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SPECIAL PAPER

Psychiatric rehabilitation in Oman: service gaps and a framework for recovery-oriented care

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Psychiatric rehabilitation is a crucial aspect of recovery-oriented mental healthcare, yet it remains underdeveloped in Oman. This paper reviews the current state of rehabilitation services, identifying systemic gaps in in-patient, day care and community-based provisions. Services are fragmented, lacking adequate multidisciplinary integration, sufficient community rehabilitation and supported housing, which leads to prolonged hospital stays. Additionally, broader challenges such as stigma and limited intersectoral collaboration hinder service development. The paper suggests practical strategies to enhance rehabilitation services, including the establishment of multidisciplinary teams, expansion of community programmes, provision of supported accommodation and workforce training, all aligned with Oman Vision 2040 and the principles of recovery-oriented mental health care.

Psychiatric rehabilitation combines clinical, psychosocial and vocational interventions to support recovery, independence and social participation. It offers a cost-effective alternative to custodial care for people with severe mental illness (SMI) by equipping them with the skills needed for community living.[1] Without such services, SMI is often associated with long-term disability, marginalisation and increased mortality, particularly when standard treatments do not achieve remission.[2] Evidence from high-income settings shows that two-thirds of long-stay patients in rehabilitation facilities can transition successfully to community living within 12–18 months, with many maintaining independence in the long term.[3] Recovery-oriented care, grounded in human rights, person-centred practice and peer involvement, is now the international standard.[4] Yet in many low- and middle-income countries, rehabilitation remains fragmented and underfunded.[5] Oman, a high-income country in the Gulf of Oman, has made major advances in psychiatric service provision, with out-patient clinics in most governorates and a national tertiary facility, Al Masarra Hospital, offering a wide range of subspecialties.[6] However, the development of psychiatric rehabilitation has lagged. Existing in-patient, day care and community services remain limited in scope, and systemic gaps continue to hinder recovery. Addressing these challenges is essential if Oman is to align with the principles of Vision 2040 and move from custodial care towards recovery-focused mental health services.

Current status

Al Masarra Hospital currently has two gender-specific rehabilitation wards. However, these wards mainly serve as step-down facilities to ease pressure on acute beds and maintain a structure similar to that of acute wards, primarily admitting patients who are less acutely ill rather than offering structured rehabilitation environments. Patients are often transferred without thorough rehabilitation assessments or individualised care plans, and discharge decisions are typically made by the treating psychiatrist instead of through a multidisciplinary team process. As a result, readmission rates are high: a retrospective study conducted at two tertiary psychiatric facilities in Oman found a 39% 1-year readmission rate.[7] Additionally, over 25 patients remain in long-term general psychiatric wards, with some having been hospitalised for several decades. In many instances, prolonged hospitalisation does not indicate ongoing clinical instability but rather a lack of adequate social support, community accommodation and structured pathways for community reintegration. This situation underscores the need for clear rehabilitation referral pathways and supported housing options, which are essential components of modern rehabilitation psychiatry.

The current day care within the hospital offers vocational activities, activities of daily living training, creative therapies and physical exercise. Recreational facilities include a swimming pool, sports courts and garden areas. However, these services are not sufficiently integrated into structured rehabilitation programmes, which limits their potential contribution to recovery-oriented care.

Gaps and challenges in Oman

Despite the expansion of psychiatric services in Oman, rehabilitation psychiatry is still in its early development stages and faces considerable systemic challenges.[8] The existing service structure reveals gaps in in-patient care, community support, workforce capacity and governance, all of which hinder the provision of recovery-oriented care.

In-patient and multidisciplinary care

A major gap is the lack of a dedicated in-patient rehabilitation model based on recovery principles.

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Current wards do not have structured multidisciplinary input or a therapeutic, home-like environment, which hinders comprehensive rehabilitation. This leads to fragmented care, fewer opportunities for functional recovery and extended inpatient stays. Workforce limitations further complicate this issue, restricting access to specialised input across various care settings.

Day care services

Although there is a well-developed infrastructure for day care services, these are underutilised due to accessibility challenges and staffing shortages. Attendance is often impeded by transportation, financial issues and social stigma,[9] particularly for individuals in rural areas. Additionally, a lack of trained occupational therapists and minimal integration with ward-based teams, evident in their limited participation in multidisciplinary meetings and care planning, diminish the effectiveness of rehabilitative interventions.

Community-based rehabilitation

Community rehabilitation in Oman is still underdeveloped. The current Community Mental Health Service relies on a small outreach nursing team that supports approximately 98 patients, primarily focusing on medication delivery and clinical follow-up. Although a pilot study has shown reductions in hospital admissions and associated costs,[10] this model offers limited access to structured psychosocial rehabilitation and specialised psychiatric support in community settings. Key elements of modern rehabilitation psychiatry, such as skills training, supported employment, vocational rehabilitation and family psychoeducation, are largely missing. Additionally, the absence of a multidisciplinary community rehabilitation team restricts the range of available interventions, undermining continuity of care following discharge and hindering long-term recovery and reintegration into the community.

Structural and systemic barriers

These service gaps are compounded by broader structural challenges, including the absence of supported accommodation, a coordinated clozapine monitoring system and limited intersectoral collaboration. Additional contextual factors, particularly stigma and culturally influenced help-seeking behaviours, further restrict access to care and negatively impact recovery outcomes. Evidence from Oman shows that mental illness is often interpreted through spiritual or traditional lenses, leading many families initially to seek assistance from traditional healers rather than from formal mental health services.[11]

This pattern of seeking help is linked to delays in obtaining psychiatric care. In a study of drug-naïve adolescents in Oman presenting with first-episode psychosis, the average duration of untreated psychosis was 4 months, with reliance on traditional healing methods significantly correlating with longer delays.[12] These findings highlight the effects of stigma and non-medical care pathways on timely engagement with mental health services, ultimately contributing to poorer long-term outcomes.

A way forward

To address the gaps in psychiatric rehabilitation in Oman, a coordinated and culturally sensitive approach is essential, with careful consideration of feasibility within current service structures. Many proposed reforms can be implemented incrementally through service redesign rather than relying on new infrastructure.

First, existing rehabilitation wards can be transformed into recovery-oriented environments with clearly defined multidisciplinary pathways. This can be achieved by reorganising current resources, providing targeted staff training and introducing structured assessments and individualised rehabilitation plans.

Second, community and outreach services should extend beyond medication provision. By building on the current outreach nursing model, we can develop multidisciplinary community rehabilitation teams in phases. These teams should incorporate assertive outreach, home-based interventions, vocational support and family involvement, offering a pragmatic and scalable approach to improving continuity of care.

Third, the treatment of treatment-resistant psychosis, particularly through clozapine, can be optimised by establishing specialised clinics that integrate psychiatric and physical healthcare. Implementing structured clozapine monitoring systems is feasible within existing out-patient and laboratory frameworks, which would enhance safety and long-term outcomes.

Fourth, developing supported accommodation is crucial for reducing long-term institutionalisation. A tiered model of housing support could be introduced through collaboration with the Ministry of Social Affairs and partnerships with non-governmental organisations, allowing for gradual implementation aligned with available resources.

Fifth, strengthening engagement with service users and the community represents a low-cost, high-impact strategy. Integrating family psychoeducation and public awareness initiatives into existing services can help reduce stigma and promote earlier help-seeking, because these initiatives are culturally adaptable. Addressing disparities in access, especially for rural populations, will necessitate the expansion of outreach services and the integration of telepsychiatry. These approaches are increasingly feasible within evolving digital health systems and can be scaled progressively.

Finally, workforce development and service evaluation are critical for sustainability. Embedding rehabilitation principles within existing training programmes, along with routine audits and the use of culturally appropriate outcome measures, will support ongoing service improvement.

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Conclusion

Psychiatric rehabilitation in Oman stands at a critical juncture. Although infrastructure such as rehabilitation wards, day care programmes and community outreach exists, fragmented services, workforce shortages, underuse of evidence-based treatments and cultural barriers continue to limit recovery. Implementing coordinated reforms strengthening in-patient care, expanding community services, creating supportive housing, optimising clozapine use, reducing stigma and investing in workforce development can bridge the gap between acute treatment and long-term recovery. Aligning these initiatives with Oman Vision 2040 offers a roadmap towards recovery-oriented, person-centred mental healthcare that fosters independence, social inclusion and dignity for individuals living with severe mental illness.

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Declaration of interest

None.

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