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Psycho Social Rehabilitation of Long Stay Mentally ill Patients

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Abstract: *Over the past few decades there has been a surge in the field of psycho social rehabilitation for the mentally ill patients who have developed chronicity. Basic objective of psycho social rehabilitation is to reduce the deleterious effect of psychiatric disorder on the sufferers' socio-occupational functioning and life skills. It was seen previously that patients who had been put in a mental hospital for long time after discharge they would tend to develop maladjustment with their own environment. These patients develop incapacity to interact with the community people and find themselves in awkward position while mixing with the people living in community. In spite of considerable achievement in the field of psychopharmacology a significant number of severely ill psychiatric patients tend to develop refractoriness in their illness. So this group of people are at the risk of developing chronicity and do require prolong inpatient treatment because of the problematic psychopathologies of the illness. Psychosocial rehabilitation is a multidimensional therapeutic measure which requires active participation of many persons, e.g., patients, caregivers, mental health professionals, social network, administration and policy makers, so forth. Psychosocial rehabilitation is not only a therapeutic endeavour but in true sense it has some reformatory connotation too.*

Keywords: *Psycho Social Rehabilitation, Long stay mentally ill patients*

I. Introduction

Over the past few decades there has been a surge in the field of psycho social rehabilitation for the mentally ill patients who have developed chronicity. Basic objective of psycho social rehabilitation is to reduce the deleterious effect of psychiatric disorder on the sufferers' socio-occupational functioning and life skills. It was seen previously that patients who had been put in a mental hospital for long time after discharge they would tend to develop maladjustment with their own environment. These patients develop incapacity to interact with the community people and find themselves in awkward position while mixing with the people living in community. In spite of considerable achievement in the field of psychopharmacology a significant number of severely ill psychiatric patients tend to develop refractoriness in their illness. So this group of people are at the risk of developing chronicity and do require prolong inpatient treatment because of the problematic psychopathologies of the illness. Psychosocial rehabilitation is a multidimensional therapeutic measure which requires active participation of many persons, e.g., patients, caregivers, mental health professionals, social network, administration and policy makers, so forth. Psychosocial rehabilitation is not only a therapeutic endeavour but in true sense it has some reformatory connotation too.

II. Who are Long stay patients?

Long stay patients are those who at the time of anticipated or planned discharge reside in a long term or rehabilitation ward of the hospital or have a length of stay of 30 days or longer. Forensic patients are excluded from this definition (Division of Mental Health, Developmental Disabilities & Substance Abuse services, Policies & Procedures USA, APSR, revised in 2006)

The most devastating of dimension of severe mental illness is that psychiatric symptoms often tend reoccur and persist, in one form or another, sometimes for the entire life of the individuals of have developed it. Individuals who experienced and developed the enduring pattern of illness are often insensitively labeled to as "chronics." Fortunately, this terminology has fallen out of favor for the following reasons:

- First is the emergence of person-first language (e.g., "a person with schizophrenia" rather than "a schizophrenic");
- Second is that "chronic," which simply means "lengthy," has gradually become equated with "low functioning" and "hopeless."
- The overall negative associations with this label turned out to be not only inaccurate, but also very harmful

Chronic Mental Illness (henceforth it will be abbreviated as CMI whenever required) is characterized by chronic deficits in personal and social functioning. Many people with CMI are unable to perform the basic

activities of daily living and others remain unemployed, dependent on welfare services for their survival. In addition to that, the chronically mentally ill individuals also have to deal with the pernicious and negative attitude of the society in the forms of stereotypes, stigma and prejudices. These factors put together to make them "one of the most needy and disadvantaged groups of society" (Shadish *et al.*, 1989). In a nutshell it is very difficult to draw the definition of CMI-but before the popularization of the "de-institutionalization Concept", the criterion for chronicity was current or prior hospitalization (Bachrach, 1998). But now researchers and clinicians of mental health put forward three criteria to define chrnocity, e.g, a) duration, b) diagnosis and c) disability.

The persons with CMI develop very significant and to some extent irreversible functional impairment due to presence of enduring and debilitating psychopathologies. The functional incapacity and presence of psychopathology make these people the subject of bigotry and social alienation. Even the families of those people are not spared by the society- and they also become the prey to the inimical attitude of the society. The society unequivocally puts some derogatory adjectives upon them as 'others' or 'deviated', 'insane', etc and disallows them to interact with the other members of the society.

III. Definition of Psychosocial & Psychiatric Rehabilitation

- According to Anthony & Nemec (1983) psychiatric rehabilitation is the *"treatment that teaches chronically ill individuals the physical, emotional and intellectual skills necessary to live, learn, and work in their own particular environments".*
- Psychosocial rehabilitation is a term used to describe services that aim to restore the patient's ability to function in the community. It not only includes the medical and psychosocial treatment but also include ways to foster social interaction, to promote independent living, and to encourage vocational performance (Cook and Razzano 2000).
- Psychosocial rehabilitation can be defined as a process initiated by a health or mental health professional, in collaboration with the patients, families and community and supported by policy planners, focused on developing and implementing an individualized programme that seeks to maximize the patients assets and minimize disabilities in the area of socio occupational functioning, , centering around the philosophy of mobilizing and utilizing resources available to the community, with the final objective of mainstreaming the client.
- Bachrach (1992) defines psychosocial rehabilitation as *"a therapeutic approach that encourages a mentally ill person to develop his or her fullest capacities through learning and environmental supports".*
- The World Health Organization (1995) defined psychosocial rehabilitation as: *"psychosocial rehabilitation is a comprehensive process that offers the opportunity for individuals who are impaired, disabled or handicapped by a mental disorder to reach their optimal level of independent functioning in the community".*
- Cnaan *et al* (1989) defined psychiatric rehabilitation as: *"The process of facilitating an individual's restoration to an optimal level of independent functioning in the community . . . psychosocial rehabilitation encourages people to participate actively with others in the attainment of mental health and social competence goals".*
- In 1985, the International Association of Psychosocial Rehabilitation Services (IAPRS) published a definition of psychosocial rehabilitation as: *"Psychosocial rehabilitation is the process of facilitating an individual's restoration to an optimal level of independent functioning in the community".*
- Psychosocial rehabilitation invariably encourages persons to participate actively with others in the attainment of mental health and social competence goals. The rehabilitation process emphasizes the wholeness and wellness of the individual and seeks a comprehensive approach to provide the vocational, residential, social/recreational, educational and personal adjustment services to the chronic mentally ill persons (Cnaan *et al.*, 1988).
- Cnaan *et al* stated (1988) that psychosocial rehabilitation is based on a number of assumptions, including the following two most important ones:
  1. People are motivated by a need for mastery and competence in areas, which allow them to feel more independent and self-confident.
  2. New behaviour can be learned and people are capable of adapting their behaviour to meet their basic needs.

IV. Historical Origin of Psychosocial Rehabilitation of Long Stay Patients

Psychosocial rehabilitation has made a long journey since the appearance of the concept of humanization of mental health service in the 2nd decade of 20th Century. Reformatory movements like "Mental Hygiene movement" and "Deinstitutionalization in the treatment of chronic mental patient" nourished and propelled the psychosocial rehabilitation significantly in positive manner. But if we categorically look back to the history of mental health, then we can find that the origins of the psychiatric rehabilitation field are embedded

in several historical developments: (1) the moral therapy era; (2) the inclusion of the psychiatrically disabled into public-supported vocational rehabilitation programs; (3) the development of community mental health ideology; (4) the psychosocial rehabilitation centre movement; and (5) the development of skills training techniques as an effective mental health intervention (Anthony & Liberman, 1986). The 19th Century reformists had put stress on ensuring more humane care to the mentally ill persons and providing care to the chronic mental patients to let them feel comfortable. The moral treatment put forward a comprehensive assessment of the person with psychiatric disorder which would thoroughly examine the person's work, play, and social activities (Anthony & Liberman, 1986).

Later in developed countries another feat had been achieved in the form of 'inclusion of the psychiatrically disabled into public-supported vocational rehabilitation programs'. After the World War-I it was felt in many countries that rehabilitation of the physically and subsequently psychologically disabled people could be held as societal responsibility and the administration should come forward to take over the responsibilities of these people. This matter sparked the public sentiment and many individuals and organizations had come forward to take this issue. In many countries legislations and policies had been tabled and implemented to provide welfare to this segment of the people. Example of such effort is 'Amendment of the United States Vocational Rehabilitation Act of 1943'. In this amendment several provisions had been made to extend financial support and vocational rehabilitation services to the psychiatrically disabled persons. Same kind of legislation appeared at the same time in England. These governmental actions provided legitimacy to the idea of training and rehabilitating people with psychiatric disabilities and grounded the practice of psychiatric rehabilitation in the vocational arena. The discovery of the capacity of the mentally retarded for gainful employment (ntract work into large mental hospitals (Carstairs *et al*., 1956).

The deinstitutionalization movement gave the nourishment to the community based mental health care O'Connor & Tizard, 1956) led to studies on the effects of psychiatric disability on work and to the introduction of paid industrial subco and rehabilitation of the chronic psychiatrically ill persons. The deinstitutionalization movement pinpointed that work and various skills training of the patients should be done at community level instead of mental hospitals for their appropriate resettlement in the community. This way several community based model of disbursing treatment and rehabilitation had come up in many countries in the decades of 1960s and 70s. Major thrust of community based approach was to reverse the disabling effects of the social breakdown syndrome among the chronic mental patients. This problem mainly occurs due to institutionalism or keeping the chronic patients in the mental hospitals for long time either for providing treatment or rehabilitation services.

Introduction of social skills training methods empowered the field of psychosocial rehabilitation greatly. The social skills training approach is based on social learning principles, human resource development training, and vocational rehabilitation. Basic objectives of social skills training approach are to enhance coping and problem solving skills of the patients with life stressors. To ensure the homeostasis in the socio-occupational functioning of the patients few tasks are to be done e.g., enhancement of effective coping and problem solving skills in the patients, engagement of the patients in the successful affiliative and instrumental relationships with others, mobilization of the supportive networks towards the positive direction. Rehabilitation techniques used in social skills training approach are: active-directive learning principles—behavioural practice and role playing, social and tangible reinforcement, shaping, coaching, and prompting, and generalization activities. The basic rationale of social skills training approach is to strengthen an individual's problem-solving capacities and confer protection against exacerbations of psychiatric symptoms (Cohen *et al.,* 1983; Wallace & Liberman, 1985; Wallace *et al.,* 1980).

V. Why psychosocial rehabilitation is necessary?

There are many sociological factors that can affect a person's adjustment to disability. People with any disabling condition must face the task of adjusting to their conditions, disabilities, and to their environment. Psychological stress results from a particular relationship between the person and the environment, one that persons with disabilities often may perceive as either taxing or exceeding their resources and endangering their well-being. In developed country like USA it is estimated that more than 40 million people have psychiatric impairments; of that number, 4 to 5 million adults have a severe psychiatric disability. In USA severe psychiatric disabilities are described as persistent mental or emotional disorders that significantly interfere with a person's ability to carry out such primary aspects of daily life as self-care, household management, interpersonal relationships, and school or work. Primarily, these psychiatric diagnoses include schizophrenia, affective disorders, and anxiety disorders (Bond, *et al.,* 1995). Satisfactory or moderate level of functional recovery and regaining of social skills cannot be possible through only medication or other kinds of psychotherapies in case of the patients with long-term psychiatric illness. Because these people already developed refractoriness in their illness and some irreversible damages are caused by the illness. So to relieve them to some extent appropriate forms of psychosocial rehabilitations in conjunction with other modes of treatment are required.

Modern psychiatric rehabilitation programmes give high degree of importance on the community instead of institutionalized rehabilitation service, because of few things, e.g., 'community based psychosocial rehabilitation programmes are 'cost effective', 'involves less stigma to the subscribers', 'lessening of the burden of existing mental hospitals', 'optimal use of trained manpower' and finally 'inclusion of community in the rehabilitation and aftercare of the long-term ill patients enhance their social interactiveness and responsiveness, and befriending of community people'. In developing countries community centred approach of rehabilitation is always welcome to provide care to the patients. Unfortunately, many rehabilitation professionals are neither aware nor appropriately prepared to provide the level of services that are needed by individuals with psychiatric disabilities to re-enter the community and function in the workplace.

Despite commendable advancement in the pharmacological management of the severe mental disorder, still a significant proportion of the patients tend to develop chronicity and chronic course of the illness makes them reclusive, socially unresponsive and marked impairment in their occupational functioning. Additionally, the prognosis of affective disorder, traditionally thought to be more favourable, can be poor especially for those with psychotic symptoms (Wiersma, 1998; Shepherd, 1989). Approximately 30% of patients with psychosis respond poorly to medication and continue to have significant amount of psychopathology and functional impairment (Kane, 2003). Furthermore, pharmacological treatment on its own has only a moderate impact on the social function of patients with schizophrenia. Psychosocial rehabilitation offers an important adjunct to pharmacotherapy (Bachrach, 2000) and may offer unique benefits to patients with psychosis (Bacharach, 1992; Bachrach, 2000). The goal of these interventions is to enable individuals to achieve the highest feasible quality of life by ensuring that they can perform the physical, emotional, social and intellectual skills required to live in the community (Anthony & Nemec, 1983). Yet the potential benefits of psychosocial rehabilitation may not be fully understood as there is a relative shortage of published research in the area particularly among persons with a first-episode of psychosis.

VI. Barriers in psychosocial rehabilitation

There are ample numbers of barriers can be emerged at the time of disseminating the rehabilitative services to the chronic mental patients. Those barriers could be infrastructure related, logistic, attitude of the community and the persons and professionals engaged in psychiatric rehabilitation, funding, sate policies, so on. In developing countries where resources are limited the problems are different but in developed countries the problems are of different nature, they are: bureaucratic hurdles, uncooperative attitudes of relatives and societal insensitivity (Bond *et al.*, 1999).

Impediments to psychosocial rehabilitation are:

- **Irregular Follow Up due to financial problems:** Most of the patients coming into government institute in the developing countries are from lower socio-economic strata and most of them are daily wage earners. Due to financial problem most of the patients cannot turn up to the mental health professionals for follow-ups. When earning member of family develops illness, the problem becomes more acute. A survey of an urban community in southern India, served by four state-run general hospitals with psychiatric services and a large psychiatric institution, found that a third of people with schizophrenia had never accessed any treatment (Padmavati *et al.,* 1998). Even after these individuals and their families were offered treatment, a third of them continued in their untreated state (Srinivasan *et al*., 2001).
- **Lack of agencies/networks for providing vocational support/ rehabilitation to the patients:** Number of the vocational training centers is inadequate in the developing countries. Some private day care centers are operational in metros and big cities but the intake capacity of these institutes is limited. In addition to that the social marketing system in the country like India is not sound and the products which are developed by the patients in various sheltered workshops remain unsold as there are no buyers or lack of awareness among the business fraternity about this issue or their reluctant attitude. Another problem is that most of the time the materials produced by the patients are not so good in quality so those materials cannot compete with the products being made by corporate sectors or skilled artisans.
- **Shrinkage in job market:** In developing country unemployment is a major problem, even the educated people don't get job, so it is very difficult for the mentally ill patients to get job. Irony is that some person develops the mental illness because they are not having job. The occupational functioning of men is still crucial in the Indian setting for winning the social status, so prolong unemployment make the people vulnerable to develop psychological problems due to cropping up of the problems like frustration and sense of inferiority. Here unemployment and underachievement act as threats to people's social status. Compounding this situation, the social security system in India does not consider patients with severe mental illness like 'schizophrenia' as its beneficiaries. In India mental illness are not yet eligible for any welfare measures (Thara *et al.,* 2004). Employment provides not only a monetary recompense but also 'latent' benefits — non-financial gains to the worker which include social identity and status; social

contacts and support; a means of structuring and occupying time; activity and involvement; and a sense of personal achievement (Shepherd, 1989). People with mental illness are sensitive to the negative effects of unemployment and the loss of structure, purpose and identity, which it brings (Rowland & Perkins, 1988).

- **Hospital as a dumping site:** Many relatives of the patients are not interested in the treatment or rehabilitation of the patients. Their main aim is to get the patient admitted in the mental hospital and get rid of him. These way mental hospitals become overloaded with the patients and due to lack of mental health and allied manpower adequate and appropriate psychosocial rehabilitation and aftercare of the patients are not done. There are many explanations of 'dumping attitude' of the care givers of the chronic mental patients, e.g., firstly, some families' economic conditions are poor. So they cannot take care of the patient. *Secondly,* many families' lives in small house, which has no room for the patient. *Thirdly,* many patients though improve up to a significant extent are still unable to find a job. So they stay at the home throughout the day. The male members, when they go out for a work in daytime, don't want to keep patient near female members. They fear that the patient might not be managed by the females if he becomes aggressive or the patient may do sexual assault on the female members of the family. *Fourth reason* is social stigma attached to the mental illness.
- **Expressed emotions and relapse:** overwhelming presence of negative expressed in the family against the mentally ill member can also be posed as a constraint psychosocial rehabilitation. Because negative expressed emotions can cause frequent relapses to the patients- so that patients require repeated psychiatric treatment every time after the relapses occur. In every relapsing episode some amount of residual mental health is lost in the patients and the families have to take extra burden. This way psychosocial rehabilitation becomes a secondary thing to the families (Brown, 1985; Leff & Vaughn, 1985). Sometimes after long hospitalization, when a patient returns home, his relatives treat him as an outsider. They have established a family equilibrium without the patient so when the patient returns this equilibrium is disturbed. They unconsciously treat the patient as alien. The patients continuously feel that he is unwanted in his family.
- **Societal Insensitivity:** Many patients when returned to the society face insults. The society shows discriminating attitude to them either overtly or covertly. Community people don't include the patients in their friendship circle easily and the patients have not been given the social status what they should have been. So the patient becomes lonely and isolated. A recent report, based on responses from 556 UK users, shows that 70% have experienced discrimination in some form: 47% in the workplace, 44% from general practitioners and 32% from other health professionals (Mental Health Foundation, 2000). Manning & White (1995) reported that 90% of mental health professionals who had a family member with mental illness, frequently heard colleagues make "negative or disparaging remarks" about patients: the majority of these professionals stayed silent and did not disclose their relative's illness. Lefley (1987) reported UK employers' reluctance to hire someone with mental illness. Mansouri & Dowell (1989) report that stigma is a significant source of distress in, for example, people with severe enduring mental illness in a community-support programme, where it correlates with self-esteem. In cinema and television, mental illness is the substrate for comedy, more usually laughing at than laughing with the characters (Byrne, 1997). Negative attitudes to people with mental illness start at playschool and endure into early adulthood: one cohort confirmed the same prejudices on re-examination eight years later (Weiss, 1994). These add tremendous strain to already poorly compensated defense mechanisms of the patient and patient may worsen again.
- **Problems patient with co-morbid substance addiction:** psychosocial rehabilitation to the patients with dual diagnosis, i.e., substance addiction and chronic mental disorder is a very complex job. In this case extra efforts are required to keep the patient abstinent as well as to make the patient functional. In many cases due to societal and family conditions such kinds of patients tend to relapse. Patients with both substance addiction and chronic psychiatric disorder require more systematic, enduring course of psychosocial rehabilitation, but due to lack of resources and presence of antagonistic environment psychosocial rehabilitation cannot be given in adequate manner.
- **Burn out of hospital staff:** - Psychosocial rehabilitation is a labor-intensive process. Success of psychosocial rehabilitation largely depends on the motivation and willingness of the professionals attached to it. But psychosocial rehabilitation professionals are very much burn out prone which have been seen in many empirical studies. These professionals tend to be burned-out because of insurmountable work pressure, emotional exhaustion, tendency to develop cynical and negative attitudes towards others and negative self-evaluation, especially regarding personal accomplishment at work (Maslach & Jackson, 1986). The daily work of continual confrontation of illness, sadness, suffering, fear and pain makes staff insensitive towards patients. This way such group of professional became quite lethargic to provide adequate psychosocial rehabilitative services to the patients.
- **Lack of qualified and skilled staff and over burdened Staffs in existing institutes: -** The staffs of the hospitals are woefully overburdened in the developing countries. The ratio of staff to patients is rarely in accordance with law and guidelines. In India there are now 37 mental hospitals in the country with a total

bed strength of 18 024 (National Human Rights Commission of India, 1999). The beds are grossly inadequate in comparison to number of patients and population. In the developing country like India the psychiatrists have to manage the average OPD of 70 to 80 patients. Along with managing OPD they also have to do the administration work and management of staff. So the very little time is left for rehabilitation work and its supervision. The low salary in comparison to private practice make government job unattractive, so many posts of psychiatrist in the government hospitals are vacant. So the work of rehabilitation remains in a sorry state. Another major problem is brain drain of psychiatrists and nursing staff to developed countries, which provides better working conditions and higher salaries.

- **Impact of stigma on psychosocial rehabilitation: -** Massive stigmatization can spoil the effectiveness of psychosocial rehabilitation or even it could become a major impediment to the application process of psychosocial rehabilitation. It was noticed in many studies that people with psychiatric disabilities have to face the problem of unemployment and economic dependency in a considerable manner. Mental illness limits the employment prospects of people with psychiatric disabilities (National Institute on Disability and Rehabilitation Services, 1993). According to Mechanic (1996), stigmatization of people with mental illness has been a pervasive problem. In resource constrained programs, staff often prefer to work with those having lesser degree of illness and those who seem to offer greater promise of substantial improvement. There is a long legacy of neglect of those most in need, in part because they were devalued. In fact, mental health and vocational rehabilitation workers often inadvertently reinforce stigma through their interactions with patients by holding faulty ideas about the nature of the disability, by perpetuating negative stereotypes by expecting patients to conform to dictated treatment and dependency roles, and by using unskilled jobs inappropriately. For example, vocational workers often limit vocational placements to the so-called four F's: food, flowers, folding, and filth (referring to the stereotypical entry-level positions often offered to clients with long-term mental illness: food service, gardening, laundry or clerical work, and janitorial services). The handicapping effects of stigma may often be more powerful than the disability itself. There is no reason for anyone to be ashamed of having a mental illness and yet many people feel that way and experience unwarranted discrimination due to the associated stigma.
- **Treatment Refractory Patients:** Treatment-refractory patients whose cognitive and higher mental functioning are highly compromised, in those cases general vocational rehabilitations or other psychosocial rehabilitations may not be possible or require more specific individualized forms of psychosocial rehabilitation. Specific technique based on social learning can be most effective means of rehabilitation in those cases. But all times this cannot be done, due to many obstacles, i.e., lack of trained professionals, time factor, financial causes, etc (Spaulding *et al.,* 1986).
- **Limitation of vocational rehabilitation in schizophrenia:** - Rehabilitation measure like vocational rehabilitation is much shouted and accepted form of rehabilitation to the schizophrenia affected patients. But truly it is not so successful in the case of schizophrenia. Despite very commendable advancements in psychopharmacology schizophrenia still appears to be enigmatic and to some extent unamenable to treatment. Empirical studies have shown that people with schizophrenia may not have benefited as much from the various measures of psychosocial and vocational rehabilitation as have those with other psychiatric disorders. Follow-up studies of cohorts with schizophrenia have found that they experience low levels of employment and vocational functioning for many years after the onset of their illnesses. There are some empirical evidences that suggest that vocational rehabilitation interventions do not work effectively for individuals with schizophrenia as they do for those with other psychiatric disorders. Finally, it appears that large proportions of people with schizophrenia do not have vocational services included in their treatment plans and do not receive vocational rehabilitation services concordant with standards of good clinical practice (Cook & Razzano, 2000; Lehman and Steinwachs, 1998a, b).
- **Other Barriers:** There are two types of proved barriers in psychosocial rehabilitation, such as *firstly,* individual service providers lack the basic knowledge and skills required to assimilate evidence-based practices into their regular approach to treatment. Moreover, work-related variables—for example, job burnout—undermine some staff members' interest in new and innovative practices. *Secondly,* many evidence-based practices require a team of service providers. Organizational barriers, such as poor leadership, a change-averse culture, insufficient collegial support, and bureaucratic constraints, hinder the team's effort to implement and maintain such practices (Corrigan *et al.,* 2001). Additionally success of psychosocial rehabilitative measures' in areas like social, vocational, and independent living domains has been limited in several ways. *First,* the functional changes do not consistently occur; *second,* there is wide individual variation and heterogeneity in rehabilitation outcomes from even effective programs; and third, most functional gains do not last when the intervention ends (Bustillo *et al.,* 2001).

VII. Role of family in rehabilitation

Several studies have been conducted so far to establish the role of family in psychosocial rehabilitation. Different authors have stated that families are happened to be the primary source of acute treatment care for adults with chronic mental illness so in that way it can also be a major source of psychosocial rehabilitation to the patients. Development of severe mental illness to one of the member of a given family network is a catastrophic thing for the entire family system so families are also required clinical and professional support to get over from this catastrophe. So inclusion of families in the long term psychosocial rehabilitation of chronic mental patients can be helpful to both the family members and patients (Goldman, 1982, Drapalski *et al*, 2008). The role of the family in the recovery process of the long stay patients has become increasingly important in the modern day multidisciplinary team approach of psychiatric rehabilitation. Today long term hospitalization is not preferred by most of the modern clinicians and community centred approach of treatment and care is the mainstay- this made the role of family more instrumental in the psychosocial rehabilitation of the chronic patients (Hatfield *et al*, 1995). But in most of the cases families provide the care to their ill relatives with little or no information about the aetiology, treatment, course and prognosis of psychiatric disorders, and most importantly without having adequate professional assistance from the mental health professionals. This problem is quite prevalent in developing countries where awareness and literacy about mental health and illness are very little in the society. In West, several organizations and advocacy groups are available to solicit support and information to the families with long-term mentally ill patients. Approaches like 'multi-family intervention' and 'self-help group' are found to be quite helpful to these families to lessen their sense of alienation, grief and social exclusion. Frequent encounter with same kind of families can help these people to learn or let others learn about the coping and problem-solving strategies and how to keep a balance between patient-care and maintenance of normal family functioning at the optimal level (Ohaeri, 2003; Pickett-Schenk, 2006).

Families report a wide range of consequences related to their care-giving efforts, including negative effects on their psychological health and on relationships with their ill relatives. Many family members of adults with mental illness report high levels of depression and anxiety, poor social functioning, and excessive feelings of fear, worry, and guilt, and describe frustrating interactions with their ill relatives (Martens & Addington, 2001). Factors like 'lack of practical knowledge' and 'lack of emotional support' work as the causal factors for decreased subjective sense of well-being and strained relationships in the families with chronic psychiatric patients. Lack of information about the maladaptive behaviours and psychiatric symptoms, such as hostility, apathy, and social withdrawal can make the families attribute these behaviours as the form of negative aspects of their ill relatives' personality; these individuals are more likely to experience psychological distress and express greater criticism of their ill relatives (Harrison *et al*, 1998; Hooley & Campbell, 2002).

Psychosocial interventions that give education about the aetiology of mental illness and availability standard clinical treatments, problem-solving and coping skills training, and family support programmes have the efficacy to improve family members' ability to cope with their relatives' illness and reduced their relatives' psychiatric recidivism. Researches showed that family psycho-educational interventions given by trained mental health professionals can ensure better results in treatment and rehabilitation programmes given to the patients. Psycho-educational programs are mainly are of use to reduce the chances of relapses, securing family's active participation in the rehabilitation process, limiting family's expectations from the clinicians as well as the patient, reducing the chances of developing negative attitudes towards the patients, etc (Dixon *et al*, 2001).

The importance of families in the lives of adults with severe and chronic mental illness like schizophrenia is well documented. Persons with schizophrenia frequently live with their families of origin or have significant family contact (Solomon, 1994). Families of persons with schizophrenia cite their own need for education and support to cope with their family member's illness (Greenberg *et al*, 1995). Numerous empirical evidences showed that specific family interventions and inclusion of the family in treatment and rehabilitation process of the chronic mental patients can hasten the good outcome of the illness and lay of better opportunities to the patients to inculcate the skills important for life functioning (Dixon & Lehman, 1995; Lam, 1991).

The Schizophrenia Patient Outcomes Research Team (PORT) has developed treatment recommendations for the care of persons with schizophrenia (Lehman & Steinwachs, 1998). These recommendations were psychosocial and psychopharmacologic treatments, with special emphasis on family psychosocial interventions and families inclusion in the rehabilitation process. The PORT team's recommendations were as:

I. Firstly, patients who have ongoing contact with their families should be given a family psychosocial intervention that should continue for at least nine months and that should provide a combination of education about the illness, family support, crisis intervention, and training in problem-solving skills.
II. Secondly, family interventions should not be restricted to patients whose families are identified as having high levels of *"expressed emotion."*

III. Thirdly, family therapies that are based on the premise that family dysfunction is the aetiology of the patient's schizophrenic disorder should not be used in correcting the family dysfunctions or providing family interventions.

The PORT has categorically pointed that long term outcome of schizophrenia largely depends on families attitude and behaviours towards the patients.

VIII. Conclusion:

Psychosocial rehabilitation is a multidimensional therapeutic effort which requires active participation of many people and professionals, e.g. mental health professionals, occupational therapist, policy makers, judiciaries, social activist and most importantly patients and their key caregivers. Psychosocial rehabilitation is a comprehensive approach that includes numerous therapeutic ingredients such as an emphasis on medication compliance, tenacious and optimistic staff involvement with high degree of motivation, an accepting and supportive social environment for the patients, and provision of basic needs for decent housing and daily structure. Psychosocial rehabilitation is a dynamic concept and has to be altered and modified as per requirement of the patients, demands of time and environment, obviously according to the socio-cultural and economic background of the patients. Modern day psychosocial rehabilitation does not come alone and good results can be expected only when there is a synergistic relationship and co-ordination among the various professionals and agencies.

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