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SPECIAL  
PAPER

# Psychosocial rehabilitation for severe mental illnesses in general hospital psychiatric settings in South Asia

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**In South Asia, general hospital psychiatric units (GHPUs) have developed as an alternative to mental hospitals for the provision of comprehensive mental health services, training and research. GHPUs provide clinical care for all types of patients, including those with severe mental illnesses (SMIs). However, psychosocial rehabilitation is often neglected in GHPUs, partly because of the predominance of the medical model in routine clinical care and a lack of resources. This paper discusses the challenges in the management of SMIs in GHPUs and proposes a model of psychosocial rehabilitation which could be used in such settings.**

In South Asia, patients with severe mental illnesses (SMIs) are seen in a variety of mental health service settings, including general hospital psychiatric units (GHPUs), psychiatric hospitals, psychiatric nursing homes, poly-clinics and office-based practices. A GHPU is a psychiatric wing in a medical school or general hospital (Wig, 1987).

The GHPUs are the main resource for general mental healthcare in South Asia. They serve large numbers of patients with SMIs, common mental disorders, substance misuse, psychosexual disorders and childhood psychiatric disorders. Liaison work constitutes only a small proportion of the total. The GHPUs also serve as the main teaching set-ups. However, psychosocial rehabilitation (PSR) is often neglected in GHPUs. This paper focuses on a model of PSR which could be used in such settings.

## Development and advantages of GHPUs

In South Asia, GHPUs started under the influence of wider international developments, like the establishment of psychiatric services in general hospitals and the introduction of effective psychotropic

medication. The first GHPU was started in India at Kolkata in 1933 and in Sri Lanka at Colombo in 1949. The subsequent increase in the number of GHPUs was not due to the closure of psychiatric hospitals or a decrease in the number of psychiatric beds as was seen in the West (Mendis, 2003) but was the result of poor mental health resources. In high-income countries, psychiatric services in general hospital settings generally include out-patient clinics, liaison services, emergency psychiatry, day care, substance use treatment and some other specialist clinics with or without a short-stay in-patient unit. There may also be teaching and research (Lipsitt, 2003). A large proportion of the mental healthcare is provided by specialist mental health centres or in community settings.

In contrast, GHPUs provide comprehensive mental health services in the form of clinical care, training and research. Patients with all types of psychiatric disorder, including SMIs, are managed there. They are not referred to mental hospitals and are given long-term follow-up care. The services are mostly publicly funded and patients are admitted to open wards for a short duration, either free or at very low cost (US\$10–15 a month, which includes food, essential medicines and basic recreation facilities). Family members are usually expected to stay with the patient.

The advantages of running services from GHPUs are manifold: availability of services in the community; involvement of family members in care; a reduction of stigma; and increased rates of help seeking for mental health problems. Due to inter-specialty collaboration, the physical problems associated with mental illnesses and conversely psychiatric problems associated with physical illnesses are better addressed. Also, emergency psychiatric services are integrated with hospital emergency services. GHPUs in medical schools play an important role in undergraduate teaching

and postgraduate residency training and have made significant contributions in psychiatric research (Wig & Avsthi, 2004).

### Challenges of PSR services for SMIs in GHPU settings

In South Asia, PSR services are offered in a few well resourced publicly and privately funded psychiatric hospitals and rehabilitation centres. A few project-based PSR projects (Chatterjee *et al.*, 2014) have demonstrated the usefulness of PSR in low- and middle-income countries. However, these are not necessarily replicable because they are generally carried out in ideal settings (Jacob, 2011) and are limited in both duration and funding. Furthermore, the evidence-based guidelines available from high-income countries for PSR (e.g. Dixon *et al.*, 2010) are difficult to implement because of a lack of infrastructure, staff and other resources (Soltani *et al.*, 2004).

Most GHPUs have few non-medical mental health professionals like clinical psychologists, psychiatric social workers and psychiatric nurses. It is often presumed that efforts at PSR begin only after amelioration of psychopathology, and thus PSR may not be even considered if a patient is still symptomatic. Moreover, the in-patient stay is usually restricted to a few weeks. The emphasis on a medical rather than a bio-psychosocial model of management, medical training centred in tertiary care and the large patient loads in GHPUs combine to entrench pharmacological intervention in routine practice, with minimal informal psychoeducation. Further, there is a lack of standard protocols and clinical practice guidelines tailored to local needs and resources. This results in poor integration of PSR in routine clinical practice.

### PSR for SMIs in GHPUs

South Asia has a considerable mismatch between the burden of psychiatric morbidity and mental health resources, resulting in a mental health gap of almost 90% (World Health Organization, 2001). The problem is compounded by inefficient use of existing resources (Saxena *et al.*, 2007).

In this context, GHPUs represent a different kind of resource, one which is almost universally available, as the presence of a GHPU in a medical school is a mandatory requirement for the medical school curriculum in many countries. Because they are tertiary care facilities situated in urban/semi-urban areas, they are easily accessible.

Nearly 90% of the patients with SMIs in South Asia live with their families. The families play multiple roles in care: identification of psychopathology, initiating treatment, procuring and supervising medicines, and providing psychosocial support (Avasthi, 2010). Family interventions can be planned easily because of this involvement. The life expectancy of patients with SMIs is at least 20% less than for the general population, due to the elevated risk factors for many chronic diseases, the iatrogenic effects of psychotropic medication and

poorer access to physical healthcare (Thornicroft, 2011).

Recognition and early management of undiagnosed and untreated physical comorbidities in the patients with SMIs in GHPU settings is facilitated by the availability of other specialists in the same premises. Group initiatives like day care, group therapies and family self-help groups can also be taken up because less stigma is attached to GHPU settings. Also, information technology, especially mobile phones, can be used to deliver psychoeducation (Haberer *et al.*, 2013). By establishing linkages with non-governmental and governmental organisations, social and vocational rehabilitation can also be planned.

### Conclusion

Over the last eight decades in South Asia, especially in India, GHPUs have developed as an alternative to the mental hospital model for the provision of mental health services. Patients with all types of psychiatric disorders are treated in GHPUs. It is possible to deliver PSR for patients with SMIs by optimising the use of GHPUs, according to local needs, without any additional cost.

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