.10    | 53    | 0.001   | Sig     |
| Pair 5         | Participation in community activities and leisure activities | 2.1             | 0.15              | 14.50    | 53    | 0.001   | Sig     |
| Pair 6         | Maintaining routine               | 1.4             | 7.55              | 17.91    | 53    | 0.001   | Sig     |
| Pair 7         | Self care                         | 3.4             | 0.27              | 12.55    | 53    | 0.001   | Sig     |
| Pair 8         | Vocational activities             | 0.4             | 0.56              | 11.38    | 53    | 0.001   | Sig     |
| Pair 9         | Money management                  | 0.9             | 0.12              | 7.40     | 53    | 0.001   | Sig     |
| Pair 10        | Getting around                    | 2.3             | 6.81              | 4.35     | 53    | 0.001   | Sig     |
| Pair 11        | Total                             | 126.6           | 32.37             | 3.91     | 9     | 0.001   | Sig     |
have impacted independently. In rehabilitation settings it is difficult to isolate each component to study its effect. Needless to say, rehabilitation program should be seen as an intervention package for the overall benefit of persons with chronic mental illness.

CONCLUSION

Persons with psychiatric disabilities who need support for their recovery benefit from an adequately designed rehabilitation program. When families find it difficult to implement these strategies, residential programs can help them to get their loved one back into their fold. Families also benefit from such an intervention as it reduces their burden of caring for the patient.

This was a retrospective evaluation study and it therefore has limitation in terms of the lack of a planned evaluation strategy, gaps in information and documentation, and the possible bias related to the staff subjectivity in the rating. However, such studies can provide guidelines for future research. A prospective study would perhaps provide more specific answers. A follow-up study would help us understand the long-term effect of such a rehabilitation program.

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