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# Recovery facilitation services in a mental health setting: the Institute of Mental Health and Neurosciences (IMHANS) model

**Abstract**

Chronic psychiatric illnesses cause disability. The language of recovery is now widely used globally in mental health policy, services, and research. This concept of recovery is relatively new to Indian mental health settings. The Recovery Facilitation Services initiated at the Institute of Mental Health and Neurosciences (IMHANS), Kozhikode (Calicut), Kerala, South India, follows a framework for service delivery based on sound principles of psychosocial rehabilitation. This paper elaborates on the rationale, the design, financial aspects, challenges encountered, and general observations regarding the effectiveness of the working of this service.

**Keywords:** Rehabilitation. Mental illness. Family. Psychiatric disability.

**Shibukumar TM[1], Juna B[2], Tintu T Babu[3], Reshma T[4], Aparna Rathnakaran[5], Ragesh G[6], Mohammed Ibrahim Khaleel[7], Seema P Uthaman[8], Jobin Tom[9]**

*[1]Department of Psychiatry, Government Medical College, Alappuzha, Kerala, India, [2]Department of Psychiatry, Government Medical College, Kozhikode, Kerala, India, [3]Department of Social Work, St. Joseph's College (autonomous), Devagiri, Calicut, Kerala, India, [4]The Recovery Facilitation Project, Department of Psychiatric Social Work, Institute of Mental Health and Neurosciences (IMHANS), Kozhikode, Kerala, India, [5]Institute of Mental Health and Neurosciences (IMHANS), Kozhikode, Kerala, India, [6]Department of Psychiatric Social Work, Institute of Mental Health and Neurosciences (IMHANS), Kozhikode, Kerala, India, [7]Government General Hospital, Kozhikode, Kerala, India, [8]Department of Psychiatric Social Work, Institute of Mental Health and Neurosciences (IMHANS), Kozhikode, Kerala, India, [9]Department of Psychiatric Social Work, Institute of Mental Health and Neurosciences (IMHANS), Kozhikode, Kerala, India*

**Correspondence:** Ragesh G, M Phil (Psychiatric Social Work), Ph D, Psychiatric Social Worker, Department of Psychiatric Social Work, Institute of Mental Health and Neurosciences (IMHANS), Government Medical College Campus, Kozhikode, Kerala, India-673008.
rageshpsw@gmail.com

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## INTRODUCTION

Chronic psychiatric illnesses cause significant disability among adults. Recovery is the active process by which the individual overcomes the limitations caused by the illness and proceeds to reclaim the desired life by setting one's life goals and striving to achieve them. Many evidence-based interventions are available with proven efficacy in addressing different aspects of psychiatric disability.[1-3] The Recovery Facilitation Service (RFS) at the Institute of Mental Health and Neurosciences (IMHANS), Kozhikode (Calicut), Kerala, South India, follows a framework for service delivery based on sound principles of psychosocial rehabilitation.[4] This

paper elaborates on the rationale, the design, financial aspects, challenges encountered, and general observations regarding the effectiveness of the working of this service unit.

## RATIONALE

The concept of recovery has emerged as a significant paradigm in the field of mental health services and it is relatively new to Indian mental health settings.[5-7] Recovery is the process of changing a person's attitudes, values, feelings, goals, and skills to live a satisfying life or enhancing the quality of life within the limitations caused by psychiatric illness.[8,9] Recovery is considered a journey taken by the person with mental illness rather than something done to him/her. It is assumed that professionals can facilitate recovery with carefully planned interventions. Others can assist the person in her/his recovery journey.

The disability caused by severe mental illnesses affects different domains of functioning, including personal care, other instrumental activities of daily living, communication and social interaction, work, education, and social and role functions. There are different ways in which severe mental illnesses produce these disabilities. These include inadequate control of symptoms, especially symptoms related to cognitive functions and negative symptoms; side effects of medications; effects of opportunities lost during the more active phases of the illness; restrictions due to social stigma; and internalised stigma and hopelessness.

The degree and pattern of disability in psychiatric illnesses vary widely across patients. These are influenced by sociodemographic characteristics of the individual, premorbid intellectual and personality functioning, type and duration of the disease, predominant symptoms, treatment received, degree of symptom control, attitude toward the illness and treatment, patient's understanding of the illness, available support system, societal attitudes the patient faces, etc. Many existing rehabilitation services, especially in India, have given scant attention to this fact. What is done mostly is to develop a service based on the resources available to the agency and try to fit all the patients into this. Such an approach is unlikely to provide the levels of recovery acceptable and possible for most patients.

However disabled they are, every individual will have their abilities and strengths. Recognising and mobilising these strengths is vital in every effort to assist individuals to overcome their weaknesses and limitations. Therefore, when the patient's disabilities are being addressed, their unique abilities need to be nurtured.

Recovering from disability requires continuous efforts on the part of the patient. To persist with the continuing struggle in the face of umpteen numbers of challenges that are characteristic of psychiatric illnesses requires great degrees of motivation. Perceived meaning and hope are the two most critical psychological variables in maintaining motivation. To find meaning in one's efforts, the individual needs to have personally meaningful life goals and reasonable hope of achieving them. Only a particular individual will decide on what is a meaningful goal for her/him. So it is crucial to let the individual decide on one's recovery goals.

It is very likely that in the case of a typical person with severe mental illness, the negative life experiences in the context of her/his illness and the negative messages received from the social environment have made the person demoralised and hopeless. Providing hope and assisting to develop an optimistic attitude is therefore crucial. The level of evidence available for psychosocial and rehabilitation interventions vary. Therefore, when using a combination of interventions for a particular patient, the level of evidence available for each component needs to be considered.

To summarise, the rationale for this project is the assumption that it is possible to facilitate the process of recovery of individuals with severe mental illnesses by a carefully designed intervention programme. Such a programme needs to be comprehensive, individualised, patient-directed, evidence-informed, and emphasises strengths, hope, and meaning.

## INITIATION OF THE PROJECT

RFS was initiated in February 2018 for facilitating the recovery of adults with severe and chronic mental illness through skills training and other therapeutic interventions on a daycare basis. This was started as a project with financial support from the Department of Social Justice and Empowerment, Government of Kerala. The outline of the project was developed by discussion among clinical team members of the institute, including psychiatrists, psychiatric social workers, clinical psychologists, psychiatric nurses, occupational therapists, and vocational trainers. A memorandum of understanding was signed between IMHANS and the state Department of Social Justice.

## DESIGN OF THE SERVICES

### Staff pattern

RFS is run by a multidisciplinary team of mental health professionals (psychiatrist, psychiatric social worker, clinical psychologist, occupational therapist, psychiatric nurses, placement officer with post-graduation in social work and vocational trainer). Staff recruitment was made by following routine procedures for recruitment at the institute.

### Physical infrastructure for the service

A separate protected space was made available at the institute for the activities of RFS. It included one big hall measuring about 400 square feet, two small rooms of about 50 square feet each, and a waiting area. Other facilities available in the building were used as and when available for conducting awareness classes and exercise activities. Furniture, registers, items to aid vocational training, etc. were obtained either using the fund provided by the government or mobilised as voluntary contributions.

### Criteria for selection of beneficiaries

Criteria for the selection of beneficiaries were decided by discussion among team members. The criteria thus arrived at were as follows:

- A person with severe and chronic mental illness aged between 18 and 55 years.

- A person using tobacco and occasional alcohol use will be included in the services but the person with an alcohol or other substance dependence syndrome will be excluded.
- An individual with severe mental illness (ISMI) can walk-in or may be referred by any mental health professionals from the institute as well as outside.

## Identification of beneficiaries

Beneficiaries were either identified among the patients attending the adult psychiatry services at IMHANS or referred from other psychiatry facilities in the same or nearby districts. For facilitating referral, the publicity was given in various ways such as individually informing mental health professionals, posting messages in social media groups, newspaper, etc. Some patients were brought by family members when they found the information on social media or newspaper.

## The initial assessment

Once a patient is referred to RFS for the first time, he or she is screened by a psychiatric social worker. If the ISMI is found to be suitable for RFS, he/she will be assessed along with his/her family members to understand personal goals and readiness for change irrespective of the degree of psychopathology, occupational and rehabilitation history. If he/she is found to be fit, they will be registered for the service.

Once the registration is over, the ISMI undergoes a structured assessment using the Brief Neuropsychological Cognitive Examination (BNCE),[10] the Stages of Recovery Instrument (STORI-30),[11] the Social Occupational Functioning Scale (SOFS),[12] the World Health Organization (WHO) Well Being Index,[13] the Model of Human Occupation Screening Tool (MOHOST),[14] and tool to assess social skills (prepared by the authors). On average, individual assessment, which includes sociodemographic details, past history, work history, and social skill assessment, requires a two-day minimum and a maximum of four sessions, and for family assessment, it takes a minimum of two days. A brief family assessment is also done during the initial period. The ability to work and activities of daily living (ADL) is also assessed.

## Care planning

After the initial formal evaluations are completed, the case is discussed in the care planning sessions attended by all team members. In this discussion, an individual care plan is formulated for each patient. The care plan includes interventions offered individually as well as in a group. A range of 60-90 sessions is needed to provide the services. Families have engaged actively, incorporating them as co-therapists whenever indicated. When family pathology requiring specific intervention is identified as an obstacle for recovery, such families are referred to the family therapy unit at the institute.

## Individual interventions

- Psychoeducation
- Monitoring of daily living activities
- Recovery counselling
- Neuropsychological assessment and cognitive retraining
- Psychotherapies
- Occupational therapy
- Vocational training
- Pre-vocational and vocational evaluation
- Preparing for job and job placement
- Physical exercise
- Periodic physical health checkups.

## Group interventions

Many of the interventions, especially skills training activities are better done in group sessions. Some group activities are meant for very specific purposes such as building some specific skill, whereas sometimes group activities are conducted to serve multiple purposes. Particular group sessions may focus on one or more of the following:

- Social skills training
- Cognitive retraining
- Recovery counselling
- Psychoeducation
- Resume preparation training
- Independent living skills training
- Conflict resolution/problem-solving skills training
- Interview attending skills training
- Debates based on current affairs to enhance their general knowledge
- Discussion on a healthy diet.

## Family interventions

The involvement of the family is very important in the process of recovery.[15,16] At least one family member was asked to be in contact with the treating team. They were encouraged to attend all the activities along with the ISMI for their learning. All the family members were given minimum services such as

- Family psychoeducation
- Monthly review with family members to evaluate the changes
- Home visits (if required)

## Vocational training facilities

All the ISMI were encouraged to involve in the vocational training conducted. They were trained in making eco-friendly products. Many products were sold out within the campus itself.

- Paper pen
- Paper file
- Cloth bag
- Medicine cover
- Jewelry making (bangles, bracelets, chain, anklets)
- Wine bottle decoration.

Some ISMI were encouraged to assist receptionists in the reception of the hospital, which helped them enhance their social skills. They were paid incentives for their contributions. The placement officer visits or calls the potential employers to motivate to recruit RFS service users. Once the placement is done, the placement officer visits the employer and patient at fixed intervals of time, and checks the patient's current

mental status and occupational functioning. Gradually, the frequency of visits may be reduced, and follow-up will be done over the phone. This will help the patient to live with minimal professional support.

### Other activities

The RFS team could network with various organisations in supporting the ISMI such as banks, clubs, non-governmental organisations (NGOs), etc. All the ISMI were provided a one-time meal and two times snacks to maintain their health. Along with the other activities, they were taken for outing, movie, and picnics.

## OUTCOMES

So far, 155 ISMI were registered from February 2018 to November 2019 based on the criteria. The majority (65%) are males, and predominantly (59%) are diagnosed with non-affective psychosis. Around five per cent were dropped out after the initial assessment due to various reasons such as long distance travelling, poor motivation, psychotic symptoms, stigma, etc. Around 35 (23%) are attending on a daily basis, 25 (16%) were terminated successfully after their recovery, 17 (11%) were placed in different jobs (tea shop, clerical works, accountant, receptionist, in motor workshop, salesman in textile shop, in patrol pump, information technology industries, one person received government job also) and others are attending the services on a need-based. RFS provides free of cost services on individual, group, and family levels. A formal assessment of the project outcomes is yet to be made.

## CHALLENGES

Various challenges are faced by the team, namely administrative and clinical which are significant in the service delivery.

### Administrative challenges

- Budget: Getting an adequate budget to run the facility is always a challenge.
- Finding motivated professionals to staff, and limiting staff turnover is difficult.
- Identifying prospective employers to place the ISMI is a major challenge.

### Clinical challenges

- Motivating patients to attend regularly, especially in the initial period.
- Varying levels of capabilities become a challenge when doing group activities.
- The tendency of some patients to fall back into previous dysfunctional patterns of behaviour and lifestyle, when patients are not availing the services for a few days continuously.

## CONCLUSION

The concept of recovery is now widely used in mental health-related literature, policy, services, and research. Yet the term has disparate antecedents and is used in a variety of ways.[17,18] Recovery involves growth across the developmental dimensions and this growth can be represented by phases and turning points in the recovery process.[19,20] Understanding the developmental dimensions, phases, and turning points of recovery can give hope to people with psychiatric disabilities, their loved ones, and those who care about them.[19-21] There is a scope for improving the services offered at our place in terms of offering better and more comprehensive.

## AUTHOR CONTRIBUTIONS

Concepts: All authors; design: STM, JB, AR, RG, and MIK; definition of intellectual content: STM, TTB, and AR; literature search: STM, JB, TTB, and MIK; data collection: JB, TTB, RT, AR, and RG; data analysis: STM, JB, TTB, RT, AR, and RG; statistical analysis: STM, RT, SU, and JT; manuscript preparation: All authors; manuscript editing: All authors except AR; manuscript review: All authors.

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