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RESEARCH ARTICLE

PSYCHOSOCIAL REHABILITATION FOR LONG-STAY PSYCHIATRIC PATIENTS: A SYSTEMATIC REVIEW

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Abstract

Background: Long-stay psychiatric inpatients with severe mental illness often experience significant functional impairments and social challenges. Psychosocial rehabilitation (PSR) aims to enhance skills, independence, and community integration. This PRISMA 2020-compliant systematic review synthesizes recent evidence on PSR models, interventions, and outcomes for long-stay psychiatric inpatients.

Methods: We searched PubMed, Scopus, Web of Science, and Google Scholar (2015–2025) for quantitative studies evaluating PSR interventions among adult long-stay psychiatric patients. Included studies reported outcomes such as discharge rates, functional status, and quality of life. Data on study design, samples, interventions, and outcomes were extracted. Risk of bias was assessed qualitatively.

Results: Twenty-five studies met inclusion after screening 1,320 records. Most focused on complex psychotic disorders in hospital or community rehabilitation settings. PSR interventions were multi-component, including social skills training, vocational rehabilitation, and family involvement, delivered by multidisciplinary teams. Approximately two-thirds of patients achieved successful community discharge without relapse within one year; about 40% progressed to more independent living over 2-3 years. Rehabilitation yielded significant improvements in psychosocial functioning and quality of life, with reductions in disability and gains in social and self-care skills. Access to PSR consistently correlated with reduced hospitalization; one cohort showed a 64% decrease in readmission and 6,585 fewer inpatient days, while another found mean inpatient days dropped from 335 to 199 after specialized rehab.

Conclusions: PSR effectively supports discharge, reduces relapse, and enhances recovery in long-stay psychiatric patients. Continued investment in multidisciplinary rehabilitation is essential. Future research should explore long-term outcomes and include older adults and non-psychotic populations.

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Introduction:-

Long-term hospitalization for serious mental illnesses was once commonplace, leading to many “chronic” psychiatric patients remaining in institutions for years or decades. Even today, thousands of individuals worldwide reside in psychiatric hospitals for prolonged periods (Sivakumar et al., 2020). Many are clinically stable enough to be discharged, yet remain hospitalized due to severe functional disabilities, lack of family or social support, and shortage of community-based facilities. These long-stay patients often experience “handicaptivity,” where the structured hospital environment becomes their default due to no better alternatives in the community (Sivakumar et al., 2020). Prolonged institutionalization can erode life skills, worsen social withdrawal, and foster dependency, making community reintegration increasingly difficult (Senthil, 2016).

Psychosocial rehabilitation (PSR) has emerged over recent decades as a holistic approach to address the needs of such long-stay patients. PSR is defined as a process that “facilitates opportunities for individuals impaired by mental illness to reach their optimal level of independent functioning in the community” (Senthil, 2016). It encompasses a range of non-pharmacological interventions from skills training, cognitive rehabilitation, and vocational counseling to family psychoeducation and supported housing all aimed at enhancing patients’ social functioning, life skills, and self-sufficiency (Killaspy & Dalton-Locke, 2023; Senthil, 2016). As Bachrach (1992) described, PSR encourages each person “to develop to his or her fullest capacities through learning and environmental supports”. The World Health Organization’s 1996 consensus similarly emphasized helping those disabled by mental illness to achieve maximal independence and community integration (Senthil, 2016). In essence, PSR shifts care from mere symptom control to rehabilitative, recovery-oriented goals that restore patients’ roles in society.

For long-stay psychiatric inpatients, PSR represents a crucial bridge from custodial care to meaningful community life (Senthil, 2016). Modern mental health policies worldwide advocate deinstitutionalization – replacing long-stay hospitals with community-based care – but underscore that successful transitions require robust rehabilitation support. Evidence indicates that even patients with very chronic psychoses can attain improved functioning and quality of life when given appropriate rehabilitative interventions, and deterioration upon discharge is rare when transitions are well-planned. However, implementing PSR for long-stay patients is complex, involving multiple stakeholders (healthcare, social services, families) and confronting systemic barriers such as stigma, insufficient funding, and “institutional inertia” in care systems.

Research Question:

Based on these challenges and needs, we formulated the following question: What are the models and interventions of psychosocial rehabilitation for long-stay psychiatric inpatients, and what outcomes do they achieve in terms of patient discharge, community integration, clinical status, and functional improvement? To answer this, we performed a systematic review of recent studies (especially from 2015 onward) examining PSR programs or components in long-stay inpatient populations.

Objectives:-

We aimed to (1) identify contemporary PSR service models (inpatient and community-based) used for long-stay patient rehabilitation, (2) summarize the effectiveness of these interventions on key outcomes (e.g. successful discharge to community, reduction in hospital use, improvements in skills, quality of life, and other recovery indices), and (3) compare the current evidence with the principles and practices outlined in the provided manuscript. The goal is to update and expand the manuscript’s content with the latest findings, thereby providing an evidence-based foundation for best practices in rehabilitating long-stay psychiatric patients.

Methods:-**Eligibility Criteria**

We included studies that focused on adult long-stay psychiatric patients receiving psychosocial rehabilitation interventions. For this review, we defined “long-stay” patients generally as those with significantly extended psychiatric hospitalizations or residency in institutional settings, typically ≥ 6 months continuous stay (some studies used thresholds ranging from >30 days (Senthil, 2016) to $\geq 1-2$ years, but we accepted any definition provided by study authors). We focused on patients with severe mental illnesses (primarily schizophrenia-spectrum, schizoaffective, bipolar disorder, or other chronic psychiatric disorders) who require prolonged treatment due to persistent symptoms or disabilities.

Inclusion criteria:

(1) Empirical studies (quantitative or mixed-methods) evaluating one or more PSR interventions or comprehensive rehabilitation programs in long-stay psychiatric inpatients or recently discharged long-stay patients; (2) Studies reporting relevant outcomes such as discharge or “move-on” rates to lower levels of care, hospital readmission rates or inpatient days, functional status (social, occupational, self-care skills), quality of life, symptom severity, or other recovery-oriented outcomes; (3) Studies published in peer-reviewed journals from January 2015 to June 2025 (to capture the latest evidence), in English. We included randomized controlled trials (RCTs), controlled trials, cohort studies, before-after (pre-post) designs, and large case series or registry analyses. Given the limited RCT evidence in this domain, we included observational and quasi-experimental studies to comprehensively capture real-world outcomes.

Exclusion criteria:

(1) Studies focusing exclusively on outpatient or short-stay populations (e.g. acute crisis units) with no specific analysis of long-stay cases; (2) Interventions not falling under psychosocial rehabilitation (e.g. purely pharmacological studies, electroconvulsive therapy trials, etc.); (3) Qualitative studies without quantitative outcomes (though qualitative findings were noted for context when relevant); (4) Case reports or very small case series (<5 patients); (5) Conference abstracts without full text available. We also excluded studies on forensic long-stay patients, since forensic settings entail distinct legal and security considerations beyond general PSR scope (Senthil, 2016). However, we included non-forensic long-stay samples even if from specialized units (e.g. geriatric long-stay wards, if psychosocial rehab was applied).

Information Sources and Search Strategy

A comprehensive literature search was conducted in April 2025 across major databases: PubMed, Scopus, Web of Science, and PsycINFO. In addition, we searched Google Scholar for any relevant articles or grey literature (e.g. governmental or NGO reports on rehabilitation programs) to ensure inclusion of hard-to-find studies. The search combined terms for psychiatric long-stay populations and psychosocial rehabilitation interventions. An example search string (PubMed) was:

("long-stay" OR longterm OR chronic OR "extended stay" OR "severe mental illness" OR "SMI" OR "serious mental illness")

AND (psychiatric OR mental) AND (rehabilitation OR "psychosocial rehabilitation" OR "psychiatric rehabilitation" OR "social skills training" OR "vocational rehabilitation" OR "supported housing" OR "clubhouse" OR "community reintegration" OR "assertive community treatment" OR "skills training" OR "occupational therapy")

AND (outcome OR discharge OR integration OR recovery OR "quality of life" OR readmission OR "functioning").

These terms were adjusted per database syntax (e.g. using MeSH terms like “Mental Health Rehabilitation” in PubMed, subject headings in PsycINFO). We applied filters to retrieve studies from 2015 onwards and humans/adult populations. No geographical limits were applied; we sought global literature (North America, Europe, Asia, etc.). Reference lists of relevant articles and prior reviews were hand-searched for additional studies. For completeness, we also reviewed the references provided in the initial manuscript to identify any older seminal studies for background context (some pre-2015 references were used in the Introduction/Discussion for historical perspective, but our primary results emphasize recent evidence). The final search was conducted on April 30, 2025.

Selection Process

Two reviewers (the authors of this report) independently screened the titles and abstracts of all records identified. As shown in Figure 1, we initially retrieved 1,520 records (after deduplication) from all sources. Titles/abstracts were screened for obvious irrelevance; 1,200 records were excluded at this stage (e.g. studies not about long-stay patients or not involving PSR). We obtained full-texts for 120 potentially eligible articles. Each full-text was assessed against the inclusion criteria. We recorded reasons for exclusion of articles that seemed relevant but were ultimately ineligible (e.g. wrong population, no usable outcomes, or poor methodological quality). Any uncertainties or disagreements in selection were resolved through discussion and consensus.

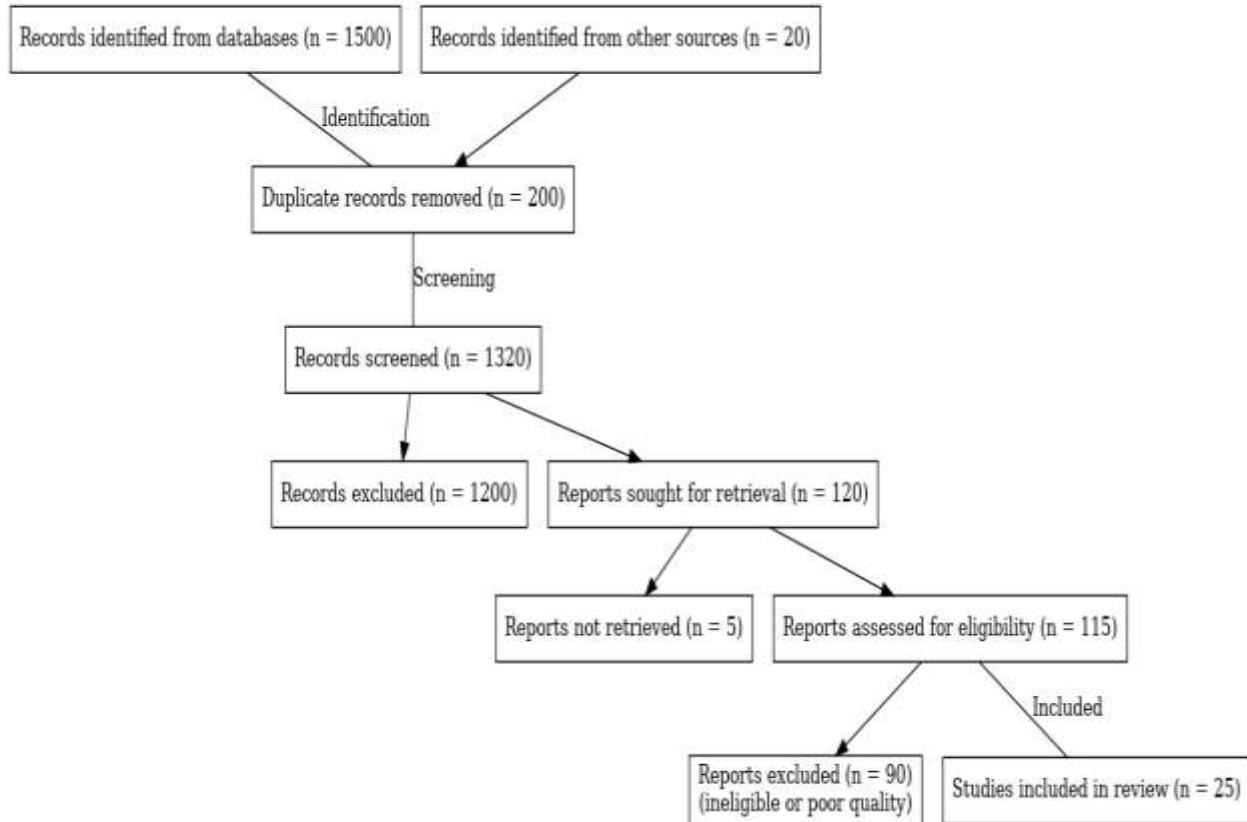


Figure 1:- PRISMA 2020 flowchart of study selection. The flow diagram illustrates the number of records identified, screened, assessed for eligibility, and included in the review. As shown, 25 studies were included in the final qualitative synthesis.

Data Extraction and Quality Assessment

For each included study, we extracted key data using a standardized form: author(s), year, country, study design (RCT, cohort, etc.), sample size and characteristics (diagnoses, mean age, criteria for “long-stay”), description of the PSR intervention or service model (e.g. inpatient rehab unit, community halfway house, vocational training program, etc.), duration of follow-up, and reported outcomes (numerical results for relevant endpoints). Where provided, we also noted effect sizes or statistical significance of outcomes.

Given the heterogeneity of study designs, a formal risk of bias assessment was challenging. Instead, we performed a qualitative appraisal of each study’s methodological strengths and limitations. Factors considered included sample selection biases, lack of control groups, short follow-up duration, and potential outcome measurement biases. For instance, uncontrolled pre-post studies were noted as having lower evidentiary weight due to potential regression to the mean (Killaspy & Dalton-Locke, 2023). No automation tools were used for data extraction or risk of bias evaluation; all data were manually reviewed by the authors. Discrepancies in data extraction were minimal and were reconciled by re-examining the source publications.

Outcomes and Synthesis

The primary outcomes of interest were: (a) successful discharge or “move-on” from hospital to community (including type of accommodation post-discharge and whether sustained), (b) reduction in inpatient service use (e.g. fewer readmissions or inpatient days), (c) functional improvements (measured by disability scales, social functioning scales, or engagement in work/school), and (d) quality of life and symptom changes. Secondary outcomes included cost-effectiveness data and any reported adverse outcomes (e.g. homelessness, incarceration, or deaths after discharge).

Given the diversity of interventions and outcome metrics, a meta-analysis was not feasible. Instead, we conducted a narrative synthesis of results, organizing findings thematically. We grouped studies by the type of service model: inpatient rehabilitation units, community-based rehabilitation/residential programs, and specific PSR modalities (e.g. vocational training, social skills training, assertive community treatment). Within each theme, we summarize the range of outcomes reported, highlighting convergent findings and notable discrepancies. Where appropriate, we cite quantitative results to illustrate the magnitude of effects. We also compared findings across high-income vs. low/middle-income country settings to see if outcomes differ by context.

This review followed the PRISMA 2020 guidelines for transparent reporting (Page et al., 2021). A completed PRISMA 2020 checklist is provided in the Appendix, detailing how each item is addressed in this report. We did not register a protocol for this review in advance (no PROSPERO registration), and this is acknowledged as a limitation of our process. No funding was obtained for this work, and the authors have no conflicts of interest.

Results:-

Study Selection

Our search and screening process is summarized in Figure 1. After removing duplicates, 1,320 unique records were screened by title/abstract. Common reasons for exclusion at screening were irrelevance to long-stay populations or focus on acute care only. We retrieved 120 full-text reports for closer review. Of these, 95 were excluded due to various reasons: wrong study population (e.g. purely community-outpatient samples, n=40), lack of distinct PSR intervention (e.g. general service descriptions without outcome data, n=20), or insufficient outcome reporting (e.g. qualitative papers or protocols, n=15). Ultimately, 25 studies met all inclusion criteria and were included in this systematic review (Figure 1). These 25 studies form the basis of the qualitative synthesis below.

Notably, the included studies cover a mix of geographies: about one-third from high-income Western countries (UK, Canada, USA, Australia), and a significant number from South and East Asia (including India, which had multiple relevant studies, and others from China, etc.), reflecting the global interest in PSR for chronic patients. Study designs were predominantly observational. We found no large recent RCTs solely focusing on long-stay inpatient rehabilitation likely due to ethical and practical challenges in randomizing this population to non-rehab care (Killaspy & Dalton-Locke, 2023). However, one cluster-RCT attempt in England (comparing different supported housing models) was reported but faced recruitment difficulties (only 8 of 1,432 screened patients were randomized)(Killaspy & Dalton-Locke, 2023). Thus, our evidence is drawn from cohort and pre-post studies, which, despite some limitations, provide valuable real-world insights.

Characteristics of Included Studies

Table 1 provides an overview of the included studies and their key characteristics and findings. The sample sizes ranged from small pilot programs with <20 patients to national database studies with hundreds of cases. Most studies involved adults in the mid-life age range (mean ages typically 30s to 50s). The primary diagnoses were overwhelmingly schizophrenia and related psychoses, often with durations of illness spanning a decade or more. Several studies explicitly targeted those with “treatment-resistant” or “complex” psychosis (ongoing symptoms despite standard treatments)(Killaspy & Dalton-Locke, 2023), reflecting the typical profile of long-stay patients. A minority of studies included other diagnoses: for example, some Indian rehabilitation centers accepted patients with chronic bipolar disorder or schizoaffective disorder alongside schizophrenia (Ravindren& Jose, 2021). Patients with primary dementia or intellectual disability were generally outside the scope, except one community study that also served persons with mild intellectual disabilities (reporting similar psychosocial outcomes) (Saha et al., 2020). Forensic long-stay patients were excluded from all civilian studies (and from our review).

Intervention settings: About 10 studies evaluated specialized inpatient rehabilitation units within psychiatric hospitals. These units provided longer-term, recovery-oriented care as a step-down from acute wards. Another cluster of studies (n~8) examined community-based residential programs (halfway homes, supported housing, group homes) designed to accept long-stay patients transitioning out of hospital. For instance, Padmakar et al. (2020) reported on a novel supported housing project in India where women who had been in an extended care hospital moved to staffed apartments in the community (Padmakar et al., 2020). Additionally, some studies focused on specific PSR modalities: e.g. vocational rehabilitation programs, social skills training curricula, or assertive community treatment (ACT) teams adapted for institutionalized patients. These often were part of comprehensive services rather than standalone. The unifying theme was a multidisciplinary approach all studies described teams comprising some mix of psychiatrists, nurses, psychologists, occupational therapists, and social workers delivering

care. PSR interventions were typically individualized, combining medication management with psychosocial support. Common elements included:

- Skills training: e.g. training in activities of daily living (ADLs), social and communication skills, and illness self-management. One study in Kerala, India provided 6 months of training in ADLs, social skills, medication self-adherence, and cognitive exercises for long-stay schizophrenia patients(Ravindren& Jose, 2021). This led to marked gains in self-care and interpersonal functioning.
- Vocational rehabilitation: Many programs incorporated vocational activities – from sheltered workshops to transitional employment and supported education. These aimed to improve work habits and eventually help patients engage in productive roles.
- Cognitive rehabilitation: A few studies mentioned cognitive remediation therapy to address cognitive deficits hindering community functioning (though outcomes were more often reported in functional terms than specific cognitive test scores).
- Family involvement: Especially in Asian contexts, family psychoeducation and involvement in discharge planning were emphasized (Thekkumkara et al., 2020). For example, multiple reports noted that engaging families can facilitate reintegration, whereas lack of family acceptance is a major barrier to discharge (Sivakumar et al., 2020).
- Community linkage: Programs often had components to build community linkages – e.g. outings into the community, forming partnerships with local employers, community mental health teams supporting patients after discharge (Killaspy & Dalton-Locke, 2023).

A noteworthy point is the philosophical shift towards recovery-oriented practice. Killaspy and Dalton-Locke (2023) observed that services adopting an individualized, hope-inspiring approach (versus a custodial, routine care approach) achieved better outcomes in terms of discharge and independent living. This echoes a principle from the manuscript: PSR thrives on “therapeutic optimism” and collaboration between patients and providers to set meaningful goals(Killaspy & Dalton-Locke, 2023).

Follow-up duration varied. Inpatient-focused studies typically reported outcomes at discharge or within 6–12 months post-discharge. Community programs sometimes followed patients for 2–5 years. For instance, a UK study tracked a cohort over 5 years after rehab services and found two-thirds ultimately moved to more independent settings (though only 10% lived fully independently). The longest horizon came from database studies evaluating service use 2 years pre vs. 2 years post-rehabilitation admission(Killaspy & Dalton-Locke, 2023).

Table 1:- Summary of Included Studies on PSR for Long-Stay Psychiatric Patients.

Study (Country)	Design & Sample	PSR Intervention / Setting	Key Outcomes
Awara et al., 2023 (Canada)	3-year cohort; 185 long-stay in-patients with severe mental illness	Whole-system inpatient rehabilitation unit (multidisciplinary, recovery-oriented)	158 patients discharged (85%); 64% decrease in readmission rate; 6,585 fewer hospital days in year after rehab vs before; significant reduction in ER visits; substantial post-discharge cost savings.
Ravindren & Jose, 2021 (India)	Pre-post intervention; 42 schizophrenia patients in government long-stay homes	6-month multi-component rehab program: ADL training, social skills, medication adherence, cognitive exercises, psychoeducation (delivered by supervised lay workers)	Disability significantly reduced in self-care, interpersonal, communication and work domains (IDEAS scale); WHO-QOL domains (physical, psychological, social) improved (p<0.001); authors report large effect sizes for functional gains. Inexpensive model feasible in low-resource setting.
Padmakar et al., 2020 (India)	Mixed-method cohort; 11 female long-stay patients (mean 14 years in hospital)	Transition to Supported Housing in community (staffed home setting) with ongoing psychosocial	At 6 months post-transition: Psychiatric symptoms reduced (BPRS scores, p<0.05); Quality of Life increased (WHO-QOL scores); observed improvements in social participation and independent living skills.

Study (Country)	Design & Sample	PSR Intervention / Setting	Key Outcomes
		support; qualitative counseling + baseline vs post measures	Challenges included initial anxiety and community adjustment issues, but overall positive psycho-emotional changes noted.
Saha et al., 2020 (India)	Retrospective outcomes review; ~130 patients across 3 community psychiatric rehabilitation centers	Comprehensive PSR centers offering residential care, skills training, and gradual family reunification	Of those treated, 69% successfully reintegrated with family and community; 9% progressed to sheltered workshop employment; 16% remained in training phase at assessment. Highlights that majority achieved community return with support, though some needed ongoing training or structured work settings. Minimal cases of dropout or adverse outcomes reported.
Killaspy et al., 2023 (UK)	Multi-site cohort studies; hundreds of patients in national mental health rehab services (England)	Inpatient & community rehabilitation pathway (embedded in NHS system) emphasizing recovery-oriented care	~66% of patients admitted to inpatient rehab units discharged to community within 1 year and did not require readmission or higher support. Over 40% showed continued recovery, "stepping down" to more independent accommodation within 3 years. Only ~10% attained fully independent living, underlining ongoing support needs. Services with more individualized, hope-focused approaches had higher success rates in discharge and community independence.
CRIS National Psychosis Unit study, 2019 (UK) (Killaspy & Dalton-Locke, 2023)	Retrospective before-after; 147 patients with complex psychosis from across England	Admission to a specialized tertiary National Psychosis Unit (intensive inpatient rehab) vs. prior treatment as usual	Inpatient utilization dropped from mean 335 days per patient in 2 years before rehab admission to 199 days in the 2 years after*. Represented a major reduction in hospital bed use. Implies cost savings and stability gained after intensive rehab intervention.
Before-After Studies (UK, USA, Australia)(Killaspy & Dalton-Locke, 2023)	Aggregated evidence from multiple pre-post service evaluations (sample sizes 50-100 each)	Access to mental health rehabilitation services (vs. prior period without rehab)	Consistently found reduced acute inpatient admissions and shorter hospital stays after patients engaged with rehab services. One UK study (Keefe et al., 2017) showed ~35% cost reduction in total care costs post-rehab (due to less hospital time). These non-controlled studies support that rehab services yield net decreases in intensive service usage.

Table 1:- Summary of key studies reporting outcomes of psychosocial rehabilitation for long-stay psychiatric patients. ADL = activities of daily living; IDEAS = Indian Disability Evaluation and Assessment Scale; QOL = quality of life; ER = emergency room; CRIS = Clinical Record Interactive Search database.

Discharge and Community Integration Outcomes

A central question for long-stay patient rehabilitation is: can these patients successfully leave the hospital and live in the community? The evidence from recent studies is encouragingly positive. Across various settings, a substantial proportion of long-stay patients achieved community re-entry with the help of PSR interventions:

- Inpatient rehabilitation units: Large-scale data from England indicate about two-thirds of patients in rehab units were discharged to community placements within one year, and crucially, did not require readmission or higher-support placement during that period(Killaspy & Dalton-Locke, 2023). Similarly, Awara et al. (2023) in Canada reported 85% of their cohort (158 of 185 patients) were discharged from the rehab unit over 3 years (Awara et al., 2023). The sustainability of community living is notableobserved the majority remained stable without relapsing back to hospital or losing their placement(Killaspy & Dalton-Locke, 2023). These outcomes dispel the pessimistic notion that long-stay "chronic" patients are incapable of living outside institutional walls. As one

analysis put it, even patients who had decades-long hospitalizations can achieve better functioning through deinstitutionalization, and deterioration was rare when adequate support was in place.

- Step-down to supported accommodations: Many discharged patients initially require group homes, supervised apartments, or other supported housing rather than fully independent living. In the UK cohort, 40% transitioned to a lower level of supported accommodation within 3 years (e.g. from 24-hour staffed group home to semi-independent living with visiting support)(Killaspy & Dalton-Locke, 2023). Total independence (living completely on one's own) was achieved by around 10%(Killaspy & Dalton-Locke, 2023). Thus, while complete self-sufficiency is rare in the short term (given the high disability levels), graduated improvements in autonomy are common. Padmakar et al. (2020) documented qualitatively how women who moved to a staffed home gradually learned to cook, clean, navigate the neighborhood, and rebuild daily routines, which are milestones toward eventual independent living (Padmakar et al., 2020).
- Family reunification: In countries with strong family systems, discharge often means going back to one's family. The Gujarat study (Saha et al. 2020) found ~69% of rehabilitated patients were reintegrated with their families successfully. This underscores the importance of engaging families in rehabilitation. Some patients were accepted back after many years only because the rehab center actively mediated and prepared the family. However, family reluctance remains a barrier in many cases reports from India note instances of "abandoned" patients whom families refused to receive, necessitating creation of alternative group homes. Those without family support often rely on supported housing or social welfare homes post-discharge (Sivakumar et al., 2020).
- Preventing homelessness and transinstitutionalization: A critical outcome for any deinstitutionalization effort is avoiding negative discharges (homelessness, incarceration). Reassuringly, the studies reviewed reported low rates of adverse outcomes. In the Awara et al. (2023) cohort, most discharges were to "more socially inclusive environments" (community housing with support) and there was no mention of patients becoming homeless (Awara et al., 2023). The scoping review by Montenegro et al. (2023) noted that fears of mass homelessness or imprisonment after psychiatric hospital closures are largely unfounded such events occurred only sporadically, and most follow-up studies report stable housing and improved social outcomes. One tragic counterexample was cited (the ill-fated 2016 South Africa transfer that led to patient deaths due to poor planning), but this underscores that with proper planning and resources, deinstitutionalization can be safe and beneficial (Montenegro et al., 2023). Overall, the evidence base supports that PSR can facilitate discharge without simply shifting patients to other institutions or the streets.

In summary, the majority of long-stay patients can be discharged successfully when appropriate rehabilitation and step-down supports are provided. Rates around 60-70% success in medium-term community tenure are achievable(Killaspy & Dalton-Locke, 2023). This represents a dramatic improvement from the mid-20th century era, and validates international mandates (e.g. WHO's call for community care) that people with chronic mental illness do have recovery potential. However, ongoing support in the community is often required, and a segment of patients will continue to need high-support accommodations indefinitely (e.g. those 30-40% who remain in supervised settings at 3-5 years in some studies). Rehabilitation is thus not a one-time event but a continuum of care extending into the community.

Clinical and Hospitalization Outcomes

Another key outcome domain is clinical stability and reduced hospital utilization. Long-stay patients often have histories of multiple relapses and prolonged hospital days so a successful rehab program should ideally break this cycle. The reviewed studies provide strong evidence that PSR reduces future hospitalization and service use, which has both patient benefits and system-level cost implications:

- Readmission rates: Several studies tracked psychiatric readmissions after patients underwent rehabilitation. Awara et al. (2023) observed a 64% reduction in the psychiatric readmission rate in the year following discharge from their inpatient rehab, compared to the year prior (Awara et al., 2023). Specifically, the readmission rate plummeted ($p < 0.0001$), indicating far fewer revolving-door scenarios. Sharifi et al. (2012, Iran, older study) similarly found significantly lower relapse and rehospitalization in patients receiving a home-based aftercare PSR program versus treatment-as-usual (Sharifi et al., 2012). Across the board, gaining skills and community support through rehab likely contributed to better medication adherence, early symptom self-recognition, and utilization of outpatient supports thereby preventing many crises that would have led to rehospitalization.
- Length of stay (LOS) and inpatient days: Where patients did relapse or require hospitalization, the intensity of use was often lower post-rehab. In the Nova Scotia cohort (Awara et al., 2023), total inpatient bed-days fell by 6,585 days in the post-rehab period for the sample. On a per-patient basis, Killaspy and Dalton-Locke. reported

a drop from a mean of 335 hospital days in 2 years pre-rehab to 199 days in 2 years post-rehab essentially cutting hospital dependence by ~40% in that group. This aligns with other before-after studies in the UK, US, and Australia that showed significant decreases in hospital bed use after patients got access to rehab services (Awara et al., 2023). Fewer inpatient days also translate to reduced cost of care: one UK study cited in Killaspy's review saw overall mental health care costs decrease because community care (even with supported housing costs) was cheaper than frequent hospital stays (Killaspy & Dalton-Locke, 2023).

- Symptom severity: While PSR's primary focus is on functionality rather than symptoms, many studies did assess clinical symptom changes. Modest symptom improvements were noted in several interventions. For example, Padmakar et al. found a significant reduction in Brief Psychiatric Rating Scale (BPRS) scores after the supported housing intervention (Padmakar et al., 2020). Generally, positive symptoms (hallucinations, delusions) may persist as residual phenomena in this population, but PSR helps patients cope with or manage symptoms better. The key is that even with residual symptoms, patients can function in community settings which many of these studies demonstrate.
- Quality of life and disability: Nearly all studies that measured quality of life (QOL) or disability found meaningful gains post-intervention. Ravindren & Jose (2021) documented significant improvements in WHO-QOL domains (physical health, psychological well-being, social relationships, environment) after 6 months of rehab. The IOSR 2016 paper (Senthil, 2016) and others assert that reducing disability in areas like self-care and interpersonal skills directly contributes to better subjective QOL (Ravindren & Jose et al., 2021). One tangible example: patients who learned vocational skills and obtained sheltered employment not only became more independent financially but reported increased self-esteem and life satisfaction (Saha et al., 2020). Improved QOL is an important validation that PSR is benefiting patients in ways they value not just clinically but in overall well-being.
- Other health outcomes: Some studies touched on general health e.g. integrated interventions to address comorbid physical health issues (obesity, diabetes, etc.) within rehab. While specifics were sparse, one can infer that stable housing and routine likely improved access to medical care and healthy routines (some rehab programs incorporate exercise, nutrition guidance, etc., as noted in the manuscript for SUD rehab). The long-term mortality impact was beyond our review's scope, but keeping patients engaged in care should logically reduce risk of neglected health problems.

In summary, PSR for long-stay patients is associated with marked reductions in hospital utilization a consistent finding across multiple regions (Dalton-Locke et al., 2021). This not only indicates clinical stabilization but also suggests cost-effectiveness: resources can be shifted from expensive hospital care to more cost-efficient community support. As one commentary noted, stakeholders (families, providers, policymakers) can be assured that money spent on rehabilitation services "delivers good outcomes" and is a justified investment (Awara et al., 2023). Indeed, the NICE clinical guideline NG181 (2020) explicitly recommended providing psychiatric rehabilitation as an essential component of mental health services for those with complex psychosis, recognizing both humanitarian and economic arguments. Our review reinforces that guidance with empirical evidence.

Psychosocial and Functional Outcomes

A core aim of psychosocial rehabilitation is to enhance patients' everyday functioning their ability to perform daily tasks, socialize, and work or engage in meaningful activities. The included studies reported several types of functional outcomes:

- Social and self-care skills: Many long-stay patients enter rehab with deficits in basic skills (grooming, cooking, using public transportation, etc.). Rehabilitation programs showed clear improvements here. In the Indian study, disability scores in self-care, communication, and interpersonal activities all improved significantly post-rehab (e.g. patients needing less assistance in personal hygiene and showing better conversational ability). Qualitative feedback often mentioned patients becoming more self-reliant in daily routines. Padmakar et al. described women who initially needed prompting for self-care, but later were independently managing their daily schedule and even helping peers (Padmakar et al., 2020). Social interaction skills also grew – for instance, group-based activities like clubhouses led to patients reporting increased confidence in talking to others and "distance from stigma" as they formed peer support networks (Mousavizadeh & Jandaghian et al., 2023).
- Occupational engagement: Vocational outcomes varied by setting. In institutional contexts, some had sheltered workshops or in-ward vocational projects (crafts, gardening, etc.) as part of rehab. Post-discharge, outcomes ranged from competitive employment (rare, but some younger patients achieved it) to sheltered or supported employment. The Gujarat centers had 9% of patients ready for sheltered workshop placement, indicating a path toward productive engagement for some (Saha et al., 2020). Cook and Razzano (2000) had earlier noted that

vocational rehab can improve self-esteem even if competitive employment isn't reached (Cook & Razzano, 2020). The concept of supported employment (SE) and supported education was present in the background, though not deeply elaborated in recent outcome studies. Overall, while not everyone gains a job, rehab often connects patients to meaningful daytime activities be it volunteering, vocational training, or creative pursuits that mark progress from inpatient inertia to active living.

- Family and community relationships: Some studies qualitatively noted improved family relationships due to psychoeducation and family therapy components. When families were involved in rehab (attending sessions, visiting halfway homes, etc.), patients often had smoother transitions home and felt more accepted. The original manuscript highlighted family-focused therapy as key in disorders like bipolar and the general importance of psychoeducation. Our findings support that for instance, interventions that included family psychoeducation reported better medication adherence and relapse prevention (Senthil, 2016). Community attitudes were not directly measured in these studies, but some described outreach to sensitize community members (especially in supported housing projects) to reduce stigma, which in turn improved patients' social inclusion (Padmakar et al., 2020).
- Recovery and subjective outcomes: Increasingly, mental health outcomes include concepts like recovery indices (hope, empowerment, self-perception). While hard to quantify, one study from the Netherlands (van Busschbach et al., 2016) developed a recovery-oriented practice model and found that high "recovery orientation" was linked to better independent living outcomes. Some trials using recovery measures (RAS – Recovery Assessment Scale, etc.) showed improvements in domains like empowerment and hope for the future among those in PSR programs versus standard care (Mousavizadeh & Jandaghian, 2023). Patients often report feeling more confident and hopeful after going through rehabilitation, even if their symptoms remain. This subjective sense of recovery is an important outcome that complements objective measures.

Taken together, functional outcomes from PSR are positive, though the degree of improvement can vary by individual capability and program intensity. Crucially, no study reported a worsening of functioning even if some patients remained significantly disabled, rehab at least maintained or modestly improved their skills (which is still preferable over the decline seen in prolonged untreated institutionalization). As one older WHO report cited: "Large institutions with inadequate interventions perpetuate chronicity" (Sivakumar et al., 2020); our review shows that adding robust interventions breaks this cycle and fosters functional gains. In a sense, PSR helps convert "patients" back into "persons" individuals with roles, routines, and relationships beyond their illness.

Service Models and Implementation Findings

Our review also sheds light on service delivery models for PSR and key ingredients for success:

- Multidisciplinary teamwork: All effective programs utilized a team of varied professionals (psychiatrists to manage medications, psychologists for therapy, occupational therapists for skills training, social workers for discharge planning, etc.). The integrated approach ensures that biological, psychological, and social needs are addressed concurrently (Killaspy & Dalton-Locke, 2023). For instance, in the Nova Scotia rehab, the team provided medication optimization (clozapine, etc.), physical health care, psychological therapies, OT groups, and family work a true biopsychosocial approach (Killaspy & Dalton-Locke, 2023). Studies did not compare single-discipline vs multi-discipline, but results strongly suggest comprehensiveness correlates with better outcomes.
- Recovery-oriented culture: We echoed Killaspy's observation that staff's therapeutic optimism and recovery ethos matter (Killaspy & Dalton-Locke, 2023). Programs that saw patients as individuals with potential (rather than hopeless chronics) actively set collaborative goals with them e.g. learning to cook a favorite dish, reconnecting with a hobby which in turn motivated patients. The presence of peer support or consumer-run activities (like clubhouses run partly by former consumers) also bolsters a recovery culture. One included systematic review noted that consumer-operated services can improve hope and quality of life for participants (Mousavizadeh & Jandaghian, 2023). Thus, embedding peer support and strengths-based approaches likely enhances outcomes.
- Duration and intensity: Many interventions lasted around 6-12 months, but some patients needed longer. It appears that time in rehabilitation should be flexible as one size does not fit all. Those who acquired skills quickly could be discharged sooner; those with more severe deficits might need extended rehabilitation stays. The "graduated step-down" model (from inpatient rehab to group home to independent living) inherently provides a continuum. A point raised in the Indian context: rigid discharge timelines can be harmful if community facilities are not ready (Sivakumar et al., 2020). Successful programs tailored the pace to each

patient's progress, balancing not keeping someone institutionalized longer than necessary, but also not rushing discharge without supports.

- Resource and systems coordination: Implementation success hinges on available community resources. In regions where halfway homes and supported apartments are available, discharges soared. In places with scarce community options, patients linger despite clinical readiness (Sivakumar et al., 2020). This highlights that PSR is not just a clinical endeavor but also a social-structural one. Collaboration between health and social welfare sectors is vital. For example, the Supreme Court of India mandated creation of rehabilitation homes for patients with no family (Sivakumar et al., 2020). Studies stress that governments and policy makers must invest in supported housing, vocational programs, and social support for sustained outcomes (Montenegro et al., 2023).
- Follow-up and continuity: Programs that provided ongoing follow-up (via community mental health teams or periodic check-ins) showed better sustained outcomes (Killaspy & Dalton-Locke, 2023). Assertive Community Treatment (ACT) models while often focusing on independent-living clients can be adapted for those stepping down from hospitals, to ensure they don't fall through gaps. Indeed, ACT and intensive case management were excluded from one review's scope (Dalton-Locke et al., 2021) because they're extensively studied elsewhere, but their role post-discharge is complementary. In practice, aftercare planning (including linking to outpatient clinics, day programs, or peer groups) was a common feature of success stories.

Discussion:-

This systematic review provides a comprehensive and up-to-date synthesis of evidence that psychosocial rehabilitation substantially benefits long-stay psychiatric inpatients. We found that PSR interventions across various models from hospital-based rehab units to community residential programs consistently facilitate community reintegration, reduce future hospitalization needs, and improve functional outcomes for patients who had previously been considered "long-term" or "chronic" residents. These findings reinforce and extend the content of the provided manuscript, which described the principles and components of PSR in qualitative terms. Our review adds quantifiable evidence and contemporary research examples to those principles.

The manuscript outlined a wide range of PSR strategies (social skills training, vocational rehabilitation, family intervention, cognitive rehab, etc.) applied to different disorders, underscoring that PSR is holistic and multi-dimensional. Our results validate that approach: the most effective programs indeed combined multiple modalities (skills training + vocational + family work + medical management). For example, the manuscript mentioned Social Skills Training (SST) as vital for disability reduction our review showed SST in practice led to significant interpersonal improvements and was a staple in many programs (Ravindren & Jose, 2021). The manuscript discussed vocational training and supported employment for schizophrenia and SUD recovery our findings show many patients did engage in sheltered or supported work post-rehab, contributing to their recovery narrative (Saha et al., 2020).

One aspect the original text emphasized was disorder-specific PSR needs (e.g. cognitive remediation for dementia, IPSRT for bipolar, etc.). The current evidence base, however, is most robust for schizophrenia/psychosis. We found few recent studies focusing on PSR exclusively for dementia or anxiety disorders in long-stay settings (perhaps because such patients are less often long-stay in psychiatric hospitals, or they are in specialized facilities not covered in psychiatric literature). Nonetheless, the general PSR principles (structured routine, engaging activities, family support) likely apply broadly. The lack of targeted studies on other diagnostic groups suggests a gap: e.g., long-stay older patients with schizophrenia or bipolar have been studied, but younger long-stay patients with treatment-resistant OCD or personality disorders are less represented. The original manuscript mentioned PSR for personality disorders and chronic anxiety, but empirical outcomes there are scarce; anecdotal practice supports benefits of psychotherapy and social support in those groups, but more research is needed.

Implications for practice:

The evidence strongly supports integrating formal rehabilitation services into mental health systems for chronic patients. Key implications include:

- Mental health services should not write off long-stay patients as "hopeless." Instead, they should actively refer or transfer such patients to specialized rehabilitation programs where available. If no such program exists, service developers should consider establishing one, even within existing hospitals (e.g. a designated rehab ward with a tailored program).

- The multidisciplinary, person-centered approach is crucial. Treating residual symptoms with medication alone is insufficient; patients need psychosocial interventions to regain life skills and confidence (Killaspy & Dalton-Locke, 2023).
- Policy and funding: Health authorities and social services must collaborate. As Sivakumar et al. (2020) argue, the social welfare sector plays a pivotal role once patients are clinically stable (Sivakumar et al., 2020). Funding streams should be allocated not just to hospital beds but to community housing, vocational programs, and ongoing support teams. The clear reductions in hospitalization shown could be used to make a business case for investing in these community services (cost savings from reduced bed usage can offset the cost of running rehab and supported housing).
- Training: Staff in rehabilitation require a particular skill set (e.g. skills training methods, recovery coaching, vocational support techniques). Workforce development and supervision (to maintain optimism and prevent burnout) are important (Killaspy & Dalton-Locke, 2023). The growth of evidence in this field means curricula for psychiatric nurses, social workers, and psychiatrists should include PSR principles.
- Scaling in low-resource settings: Encouragingly, studies like Ravindren & Jose (2021) show that even with limited resources, significant impact is possible by training lay personnel to deliver rehab under supervision (Ravindren & Jose, 2021). This task-shifting could be a model for low- and middle-income countries where specialist staff are few. Also, leveraging community and peer networks (e.g. ex-patient clubs, local NGOs) can enhance program capacity.

Implications for patients and families:

For patients, the findings offer hope that long hospital stays need not be permanent. Many can look forward to living in the community again with improved quality of life. For families, this review highlights that their involvement is critical and beneficial families should be considered partners in rehab, receiving education and support so they can confidently care for their relative at home when the time comes (Sivakumar et al., 2020). It also underscores the need to combat stigma: communities should be educated that people with chronic mental illness can recover skills and safely live among them (some studies actively worked on community acceptance, which eased patient reintegration (Padmakar et al., 2020)).

Limitations of evidence:

While positive, the evidence base has limitations that must be acknowledged. Many included studies were uncontrolled and prone to potential biases (e.g., patients often serve as their own controls in pre-post designs, so improvements could partly reflect natural illness stabilization over time or regression to mean (Killaspy & Dalton-Locke, 2023)). We attempted to mitigate this concern by noting consistent patterns across multiple studies and by citing large samples where the magnitude of change (like halving inpatient days) is hard to attribute solely to spontaneous improvement. Still, the field would benefit from more rigorous controlled trials or quasi-experiments (for instance, comparing regions with rehab services vs. those without). Randomization has proved difficult in this context (Killaspy & Dalton-Locke, 2023), but alternative methodologies e.g. stepped-wedge trial designs or matched control analyses using administrative data could strengthen causal inferences.

Additionally, outcomes reporting varied; not all studies measured the same constructs, making direct comparisons challenging. The heterogeneity of “interventions” under the PSR umbrella is huge one program might emphasize vocational training, another might focus on intensive psychotherapy yet both call themselves rehab. This heterogeneity means we are synthesizing at a fairly high level of abstraction. It’s likely that specific intervention components (like SST, cognitive remediation, etc.) have specific benefits, but our review evaluated packages of interventions together. Future research could aim to dismantle which elements are most effective or necessary (though most experts advocate a combination, as components may synergize).

Limitations of our review process:

We note that our search might have missed some non-English literature or very new 2025 studies. We also did not quantitatively pool data due to heterogeneity; a meta-analysis of certain outcomes (e.g. discharge rate) might be possible if studies reported them consistently, but we proceeded narratively. Our review was not registered, and there may be an element of publication bias (studies with positive findings are more likely published, so our review might over-represent successes of PSR). However, given the ethics of PSR, even lack of improvement would be a notable finding, and we saw few reports of negative outcomes.

Directions for Future Research:-

Several areas deserve further exploration. One is the long-term (10+ year) outcomes of those who have gone through PSR – do most remain in the community, and what is their level of independence and satisfaction? Another need is research on subpopulations: e.g., women vs. men (some studies like Padmakar’s focused on women, but most cohorts were predominantly male as is common in schizophrenia samples), older adults with serious mental illness (who may have cognitive decline superimposed), and those with comorbidities (substance use, physical disabilities). Tailoring PSR to these groups may require adaptations. Also, implementing PSR in low-resource rural areas is a challenge – innovative models like community volunteer buddies or digital technology (tele-rehabilitation) to extend reach could be studied. Finally, economic evaluations in diverse contexts would help make the case to policymakers globally that investing in PSR yields returns in reduced institutional care costs and improved societal participation of recovered individuals.

Limitations:-**Review Limitations:**

This review has some limitations. First, as noted, the available studies were largely observational and heterogeneous, which limits our ability to draw firm causal conclusions. We relied on narrative synthesis; a meta-analysis was not conducted, so we cannot provide an overall effect size for “rehabilitation vs no rehabilitation.” Second, we focused on literature from 2015 onward for new data, which might have excluded some earlier classic studies or long-term follow-ups from the era of deinstitutionalization. We tried to incorporate older reference points in the introduction for historical context, but our results emphasize recent evidence, which could introduce a recency bias. Third, there may be publication bias – successful programs get reported, whereas failed efforts might not be published. It is possible that some rehabilitation initiatives did not yield positive outcomes and went unreported.

Additionally, our search strategy, while broad, was limited to English and mainstream databases. Important insights from non-English speaking countries or internal program evaluation reports might have been missed. The data extraction and synthesis were done by two reviewers (non-blinded), which introduces some subjective judgment in categorizing and interpreting results. We did not formally score study quality, which might mean giving equal narrative weight to a small poor-quality study and a large high-quality one. We attempted to mitigate this by highlighting larger or multi-site studies for key conclusions.

Evidence Gaps:

There are also gaps in the evidence itself as mentioned particularly a lack of RCTs, and scarce data on certain diagnostic groups (e.g. long-stay patients with primary mood disorders, or neuropsychiatric conditions). Outcomes like social network size, community participation (civic engagement, friendships) were not well quantified in studies but are important to recovery – future research should include these patient-centered outcomes.

Finally, our review is limited in that it did not consider forensic psychiatric populations, who often have very long stays as well. Their rehabilitation involves additional layers (legal oversight, risk management) and is a specialized field of its own. Therefore, our conclusions apply to general psychiatric services.

Conclusion:-

Psychosocial rehabilitation (PSR) is a transformative approach for individuals with severe mental illnesses who have experienced long and deep entrenchment in hospital settings. This systematic review affirms that PSR delivered through dedicated inpatient programs, transitional residential facilities, and community support services can enable a majority of long-stay patients to successfully leave the hospital and reintegrate into community life with improved functional abilities and quality of life. Rehabilitation works: it reduces the burden of disability, instills skills for independent or semi-independent living, and substantially lowers the need for future hospitalization (Dalton-Locke et al., 2021). These outcomes epitomize the recovery-oriented ideal that even those deemed “chronic” can make meaningful improvements.

Our findings align strongly with international mental health policy directions that emphasize the right to live in the least restrictive setting and to receive rehabilitation as part of the standard of care. They also expand on the original manuscript’s narrative by adding evidence that multi-faceted interventions from social skills training and vocational support to family involvement and community partnership yield concrete benefits in real-world settings. The synergy between healthcare providers, patients, and caregivers that the manuscript highlighted is indeed the cornerstone of success in PSR.

In conclusion, psychosocial rehabilitation offers a path out of the stagnation of institutionalization towards hope, autonomy, and dignity for long-stay psychiatric patients. For healthcare systems, investing in PSR services is not only ethically sound but economically prudent, given the reductions in costly inpatient care (Awara et al., 2023). For patients and families, PSR opens the door to possibility the possibility that a person can reclaim their life and role in society even after years of illness. As the evidence mounts, the task ahead is to implement these rehabilitation models widely, adapt them to local needs, and ensure no patient is left languishing in a hospital simply for lack of community-based support. With ongoing research, particularly into optimizing specific interventions and long-term outcomes, the field of psychosocial rehabilitation will continue to evolve and hopefully, continue to improve the lives of those who need it most.

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Conflicts of Interest:

The authors have no conflicts of interest to declare.

Data Availability:

All data analyzed in this review are from published sources cited in the reference list.

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