A structured review of psychiatric rehabilitation for individuals living with severe mental illness within three regions of the Asia-Pacific: implications for policy and practice

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There is great heterogeneity within the Asia-Pacific (A-P) region, with an array of sociodemographic influences and cultural attitudes that impact on psychiatric care (Lo et al., 2016).
The impact of severe mental illness (SMI)

- SMI has substantial personal and economic impacts which have been variously quantified across the A-P region.
- In Hong Kong, 80% of people requiring community rehabilitation services in 2001 were living with schizophrenia (Tsang et al., 2013).
- An estimated 173 million Chinese citizens suffer from diagnosable mental disorders, of whom 158 million have never received any treatment. Of these, approximately 16 million Chinese citizens are affected by SMI (Tse, Ran, Huang, & Zhu, 2013).
- In Australia, 44% of those with SMI live with the most severe disability and accompanying complex multi-agency support needs (Harvey et al., 2015).
“whole system approach to recovery from mental ill health, which maximizes an individual's quality of life and social inclusion by encouraging their skills, promoting independence and autonomy, in order to give them hope for the future and which leads to successful community living through appropriate support”
(Killaspy, Harden, Holloway, & King, 2005)
Psychiatric Rehabilitation

Figure 97–1: The major positive impacts of psychosocial approaches. Circles represent psychosocial approaches (circles with discontinuous lines indicate approaches with emerging evidence). Rectangles represent top six challenges identified by Australians living with psychotic disorders (Morgan, et al., 2011). Arrows indicate major positive impacts (discontinuous lines indicate that the evidence for the impact is less robust).
The substantial personal, societal and economic impacts highlight the importance of providing evidence-based care to patients living with SMI.

There is compelling literature on the benefits of providing psychiatric rehabilitation for people living with SMI, to assist individuals to manage, overcome or live with their mental illness and lead full lives in the community (Galletly et al., 2016).

Despite a well-established evidence-base, implementation and access to these interventions in clinical practice for people with severe mental illness in the Asia-Pacific (A-P) region is low (Jablensky et al, 2017; Nielssen et al, 2017).
Psychiatric Rehabilitation

Table 3. Rehabilitation and recovery-focused interventions received by participants in public community mental health (CMH) services only and those receiving NGO and public CMH services during previous year.

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Public CMH only (n = 876), n (%)</th>
<th>NGO and public CMH (n = 421), n (%)</th>
<th>p</th>
<th>Chi-square</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social skills training</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>762 (88.3)</td>
<td>281 (71.0)</td>
<td>0.000a</td>
<td>56.191</td>
</tr>
<tr>
<td>Yes</td>
<td>101 (11.7)</td>
<td>115 (29.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supported employment (IPS model)bd</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>261 (90.9)</td>
<td>69 (69.7)</td>
<td>0.000a</td>
<td>25.098</td>
</tr>
<tr>
<td>Yes</td>
<td>26 (9.1)</td>
<td>30 (30.3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family interventions/psycho-education</td>
<td></td>
<td></td>
<td>0.293a</td>
<td>1.105</td>
</tr>
<tr>
<td>No</td>
<td>764 (87.7)</td>
<td>339 (85.4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>107 (12.3)</td>
<td>58 (14.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Received financial help</td>
<td></td>
<td></td>
<td>0.034a</td>
<td>4.481</td>
</tr>
<tr>
<td>No</td>
<td>594 (67.9)</td>
<td>260 (61.8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>281 (32.1)</td>
<td>161 (38.2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional assistance with housingbd</td>
<td></td>
<td></td>
<td>0.000a</td>
<td>20.541</td>
</tr>
<tr>
<td>No</td>
<td>159 (73.6)</td>
<td>63 (48.8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>57 (26.4)</td>
<td>66 (51.2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Help to look after self or home</td>
<td></td>
<td></td>
<td>0.000a</td>
<td>38.849</td>
</tr>
<tr>
<td>No</td>
<td>690 (78.9)</td>
<td>263 (62.5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>184 (21.1)</td>
<td>158 (37.5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have individual recovery plan</td>
<td></td>
<td></td>
<td>0.000a</td>
<td>21.571</td>
</tr>
<tr>
<td>No/not applicable</td>
<td>598 (70.1)</td>
<td>222 (56.5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>255 (29.9)</td>
<td>171 (43.5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If has recovery plan, given copy</td>
<td></td>
<td></td>
<td>1.000a</td>
<td>0.000</td>
</tr>
<tr>
<td>No/not applicable</td>
<td>98 (40.0)</td>
<td>63 (39.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>147 (60.0)</td>
<td>96 (60.4)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Continued)
# Psychiatric Rehabilitation

## Table 3. (Continued)

<table>
<thead>
<tr>
<th></th>
<th>Public CMH only (n = 876), n (%)</th>
<th>NGO and public CMH (n = 421), n (%)</th>
<th>p</th>
<th>Chi-square</th>
</tr>
</thead>
<tbody>
<tr>
<td>If has recovery plan, involved in planning</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>25 (10.0)</td>
<td>10 (6.2)</td>
<td>0.395</td>
<td>1.860</td>
</tr>
<tr>
<td>Yes to some extent</td>
<td>119 (47.8)</td>
<td>79 (49.1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes definitely</td>
<td>105 (42.2)</td>
<td>72 (44.7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If has recovery plan, review frequency</td>
<td></td>
<td></td>
<td>0.013</td>
<td>8.763</td>
</tr>
<tr>
<td>Not at all</td>
<td>62 (28.4)</td>
<td>23 (15.5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between 6 and 12 months</td>
<td>46 (21.1)</td>
<td>32 (21.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>More frequently than 6 months</td>
<td>110 (50.5)</td>
<td>93 (62.8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participation in community rehabilitation or day therapy programme</td>
<td></td>
<td></td>
<td>0.000²</td>
<td>567.043</td>
</tr>
<tr>
<td>No</td>
<td>721 (82.5)</td>
<td>49 (12.2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>153 (17.5)</td>
<td>354 (87.8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assertive Community Treatment³</td>
<td></td>
<td></td>
<td>0.488¹</td>
<td>0.482</td>
</tr>
<tr>
<td>No</td>
<td>356 (80.4)</td>
<td>193 (77.8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>87 (19.6)</td>
<td>55 (22.2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community treatment order</td>
<td></td>
<td></td>
<td>0.681</td>
<td>7.69</td>
</tr>
<tr>
<td>No</td>
<td>668 (76.9)</td>
<td>301 (75.3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, past 12 months, not current</td>
<td>74 (8.5)</td>
<td>40 (10.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes current</td>
<td>127 (14.6)</td>
<td>59 (14.8)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


²Continuity correction used for a 2 × 2 table.

³Smaller total sample since only participants for whom question was relevant were asked about receipt.
Psychiatric Rehabilitation in the Asia-Pacific Region: Aim of Review

- Aim: to evaluate prominent themes impacting on clinical practice and policy and the implementation of psychiatric rehabilitation across the A-P region
Methods

- Structured literature search focusing on:
  - Establishing how psychiatric rehabilitation is defined in the A-P region
  - Exploring successes and challenges in rehabilitation practice and implementation within the region
- Three regions - Australia, Hong Kong and India
  - Represent heterogeneity of the Asia-Pacific
  - Pragmatic - access to relevant local experts with good knowledge of the practice and evidence for psychiatric rehabilitation within each specific region
- English language articles published between 1 January 2013 and 23 October 2017
Method

Identification
- Records identified through database searching
  - PubMed, (n = 1,720)
  - CINAHL, (n = 99)
  - Embase (n = 213)
  - PsychInfo (n = 91)
  - Web of Science (n = 238)

Screening
- Records after duplicates removed (n = 2,008)
- Records screened (n = 2,008)
- Records excluded by title and or abstract (n = 1,853)

Eligibility
- Full-text articles assessed for eligibility (n = 155)
- Full-text articles excluded, with reasons (n = 13)
  - Reasons:
    - Conference Abstract (n = 8)
    - Abstract (n = 1)
    - Book (n = 2)
    - Unable to be sourced (n = 2)

Included
- Articles included in review (n = 142)
Themes

- Policy, legislation and human rights
- Access to rehabilitation
- Evidence into practice: Indigenous models
- Spirituality and traditional practice
- Role of family
- Impact of stigma
Policies, Legislation and Human Rights

- Structural issue that divides the health and disability fields
  - Australia: most rehabilitation and recovery services are separate from mental health treatment (Harvey et al, 2015)

- Inadequate policy or poor implementation
  - India: increased alignment of mental health law with UNCRPD but concerns about poor implementation (Duffy & Kelly, 2017)
  - Hong Kong: two policy papers over the past decade for people with disabilities failed to address the special needs of people with schizophrenia (Tsang et al, 2013)
One trend consistent across the region is the desire to ensure that ongoing policy and legislation is informed by evidence (Allison et al, 2016; Waghorn, 2013).

Informed decision-making is achievable, with increasing recognition among public and policymakers that schizophrenia is burdensome (Chong et al., 2016).

Castle (2013) argues that whilst we should continue to lobby for additional resources, more acutely, we need to focus on “what can be done with what we have”; that, rather than being reliant on prominent individuals for advocacy, professional bodies and consumer and carer organisations need to coordinate and be advocates for change (Castle, 2013).
Access to Psychiatric Rehabilitation

- Absence of accessible services for people with schizophrenia in LMICs (and HICs to lesser extent)
  - India: few rehabilitation services, mostly NGO-run and charge fee for service (Chatterjee & Hashim, 2015; Chavan & Das, 2015); Thara et al (2014) suggest need for indigenous community mental health teams which make use of lay health workers
  - Australia: people with psychosis and restricted socialising have access difficulties (Harvey et al, 2015)

- Possible solutions
  - China: political commitment, transitional finances, progressive realisation of coverage (Ma, 2012)
  - Task-sharing: need to develop and research system interventions to support task-sharing (Hanlon, 2017)
  - Trans-diagnostic stepped care (Cross & Hickie, 2017)
Poor access to services adds to the personal, familial and societal burden of SMI.

There are similar and consistent barriers to access across the A-P region, but these barriers differ in the extent to which they are important, nation by nation.

Universal public finance can play a role in ameliorating the adverse economic and social consequences of SMI by enabling access to treatment in resource-constrained settings.

Political commitment, allocation of financial resources, a commitment to an integrated approach with a strong role for community-based institutions and providers, and a progressive realization of coverage, are the key ingredients for scale up of services for people with SMI.
The Role of Family in Rehabilitation

- Acknowledged importance of families
  - Australia: poorer recognition despite significant family contact - just over half of people with psychosis have daily F2F family contact (Harvey & O’Hanlon, 2013)

- Family-centred approaches
  - Hong Kong: almost non-existent (Wong et al, 2015) but increasingly recognised – two organisations have initiated service innovations to include family-centred practice but more research needed (Wong et al, 2016)

- Traditional and cultural roles in families can impact on people’s access to, and provision of, care and rehabilitation.

- India: Women’s role and the impact of SMI
  - Married women with SMI may experience separation, desertion and insecurity (Thara et al, 2003)
  - Marriages may be arranged without mention of SMI to suitors and families (Chatterjee & Hashim, 2015)
The Impact of Stigma on Recovery and Psychiatric Rehabilitation

- The influences of stigma, division and discrimination have prejudiced policy, legislation, funding, and subsequently, current care and rehabilitation of people with SMI.

- Stigma as obstacle to improved QoL – services and professionals
  - Hong Kong: reduced life satisfaction more a function of lack of recovery-enhancing environments than symptoms (Chan & Mak, 2014)
  - Hong Kong: experienced doctors have more negative attitudes than their younger colleagues (Lam et al, 2013)
  - Australia: interactions with Assertive Community Team members decreased perceived stigma and discrimination (Ye et al, 2016)

- No simple solutions, more research on effective strategies needed
  - Hong Kong: public awareness and education campaigns and a new Chinese term for psychosis, but misunderstanding and discrimination persisted (Chiu et al, 2010; Chan et al, 2016)
Religion, Spirituality, Culture and Traditional Practice’s Role in Psychiatric Rehabilitation

- Spirituality has potential to help patients in recovery and influences access to, and provision of, treatment (Ho et al, 2016; Reddy et al, 2014)
- Use of traditional or faith healers
  - India and LMIC: many seek help from traditional or faith healers (Chatterjee & Hashim, 2015; Hanlon, 2017)
- Need for shared vernacular
  - Hong Kong: patients regarded spirituality as a source of giving and receiving love and care; professionals – means of receiving support and managing symptoms (Ho et al, 2016)
  - Australia: the overall importance of spirituality and religion in contributing to psychiatric rehabilitation was low, although the public were more likely than clinicians to consider that religion might be important for people with schizophrenia (Morgan, Reavley, & Jorm, 2014).
Yoga-based practices

- Alone or as adjuncts to other treatments could be cost-effective and culturally acceptable (Deshpande et al., 2016)
- Growing evidence base which needs further development (Varambally & Gangadhar, 2016)

Australian treatment guidelines stress the importance of “culture and explanatory models in mental health”, detailing the impact culture, religion and spirituality have on caring for people with SMI; specifically, regarding refugees, migrants and Aboriginal and Torres Strait Islander peoples (Galletly et al., 2016).
Successful interventions:

- Address cultural, familial, spiritual, political, economic and accessibility factors
- Importance of input from senior clinical staff and managers
- Adequate and sustainable education and supervision for particular interventions
- Interventions don’t necessarily require additional infrastructure and resources
Making sense of it all

He shouted out about some new invention & then that thing hit him!

DeepFat '09
Do we need to reinvent the wheel?

Don't Reinvent

Perfect It
Conclusions and implications for the A-P region

Some suggested overarching strategies:

- understanding the historical conceptualisations of disability and rehabilitation, and the political overlays, will be vital in actioning recommendations.
- expanding the evidence base
- establishing quality policy and legislation that is well implemented
- recognising the roles of family from multimodal perspectives
- developing and implementing stigma reduction and empowerment-based interventions
- acknowledging and addressing barriers to access
- universal public finance
Looking to our neighbours?
There is much that countries within the A-P region can learn from one another in implementing effective care.

Through the sharing of innovations, and understanding core underlying principles affecting care, countries can develop indigenous models of care, based on an expanding evidence-base. Countries will be able to adapt evidence-based models to develop culturally appropriate rehabilitation services.

As the region continues to mature, the cross pollination of culture will propagate, making a collegiate approach and a sharing of practice and learnings more relevant.
Adaption
Looking to our colleagues?
Whether one believes the early psychosis movement has “overreached” and overshadowed the provision of better care for all (Bosanac, Patton, & Castle, 2010), it has nonetheless shed light on the power that strong advocates, collaboration, media and political influence can have on influencing care (McGorry, 2015).

Positively for psychiatric rehabilitation, whilst the evidence behind the benefit of early psychosis to overall psychiatric care is contentious (Bosanac, Patton, & Castle, 2010; Castle, 2012), there is little controversy, despite little implementation, for psychiatric rehabilitation.
This review demonstrates that strong leadership, collaboration and coordinated action among all stakeholders will be crucial for advocating for further development and implementation of rehabilitation services.
Limitations

- Even though the socio-demographic characteristics of the three regions included represent some of the region’s diversity, we appreciate that this review doesn’t include all countries within the A-P region.

- Additionally, the regions reviewed all have British colonialization influence, likely affecting their conceptualisations of disability and recovery, political systems and policy.

- We therefore focused on general themes arising, as a full analysis of treatment strategies and issues associated with implementation of psychiatric rehabilitation within each country in the A-P region, was beyond the scope of this article.
Looking to our colleagues?
The Douglas Bennett Prize

- **Eligibility:** This competition is open to psychiatrists working in rehabilitation as a trainee, in a non-career grade post, or as a consultant within two years of appointment.

- There is no set topic, but the prize given in Douglas Bennett’s name will use his guiding values in adjudication. He valued creativity with practicality, simplicity with illumination, applicability with humanity, and had an eye for clear and rigorous methodology. This is a high and demanding standard, which he applied to his research and clinical work alike, and for which he is honoured with this prize.

- The prize is awarded annually for the best paper on rehabilitation psychiatry, who presents the best original work at the Faculty’s Residential Meeting.

- The monetary value of the prize is determined by the Faculty Executive and is currently £200.
Training Opportunities in Australia......