EDITORIAL

LEARNING FROM OTHERS' MISTAKES

One often hears the lament that medical care in India lags behind that of developed countries. At times, however, one cannot help but feel that in some ways this is a blessing in disguise, because by the time a particular method of treatment gets accepted and adopted in India, we also have knowledge of its various shortcomings. If such information is appropriately made use of, it should enable us to plan and implement a better program than the pioneers of the field. This advantage by default is often encountered in the field of mental health as well.

We have come to accept the fact that despite the advances in psychopharmacology and psychosocial methods of treatment, there are many with mental illness who cannot be helped to achieve a cure, and therefore require long-term care and rehabilitative measures. The recognition of the adverse effects of chronic institutionalization resulted in the shift of the focus of care from the hospital to the community. Reducing the number of long-stay patients in the hospital became the primary goal of clinicians and hospital administrators all over the world, including India. Many took pride in the fact that the number of inpatients in the hospital had been drastically reduced over the years. Soon, however, it was realized that shifting the chronically mentally ill from the back wards to the back alleys was not necessarily a progressive step.

The decline in the number of long-term residents resulted in the closure of many mental hospitals in the West, a move which was enthusiastically pursued by politicians and bureaucrats, not always motivated by concern for the mentally ill, but by the hope that such a measure might save money (Kendell, 1989). Decades ago when State hospitals were established in the outskirts of cities, possibly reflecting society’s attitude towards the mentally ill, they were surrounded by acres of undeveloped land. Soon cities grew around the hospitals, making the hospital grounds valuable real estate. This led to attempts to shift or close down the hospitals in certain cities in the West. Often the Government’s promise to provide a ‘World-class alternative system of Mental Health Care’ remained only on paper. It is a pity that some hospitals in India too, face such a prospect. Such moves also reflect public prejudice and hostility towards the mentally ill as being "dirty, dangerous, unpredictable and worthless", who should be tucked away on the principle of ‘out of sight is out of mind’.

A major drawback of overenthusiastic de-institutionalization was that the provision for alternative care was often inadequate and occasionally non-existent for the large number of patients who were discharged into the community. It was then learnt that mere relocation is not rehabilitation. De-institutionalization can be successful only if community services are adequate (Bachrach & Lamb, 1989). It was also realized that community care does not completely exclude the need for an "asylum" for a residue of the long-stay patient population (Wing, 1990), that it is not cheaper, and that to be effective such care needs the creation of complex and administrative and financial structure.

The goals of psychiatric rehabilitation should include sustaining symptomatic improvement through medication and supportive psychotherapy; re-establishing full independent living skills and interpersonal supports through skills training; cognitive re-training; family psycho-education, peer support, and helping the individual achieve access to resources such as financial entitlement and rehabilitation. Evaluation of community care programs in the West have shown that many needs of patients in areas of social activities, occupational therapy, domestic skills, psychotherapy and counselling for relatives etc., are unmet by many of these programs (Salokangas et al, 1991).

Experience in the West has shown that what is important is continuity of care for the discharged patients, ensuring an adequately stimulating environment in the community and also provision for admission to hospital for brief periods when necessary. It is equally true that the same prescription of rehabilitation is not beneficial for all chronically ill patients, but must be tailored to local conditions to suit an individual patient’s needs. Dependent and independent patients differ in their response to a stimulating environment. More independent ones benefit whereas dependent patients became more withdrawn, probably as a consequence of demands which put too much pressure on them.

Studies on new long-stay patients have shown that accumulation of patients with protracted hospital stay is still an issue to be reckoned with despite
the continued bed closures and care in the community (Lelliott et al., 1994). Among the new long-stay patients themselves, two subgroups can be identified - a younger group of predominantly single men with schizophrenia, with a history of serious violence and dangerous behavior and an older group of predominantly married or previously married women, with poor personal and social functioning and with a high risk of deliberate self harm. These findings again underline the heterogeneity of the chronic patient group and the need for different strategies in the rehabilitation of each group.

Crepet's (1990) observation that available community facilities get used by the less ill but more neurotic patients, thus depriving the more ill and withdrawn patients of such facilities is also a fact to be borne in mind while formulating rehabilitation programs. Though some Indian studies have pointed out that provision of residential facilities may not be a matter of high priority for the chronic mentally ill in India, every clinician comes across at least a small group of patients who need such residential care, away from their homes. Here again the negative experience of Western programs should guide us to avoid such pitfalls. Group accommodation for the chronically ill is often located in dilapidated and deteriorated areas of cities where facilities for social/recreational activities are the least and the patient's only social contacts are other patients themselves; a high prevalence drug and alcohol abuse and assortative mating leading to new emotional conflicts.

Recent studies have shown that psychotic symptoms in the chronically ill can be treated with techniques such as Coping Strategy Enhancement (Tarrier et al., 1990) and Cognitive Behavior Therapy (Chadwick & Lowe, 1990). At the same time one has to be aware of the potential danger of such efforts prolonging hope in patients and their carers thereby delaying acceptance of and adaptation to persistent disability. Work is of central importance in the maintenance of social functioning for people with serious long term mental illnesses but surprisingly little attention is paid to this even by rehabilitation programs in the West (Shepherd, 1991). Its central importance in our context has been pointed out by authors like Nagaswamy et al. (1985).

The article by Gopinath and Kiran Rao in this issue provides a comprehensive review of the current status of psychiatric rehabilitation and draws our attention to the social problems and needs in the Indian context. Rehabilitation psychiatry is still at its infancy in India. In the recent years there have been some laudable efforts in this area by voluntary organizations like SCARF, Richmond Fellowship etc. The commencement of a Rehabilitation Specialty section by Indian Psychiatric Society is yet another sign of our growing interest in this field. Let us hope that these developments will inspire more individuals and organizations to get involved in this hitherto neglected area and that the experiences of colleagues in the West will help us not only to follow their right steps but also to avoid their mistakes.

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