REVIEWS OF LITERATURE
ISSN:2347-2723
IMPACT FACTOR : 3.3754(UIF)
VOLUME - 5 | ISSUE - 5 | DECEMBER - 2017

SUSTAINABLE RAHABILITATION OF ROADSIDE DESTITUTES : BEST PRACTICE BY SHRI AMRUTVAHINI GRAMVIKAS, AHMEDNAGAR (MS)

Pritamkumar Chandrakant Bedarkar
Ahmednagar College, Ahmednagar (MS).

ABSTRACT: -

The best model of rehabilitation is hierarchical in nature. This hierarchy includes immediate, intermediate and sustainable. In the field of mental health, most of the facilitators are providing immediate and intermediate services. They face many short comes while providing the sustainable services. The reasons of short coming are perception to look at mental illnesses, social stigma, rejection by family members etc. in general and gender differences, economic conditions, family relations are in specific. Sustainable rehabilitation should be the family based but due to these shortcomings mentally ill get institutionalized. The need is to propose, promote and provoke a model of family and society based rehabilitation. Shree Amrutvahini Gram Vikam Mandal, Ahmednagar is an institute established in year 2006. This institute is working on three themes i.e. Amrutmanthan, Rehabilitation of mentally ill roadside destitute and Balvikas Kendra. In present case study, activities related to the rehabilitation of mentally ill roadside destitute taken into view.

The activity of rehabilitation of homeless people with mentally ill, includes providing shelter, food, clothes, counseling and health services. The services go through following stages (i) Rescue and Legal Process (ii) Cleanliness (iii) Treatment and Counselling and (iv) Rehabilitation and Re-union. Through this stage till the date, Shri Amrutvahini has rehabilitated more than 301 people in their family.

Shri Amrutvahini has planned many micro activities those work on individual uplift, family strengthening and social orientation. The Amrutvahini has a team of speakers, street play artists that work on mental health awareness. The institute conducts the advocacy and sensitization programmes. In purposes behind present article is to (i) make a documentation of those micro activities and (ii) take creative input from scholarly in this mission.

KEYWORDS: *Rehabilitation of roadside destitutes, Amruthvahini Gramvikas.*

1.0 INTRODUCTION :

1.1. Meaning of Rehabilitation: Rehabilitation is the act of restoring something to its original state. The noun rehabilitation come from the Latin prefix re-meaning 'again' and habitare, meaning 'make fit'. J.A.L.Vaughan (1961), the word 'Rehabilitation' has been used in many contexts and in many different ways. In the medical field it's interpretation has changed considerably in the period from the year before the first world war to that after the second and the ensuring extensive social legislation which followed the Beveridge Report. The prevailing tendency to isolate rehabilitation in the

sphere of physical medicine is criticized as an attempt to evade a responsibility which the whole practicing profession must accept. Psychiatric Rehabilitation Association (2015) state that Psychiatric rehabilitation promotes recovery, full community integration, and improved quality of the person who have been diagnosed with any medical health condition that seriously impairs their ability to lead meaningful lives. Psychiatric rehabilitation services are collaborative, person directed and individualized. They focus on helping individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning and social environments of their choice.

The psychiatric rehabilitation has seven basic principles (1) Enabling a normal life (2) Advocating structural changes for improved accessibility to pharmacological services and availability of psycho-social services (3) Person-centered treatment (4) Actively involving support system (5) Coordination of efficient services (6) Strength-based approach and (7) Rehabilitation isn't time specific but goal specific in succeeding (Simon Davis 2013).

1.2. Model of Rehabilitation

Connie J. McReynolds (2002) concluded in his study that individuals with psychiatric disabilities have many of the same desires as other individuals in society – namely, to feel a part of the larger community. Work can, in many ways, help individuals with psychiatric disabilities achieve integration by providing a means to develop valued societal roles, reduce stigmatization, increase social connectedness, and serve as a normalizing factor. In his article he added, some models of rehabilitation and its characteristics.

Clubhouse Model : This model focuses on practical issues in informal settings (Bond, 1995). This model talks about community based programmes for the people with psychiatric disability. These programmes includes offering vocational opportunities, planning for housing, problem solving groups, case management, etc. Individual can learn certain empowering skills.

Individual Placement and Support (IPS): The Individual Placement and Support (IPS) program was developed at the New Hampshire-Dartmouth Psychiatric Research Center (Becker & Drake, 1993). The IPS Model recognized that "work is so many things to so many people, we might define it simply as a structured, purposeful activity that we usually do in exchange for payment" (p. iii, Becker & Drake, 1993).

Community Support System : The National Institute of Mental Health (NIMH) began the community support system (CSS) initiative in 1977. The intent was to assist states and communities in developing a broad array of services to assist people with psychiatric disability. This initiative eventually became known as the NIMH Community Support Program, with case management as one of the essential services (Anthony et al., 1990).

1.3. Challenges in Rehabilitation of Roadside Destitute :

The destitute having psychiatric problem itself experiences certain limitations in everyday activities. The limitations includes difficulties with interpersonal relations, understanding social cues, coping with stress, difficulties in concentration and lack of energy (Bond, 1995). Roadside destitute loose familial support, care and concern makes this problem more difficult. The clients may need help in learning social skills, interpersonal skills, coping skills, personal hygiene, and self-care, as well as symptom management (Corrigan, Rao, & Lam, 1999). Bellack, Mueser, Gingerich, and Agresta (1997) described social skills as interpersonal behaviors that are normative and/or socially sanctioned.

1.4. Role of Rehabilitation Psychologists:

Rehabilitation psychologists assist individuals who have disabilities and chronic illnesses; the disability may be congenital or acquired. Psychologists provide psychotherapy and administer assessments. Assessments may be neurological (testing memory and other cognitive functions) or psychological (assessing emotional handling or disability-related issues). Rehabilitation psychology duties may overlap with those of health

psychologists. Rehabilitation psychologists sometimes work alongside neuropsychological specialists. They often collaborate with other health and medical professionals, for example, physical therapists.
Rehabilitation psychologists also work at the societal level to make the lives of the disabled better. They carry out research and may be involved in program development and administration. Those in vocational rehabilitation improve lives for individuals with psychiatric illnesses as well as physical ones. In present article, the same efforts has been done.

1.4. Necessity of Sustainable Rehabilitation Model:

The WHO report says, over a billion people are estimated to live with some form of disability. This corresponds to about 15% of the world's population. Between 110 million (2.2%) and 190 million (3.8%) people 15 years and older have significant difficulties in functioning. Furthermore, the rates of disability are increasing in part due to ageing populations and an increase in chronic health conditions. Moreover, changing life style, competition is like a rat race, unpredictable life style increasing the proneness of mental illness. The proneness of mental illnesses is increasing and non responsive family members increasing the probability of the roadside destitute. The institutionalization of roadside destitute is not the solution. Institutionalization of the needye should not be encouraged.

Family is the group observed everywhere, this group discharge certain primary and secondary functions. Even in case of disabilities/disorders, family can take very responsible and significant care. Hence, author assumes that the rehabilitation of the destitute in family will be more sustainable form of rehabilitation. Amrutvahini Gram Vikas sanstha focuses on the rehabilitation of the roadside destitute in their family.

2.0. ABOUT AMRUTVAHINI :

Shree Amrutvahini Gramvikas Mandal is a registered organization established in 2006. Amrutvahini is working for homeless people with mentally ill roadside destitute. Basically organization is focusing to Rescue, Treatment, Rehabilitation and Re-union of mentally ill roadside destitute with their families across India.

2.1. Organization : The Amrutvahini Gram Vikak Mandal has total 21 number of full time staff includes medical officer, counselor, administrative officer, accountant, care taker etc. Moreover, volunteer contributing to this mission.

2.2. Functions of Amrutvahini : The organization discharge four functions. The functions includes

2.2.1. Amrutmanthan: Shri Amrutvahini Gram Vikas works for the migrant workers at Ahmednagar and Pune Pimpri-Chinchwad areas to create awareness of HIV/AIDS and reduce its prevalence. It provides regular services to nearly 20,000 migrants from Ahmednagar and Pune districts of Maharashtra. It organizes health camps, counseling sessions, condom distribution, advocacy and awareness of importance of education, health and hygine.

2.2.2. Rehabilitation of mentally ill roadside destitute: Shri Amrutvahini Gram Vikas Mandal provides food, clothing, shelter, counseling and health services through its Rehabilitation Centre to mentally ill homeless people. It rescues any mentally ill wandering destitute on the road and takes them to the centre, cleanses them, provides appropriate treatment and counseling, rehabilitates them if possible, and also conducts advocacy and sensitization programmes. The process is described in 2.4.

2.2.3. Balvikas Kendra: This is a Child Care Centre where children are provided education, shelter, recreational and nutritional support. Shri Amrutvahini Gram Vikas Mandal started a project on 'Healthcare & Education Support Programme' focusing on their education and healthcare issues at the Kendra. The Kendra currently supports children from villeges of Nevasa town in Ahmednagar. Amrutvahini offers activities related to the child development includes (i) financial assistance to economically poor student (ii) promotion of orphans/single

parent child to child welfare committee for their institutional rehabilitation (iii) food, shelter, health and allied aid to mentally challenged children.

2.3. Problems in Roadside Destitute Rehabilitation

2.3.1. Problem in Rescuing: Majority of the roadside destitute are identified at public places i.e. M.G. Road, Bank Road, ST stand, Railway Station, Hospitals and Holy Places etc. One can locate these people at these places but cannot reveal their identity. Taking someone without permission of himself/herself or their family members is serious offence. This activity may be misinterpreted as a immoral human trafficking. Need is to take help from concern area police station.

2.3.2. Problem of transportation: After rescue another major challenge is to take such destitute to the public hospital for primary health care and then to the rehabilitation centre for further procedures. This problem has two reasons. First, these people have already lost their orientation with reality. Though being institutionalized is safer of them still they deny. Second, the available number of public ambulance in proportion to the needy is very less. Rehabilitation institutes like Amrutvahini do not have their own such ambulance(s).

2.3.3. Problem of primary health aid: These destitute(s) are reluctant to take any kind of aid. They are not ready to clean themselves or clean by volunteer. The adequacy of psychiatry ward, the availability of trained health care staff is not in adequate amount. The website factordaily.com reports India has 150 million people with mental illness, and fewer than 4,000 psychiatrists. Moreover, majority of these psychiatrists are practicing in private. In such scares scenario availing primary health aid to these roadside destitute becomes a big challenge.

2.3.4. Limitations in availability of professional psychiatric expert and medicines: Psychiatric problems require more days to cure. A mild depression or disorientation may require medicines at least 3 to 6 months. In case of roadside destitute, the severity of illness increases, physiological deterioration takes place. No family attention and support. These people need at least 2 to 3 years to recover after shelter. Moreover, psychiatric medicines are comparatively expensive. Rehabilitation institutes find it difficult to hold a continuous help from professional psychiatric expert and medicines.

2.3.5. Problem of acceptance by family members: After first aid and shelter, patient(s) start gaining some amount of insight. During counselling sessions, counsellors and volunteers collect information of the family members of the patient. The purpose is to rehabilitate them in their family. In most of the cases, counsellors and volunteers get the name and address of destitute family members, But the family members reluctant to take their member (destitute) home. The reason is with the perception of society to look at mental illness.

2.4. Stages: Shri Amrutvahini Gramvikas Mandal is working for the homeless people with mentally ill. Amrutvahini provide the shelter, food, clothes, counseling and health services through the rehabilitation centre. The inmates are from all over the India.

2.4.1. Rescue and Legal Process: When Amrutvahini found any woundering mentally ill destitute on road, the volunteers pick up him/her by calling ambulance (Rented). As per legal process volunteers inform to the nearest police station.

2.4.2. Cleanliness : After arrived in Amrutvahini center at first, volunteers feed them and start cleaning them. It starts from complete removal of scalp hairs. Thoroughly washing, cleaning of teeth, changing cloths etc.

2.4.3. Treatment and Counselling: Amrutvahini volunteers start necessary psychiatric treatment after through investigations and clinical check-up. The Amrutvahini observes that in a short period patients starts improving.

When they can recollect their memory, volunteers try to find out their home address. After few days most of the inmates can recollect their address and then volunteers start investigation to find out their home and reunite with family.

Shree Amrutvahini Gramvikas Mandal is organizing mental healthcheck up camps in the rural as well as urban slums. During the year 765 beneficiaries from the families were attended the camp and taken benefits of the treatment and counseling facilities.

2.4.4. Rehabilitation and Re-union: Rehabilitation of mentally ill person is possible and successful only with their family. If no one is there to look after that particular patient at their home Amrutvahini taking all responsibilities of that inmate.

Advocacy and sensitization programme is one more activity taken care by Shree Amrutvanini Gramvikas Mandal

2.5. Best Practices and Help from Stakeholders :

The main purpose of Shri Amrutvahini Gram Vikas Mandal is to rehabilitate the roadside destitute in his/her family. For this organization has taken up some best practices, name a few given below:

Stage	Practice and Best Practices
1.	**Rescue and Legal Process**
	A) Source of Information: (Ai) Amrutvahini organizes awareness programmes in the community to orient people about mental illness and information of the present organization (Aii) Local Police Station (Aiii) Staff of Amrutvahini visit different public locations (Aiv) Volunteers of Amrutvahini visit different public locations (Av) Police Station informs the Amrutvahini about the Roadside Destitutes **(B) Rescuing Procedure** (Bi) Staff of the Amrutvahini report to the Police Station OR Police Authority report to the Amrutvahini (Bii) Amrutvahini completes the official (documentation) procedures with Police Station (Biii) Help from local Leaders to take destitute in their (Amrutvahini's) custody (Biv) Help from Primary Health Centre/Civil Hospital for primary aid (Bv) Amrutvahini organizes training programme to the volunteers about how to take destitute in custody and take him/her to the shelter home. (Bvi) Amrutvahini receives the help from local Auto Union/people to carry the destitute to the shelter home. Bvii) If required, Amrutvahini take help from SHGs
2.	**Cleanliness**
	(i) Trained staff of Amrutvahini cleans the patient include hair cutting, shaving, bathing, etc. (ii) Staff and Volunteers monitors the further cleaning, done by destitute himself (iii)Token Economy model is induced, so patient themselves can take care of cleaning (iv) Cleaning procedure is monitored continuously until patient gain insight about his/her personal care and hygine.
3	**Treatment and Counselling**
	(i) Patient is taken to the Govt. hospital for further diagnosis and treatment purpose (ii) A Psychiatrist, Dr. Anay Kshirsagar give his volunteer service to take care of the patient (iii) Staff and Doctors of Amrutvahini monitors the MES (Mental Status Examination) of the patient. (iv) Once the patient is cured, the Counsellors take case history of the patient. Many a times patient refuses to share the family information due to personal conflicts, may be the cause to left the home. The Counsellors make a use of various techniques such as Catharasis, Free Association, Socratic Questioning etc. to get the information. (v) After receipt of adequate information of the patient. One team start communicating to the family members, local leaders of that area and the police authority. However, another team take care of treatment and counseling by which patient will be convinced to go home.

4	**Rehabilitation and Re-union**
	(i) Once patient prepares his mindset to go home. The staff of Amrutvahini communicates to the family members. Staff tries to convince them to take this patient into their custody. The dark sides of the scene, if patient remain on roadside. (ii) After convinced, the staff take the written permission of the local police station to take patient to his home town. One copy Amrutvahini keep with them and the other copy of permission letter is submitted to the concern police station, where the patient resides. (iii) Staff take help and support of local police station and leaders and accommodate the patient into their family (iv) Amrutvahini take care of further medicines. The volunteers sends the medicines of three months duration by post to the patient and telephonically communicates to the family members to get the feedback. (iv) In case of socio-economically and educationally poor family. The Amrutvahini take direct feedback. The local leaders supports in this regard. (v) Amrutvanihi provides the support to the family members by family counseling (vi) Amrutvahini has offered a occupational support

2.6. Outcome of Best Practices :

The procedure of the efforts taken by staff and volunteers is described in above point 2.5. As an outcome Amrutvahini succeeded in rehabilitating around 301 patients in their family. The detail is given below the tables. . The total number of cases rehabilitated year wise given below the table.

Cases Rehabilitated									
Year	2017	2016	2015	2014	2013	2012	2011	2010	**Total**
Female	13	17	18	09	14	15	09	07	**102**
Male	29	38	31	26	23	28	16	18	**199**
Total	**42**	**55**	**49**	**35**	**37**	**43**	**25**	**25**	**301**

The district wise number cases rehabilitated given below the table.

Cases Rehabilitated in Maharashtra					
District	Male	Female	District	Male	Female
Nagpur	35	09	Dhule	02	00
Aurangabad	08	04	Amaravati	01	00
Pune	02	04	Jalgaon	04	00
Jalna	06	03	Parbhani	00	01
Raigad	00	01	Nashik	05	02
Solapur	08	00	Beed	06	01
Total (102)				**77**	**25**

The cases state wise rehabilitated given below the table

Cases Rehabilitated in Other States							
State	Male	Female	Total	State	Male	Female	Total
Odessa	01	00	**01**	Karnataka	03	00	**03**
Madhya Pradesh	02	00	**02**	Assam	02	00	**02**
Andhra Pradesh	02	00	**02**	Bihar	03	01	**04**
Tamil Nadu	00	02	**02**	West Bengal	02	01	**03**
				Delhi	03	00	**03**
Total					**18**	**04**	**22**

The cases rehabilitated in family given below the table.

Cases Rehabilitated in Family									
Year	2017	2016	2015	2014	2013	2012	2011	2010	**Total**
Female	13	22	18	12	14	21	08	11	**119**
Male	09	06	13	08	06	07	04	05	**058**
Total	**22**	**28**	**31**	**20**	**20**	**28**	**12**	**16**	**177**

2.7. Challenges faced :

(i) Non acceptance of family members. Majority of the family members insist that we are ready to give monthly maintenance but take patient in your institute.

(ii) Family members are ready to pay but they are not ready to accommodate mentally ill person in the family. Specially they don't want to carry such history in family gatherings and society.

(iii) After cure patient get accommodated in family but job related issues remained unanswered. The entrepreneurs, company owners are not ready to take responsibility. Self employment is suggestible but family members support is needed.

(iv) Police officer do not issue letter to take such roadside destitute in custody. In their perception, taking care of road side destitute is a job of medical officers.

(v) At the time of rehabilitating destitute in family. The support of concern police station is needed. In most of the cases, police authority says, 'How we can interfere in their family matters?'

3.0. Findings

(i) Majority of the roadside destitute have a significant tie in family relations. Destitute left their homes due to small discords.

(ii) Majority of the roadside destitute admitted that they have left the home due to incidental causes. After adequate time they realized their mistakes and feel to go back to home and at the same time afraid about non acceptance by their family side.

(iii) Neglecting to those roadside destitute inhibits their self respect. Long run negligence creates feelings of worthlessness and meaninglessness. Increasing small amount of self respect increases their hope. Hope to life and hope to live.

(iv) In critical situations, family need counseling and support.

(v) Shri Amrutvahini Gram Vikas Mandal offers temporary shelter as a primary rehabilitative measure. Provide counseling and guidance as a secondary measure of rehabilitation and finally majority of them rehabilitate in their family is the final rehabilitative measure.

4.0. REFERENCES :

4.1. BIBLIOGRAPHY

Anthony, W. A., Cohen, M., & Farkas, M. (1990). Psychiatric Rehabilitation. Boston: Center for Psychiatric Rehabilitation

Bond, G. R. (1995). Psychiatric rehabilitation. In A. E. Dell Orto & R. P. Marinelli (Eds.), Encyclopedia of Disability and Rehabilitation. Nw York: Macmillan.

Becker, D. R., & Drake, R. E. (1993). A Working Life: The Individual Placement and Support (IPS) Program. Concord, NH: New Hampshire-Dartmouth Psychiatric Research Center. Cross reference from Connie J. McReynolds (2002). International Journal of Psychosocial Rehabilitation.

Bellack, A. S., Mueser, K. T., Gingerich, S., & Agresta, J. (1997). Social skills training for schizophrenia: A step-by-step guide. New York: The Guilford Press.

Connie J. McReynolds (2002). International Journal of Psychosocial Rehabilitation.

Corrigan, P. W., Rao, D., & Lam, C. (1999). Psychiatric rehabilitation. In F. Chan & M. Leahy (Eds.), Healthcare and disability management (pp. 527-564). Lake Zurich, IL: Vocational Consultants Press.

PRA (2015) Psychiatric Rehabilitation Association Archieved from the original on 15 February. Downloaded on 30

April 2017.
Simon Davis (2013). Community Mental Health in Canada. Revised and expanded Edition: Theory, Policy, and Practice. UBC Press. P.90. ISBN 978-0-7748-2701-0.
Vaughan, A.L. (1961). Rehabilitation: Concept and Practice, British Journal Industrial Medicine, 18, 241.

4.2. WEBLIOGRAPHY:

https://www.vocabulary.com/dictionary/rehabilitation downloaded dated on 30th April 2017, 06.00 hrs.
www.psychologist-license.com/types-of-psychologists/rehabilitation-psychologist.html downloaded dated on 30 April 2017, 08.39 hrs.
https://www.helpyourngo.com/ngo-details.php?ngo=546&name=Shree-Amrutvahini-Gramvikas-Mandal downloaded dated on 01st May 2017 at 11.06 hrs.

Pritamkumar Chandrakant Bedarkar
Ahmednagar College, Ahmednagar (MS).