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REHABILITATION NEEDS OF SCHIZOPHRENIC PATIENTS – A PRELIMINARY REPORT

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SUMMARY

59 Feighner positive Schizophrenics were assessed for subjective rehabilitation needs using a specially designed schedule for the purpose. It was observed that employment and vocational rehabilitation were most sought after, psychosocial rehabilitation less so, and accommodation hardly at all. Both women and men had identical needs, and the necessity for individualised package programmes was identified. The implications of the findings are discussed.

No psychiatric treatment facility can lay any claim to completeness without an adequate Aftercare and Rehabilitation unit to meet the needs of the chronically mentally ill. Most Western Centres have well organised, sensitively designed, aftercare programmes in their Community Mental Health Centres, which customarily include pharmacotherapy, Industrial and Occupational Therapy, Family Counselling Programs, Support Programs, Social skills Training, and Psychosocial restructuring to mention only a few. The efficacy of Aftercare has been evaluated successfully time and again (Claghorn and Kinross-Wright 1971, Katkin et al 1971, Rosenblatt and Mayer 1974, Stein et al 1975, Test and Stein 1978, Mosher et al 1975), Mosher and Keith 1980). Anthony et al (1972) have demonstrated how special aftercare programmes reduce recidivism rates. Going one step further, Beard et al (1978) in a superbly designed study show how 'Reaching out' programmes produced even better results. Hogarty et al (1973, 1974a, 1974b) outlined the beneficial effects of "Major Role Therapy" in reducing relapse rates.

In India, rehabilitation programmes are offered only in a few of the bigger centres – the lamentable truth. Bhaskaran (1970) stressed the need for sheltered workshops and a dynamic therapeutic community. Holkar (1971) advocated a community based approach. Ramachandran and Menon (1975) demonstrated how Industrial Therapy improved capabilities and potentials by establishing outside contacts for inpatients.

Mathrubootham (1979) underscored the relative superiority of occupational over Industrial Therapy, quite in contrast to Miles (1971).

Most aftercare centres the world over, and especially in our country, thrust down

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their patients' throats, a package programme designed to the Centre's specifications. But, is this what our patients really need? No attempt has been made in India to assess the Rehabilitation Needs of a Schizophrenic population. Assessing 'felt needs' forms an important constituent in the planning of Mental Health Services (Wig and Srinivasamurthy 1981). This would suggest that the first step towards programme planning and delivery of aftercare services would be the proper evaluation of subjective rehabilitation Needs.

Assessing Needs can be done in one of the two ways. One is by assessing social behaviour, social skills, employment skills and participation in the rehabilitation programme, and concluding on objective needs as has been done by Falloon and Marshall (1983). This approach lays itself open to the criticism that you are eliminating the subjective component of the need which should be taken into account. The other approach is assessing subjective rehabilitation needs, putting the patients through a programme tailored to these needs, and studying it's efficacy.

The aim of the first phase of the study is to assess and examine subjective rehabilitation Needs of Schizophrenics.

Material and Methods

Fifty nine Schizophrenics who were a cohort on long term follow-up, were taken up for the present study. The inclusion criteria specified were as follows:

a) Definitely Schizophrenic by the Criteria of Feighner et al (1972).

b) Should have completed at least two years of follow-up.

c) Absence of Organic Brain Syndrome or Mental Subnormality.

d) Residence of Madras city and suburbs.

Originally, (at inclusion) the sample selected comprised consecutive Feighner positive schizophrenics. Since rehabilitation Needs would be expected to exist only in recovering/recovered schizophrenics, this already existent cohort was considered an ideal choice, obviating the need for a clumsy retrospective design.

All the 59 patients were assessed for subjective rehabilitation needs using a proforma speacially designed for the purpose of this study – the Rehabilitation Needs Assessment Schedule. This schedule collects purely qualitative information and does not require any observer rating whatsoever. The questions were open-ended and covered the following areas, in keeping with the suggestions of McCreadie (1982) and Mosher and Keith (1980).

1. Employment
2. Vocational training/guidance
3. Accommodation
4. Leisure activities
5. Psychosocial attitude modification
6. Skills training
7. Any help needed by the family
8. Any other need not covered by the above.

Except for items 6 and 7 (Skills training and Help for the family), which were asked of the key Informant, all the other items were asked from the patient.

Initially the patient was just asked whether he/she wanted any help aside of drug treatment. Subsequently he/she was asked whether he/she had any specific need in any of the areas outlined above, and if so, what it was. A checklist of possible items in

each area was provided and the patient's Needs were recorded. Since this was not a structured Interview Schedule, there was no question of observer rating. It was meant for qualitative rather than quantitative data. Hence, there was no need for standardisation.

Additional data on Disability (Disability Assessment Schedule, WHO 1980) and Family Burden (Family Burden Schedule), was also collected. Socio-demographic and clinical data was obtained from the patient documentation records. These have been analysed as factors affecting Rehabilitation Needs, and will be presented later.

Results

The sample (n = 59) consisted of 34 men (57.6%) and 25 women (42.4%). Their ages ranged from 16 to 43, the mean age being 24.1 (SD = 5.8). 59.3% of the patients were unmarried, 35.6% were married, and 5% were separated. 13.6% were illiterate, 27.1% had passed primary school and the rest (59.3%) had passed secondary school.

Nearly 33% of the sample still displayed some psychotic features and 67% were in a state of complete remission. 1.8% of the sample was Hebephrenic, 7.3% Catatonic, 58.2% Paranoid, and 32.7% Undifferentiated (ICD-9). The Mean duration of the illness was 18.02 months (SD = 12.0).

Eighty eight percent of the sample had a need in some area or the other, only 12% having absolutely no needs whatsoever. Table 1 depicts the overall rank order of rehabilitation needs. As most patients had multiple needs, considerable overlap is present. Interestingly enough, the difference between the two sexes regarding needs was not statistically significant, although females, appeared to give more importance to vocational training than men.

Table 1

RANK ORDER OF REHABILITATION NEEDS

1.	Want a Job	64.4 %
2.	Help for Family	54.2 %
3.	Leisure Activities	45.8 %
4.	Vocational Training	33.9 %
5.	Psycho-Social Modification	27.1 %
6.	Skills Training	22.0 %
7.	Others	13.6 %
8.	Accomodation	6.8 %

Other Needs
- Financial Help – 7
- Hearing Aid – 1

Employment Needs

About 65% of the men and 64% of the women wanted employment – there being no statistically significant difference in the sexes.

The group without employment Needs and the group who had needs did not differ significantly regarding either employment/unemployment before illness, or current employment/unemployment (Table 2). The rank order of the employment needs is presented in Table 3.

Table 2

	No Needs	Yes Needs	
Employed Before Illness	12 (57.1)	23 (60.5)	
Unemployed Before Illness	9 (42.9)	15 (39.5)	N.S.
Employed Now	11 (52.4)	17 (44.7)	
Unemployed Now	10 (47.6)	21 (55.3)	N.S.

Help for Family

Sixty percent of the men and 52 % of the women wanted some form of help for their families. 77.4 % wanted employment for some member of the family, 29 % required help in educating a family member, 16.1 %

Table 3
Employment Needs – Rank Order

		Male	Female	
1. Unskilled Clerical	34.2%	10 (45.5)	3 (18.8)	N.S.
2. Unskilled Trade/ Service	28.9%	10 (45.5)	1 (6.3)	$P < 05$
3. Skilled Trade/ Service	18.4%	5 (22.7)	2 (12.5)	N.S.
4. Skilled Clerical	15.8%	0	6 (37.5)	$P < 01$
5. Manual Labour	10.5%	1(4.6)	3 (18.8)	N.S.
6. Craft work	7.9%	0	3 (18.8)	N.S.
7. Agricultural	5.3%	1 (4.6)	1 (6.3)	N.S.
8. Unskilled Industrial	5.3%	2 (9.1)	0	N.S.
9. Skilled Industrial	5.3%	2 (9.1)	0	N.S.
10. Other Social Work	2.6%	1 (4.6)	0	N.S.

asked for health needs of their family to be looked after, 6.5% sought vocational training for a family member and 6.5% needed help in marrying off a family member. The group that wanted help for family did not differ significantly from the group that did not as far as type of family structure was concerned.

Vocational Training

Nearly twentyfour percent of the men and 48% of the women wanted vocational training. The 'Yes Needs' and 'No Needs' group did not differ significantly as far as previous employment/unemployment and current employment/unemployment were concerned. A look at the rank order (Table 4) reveals that skilled work like baking and printing is the most preferred.

Table 4
Vocational Training Rank Order

1. Skilled work	70%
2. Semiskilled repetitive work	20%
3. Domestic craft	15%
4. Industrial training	15%
5. Craft work	10%

Difference Between Males and Females N.S.

Leisure Activities

Fourtyseven percent of the males and 44% of the females required Leisure activities. The 'Yes Needs' and 'No Needs' group did not differ significantly as far as past leisure activities are concerned. Passive leisure activities like using radio, television and library facilities were more important than group discussions, games and outings (Table 5).

Table 5
Leisure Needs – Rank Order

		Males	Females	
1. Radio, TV, Etc.	85.2%	87.5%	81.8%	N.S.
2. Library Facilities	66.7%	62.5%	72.7%	N.S.
3. Group Meetings and Discussions	40.7%	53%	27.3%	N.S.
4. Indoor Games	33.3%	43.8%	18.2%	N.S.
5. Organised Outings	25.9%	37.5%	9.1%	N.S.
6. Physical Exercise/ Outdoor Games	7.4%	12.5%	0	N.S.

Psychosocial Modification

About twentyseven percent of the men and 28% of the women wanted modification of psychological attitudes, of whom 68.6% wanted their immediate family's attitude to be modified, 48.4% required modification of the attitudes of friends and neighbours and 18.8% needed their colleagues at work to modify their attitudes towards them.

Skills Training

Almost fifteen percent of men and 32% of

women wanted skills training, of whom 87.5% required training in social skills, 62.5% in household skills and 12.5% in personal skills.

Accommodation

Only 4 patients required accommodation of whom 3 were men. Three persons including one woman required independent lodging and one required group lodging.

Discussion

The fact that almost 90% of the population desired rehabilitation in one form or another underlines the urgent need for such programmes in all psychiatric treatment facilities. It also lays emphasis on the necessity for the community based approach advised by Holkar (1971), as this sample is composed exclusively of outpatient schizophrenics who have not suffered the consequences of institutionalisation. In the interest of good tertiary prevention, rehabilitation should be initiated as soon as the patient recovers from his breakdown, and need not wait for chronicity.

One of the most interesting findings in this study is that men and women do not differ as far as their rehabilitation needs are concerned. This, inspite of rigid cultural norms vis a vis the role of women in Indian society, could probably be considered a precursor to the finding that women respond better than men to high expectation rehabilitation programmes (Kaskiner and Zakman 1974, Goldmeier 1975). This area merits further exploration.

Most of the patients exhibited multiple needs, thereby emphasising the role of multifaceted, comprehensive aftercare package programmes. This would obviously involve the concerted efforts of several mental health facilities; a satisfactory model of aftercare delivery remains to be worked out and evaluated. It is also a matter of interest that 65% of the sample wants employment and not just vocational training. This increases the burden on job placement services for schizophrenics, reflecting, perhaps the difficulty experienced by the vocationally trained schizophrenic in entering the mainstream of employed life. It would probably be advisable to establish sheltered workshops for the subchronic schizophrenics on a long term basis, if only to shelter them from further employment rejection. Alternatively, job placement services should be improved upon, in collaboration with Indian industry.

Patients who do not require employment do not significantly differ from those who do, regarding past or current employment status. This apparently goes against Anthony and Buell's (1973) finding that past employment is the best predictor of future employment, in this case the desire for future employment.

Vocational training should be directed towards skilled tasks like printing and baking and unskilled repetitive work is probably best restricted to Occupational Therapy. The accent should be on job based training models which should be offered in liaison with job placement services.

More than half the sample wanting help for the family reflects merely the social problems of poverty and unemployment. With the available resources, or rather the lack of them, it would be impossible to rehabilitate the family as well, unless voluntary care agencies are sufficiently motivated in this direction. This kind of approach may well have an unpleasant backlash in that it may worsen the patient's drive and motivation; this remains to be evaluated.

Accommodation needs figuring only at the bottom of the list is not really surprising, as one would not expect an outpatient sample to require much by way of accommodation. This, of course, does not mean that the need for Halfway Homes, group lodgings, etc. is obviated. It just means that if all schizophrenics were started on a rehabilitation programme early enough, the need for accommodation would probably not arise.

Social skills training and psychosocial restructuring figure pretty low on our schizophrenic's priority list, a testimony perhaps, to the Indian way of life. In sharp contrast is the abundance in Western literature of such programmes as Network Therapy, 'Threshold's Approach', Extended Psychosocial Kinship Programme, Community Support Programmes, etc. Most patients require modification of the immediate family's attitudes towards them and their illness. This would suggest that psychoeducational approaches (Anderson et al 1980) would be a fertile ground of intervention research.

Leisure is also not perceived as a very major need, in fact those who need leisure activities do not significantly differ from those who do not as far as past leisure activities are concerned. Those who require leisure activities, restrict their needs to passive recreation like listening to the radio, watching TV, and reading books and magazines, group meetings, discussion etc. are not considered to constitute a major need, most of the patients apparently being satisfied with their current social life. This finding should be interpreted in the light of socio-cultural norms regarding the role of leisure.

The fact that this sample is a young, less chronic, well motivated group being followed up regularly probably means that their pattern of Needs will not represent the Needs of all Schizophrenics, but the important thing to be remembered is that even such a sample displays substantial Needs, reflecting the necessity for early rehabilitation.

Conclusion

It would be meaningful therefore to have a community based approach to rehabilitation. Individualised tailor made-programmes would have to be charted out and comprehensive package programmes should be evaluated. Stress should be laid on early rehabilitation of schizophrenics regardless of chronicity. Sex should not be a bar to rehabilitation and the emphasis should be on vocational rehabilitation and job placements. All schizophrenics should be offered a programme as soon as they recover from their breakdown and help should be sought from voluntary agencies in setting up sheltered workshops and other aftercare services. This, while not solving all the problems of schizophrenics, might be one of the means to an end.

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