CHAPTER 7

DISCUSSION AND IMPLICATIONS FOR PRACTICE

Content

7.1 Introduction
7.2 Profile of Rehabilitation Facilities
7.3 Resources and Rehabilitation Processes
7.4 Profile of Chief Functionaries and Care Providers
7.5 Profile of Residents
7.6 Implication for Practice
DISCUSSION AND IMPLICATIONS FOR PRACTICE

7.1 Introduction

Research studies and official documents in India documented the dearth of resources for caring the mentally ill. The facilities for long term care are scarce in the context of, large number of families unable or unwilling to give care to the severely mentally ill due to lack of resources. The voluntary initiatives of a group of individuals in the state of Kerala, seem to be relevant in this context, as a low cost community based rehabilitation model for homeless mentally ill (Santhosh, J, Anish, K.R, 2006). These centers are registered under an organisation named Kerala Federation of Care of Mentally Disabled (KFCMD) and are managed by voluntary individuals and their families who have no formal training in mental health. There is no scientific documentation on these types of rehabilitation facilities except few comments made in conferences and articles (Murali, 2002; Radhakrishnan, 2002). Kumar, Sekar, Murthy (2003) documented an evaluation report of The Banyan, an organisation for the rehabilitation of homeless mentally ill women in Chennai.

This study tried to document the rehabilitation facilities available and rehabilitation processes adopted for the care of the homeless mentally ill, driven by volunteer efforts of non-professional
individuals with no formal training in mental health. The study also explored the care providers’ orientation to mental illness. The study further explored the rehabilitation outcomes using quality of life and level of functioning as outcome measures.

The study collected data from three sources viz. chief functionaries of organisations (20), Care providers (66) and Homeless mentally ill Residents (181) keeping the objectives in mind.

The results obtained from the analysis are presented in the form of tables and figures in the Chapters 4 to 6. The current chapter focus on discussing the key findings discussed in the chapters 4, 5 and 6 with reference to literature in relevant areas and delineates the implications for practice.

The chapter 4 included the profile of rehabilitation facilities, rehabilitation processes and assessment of the quality of services. Chapter 5 discussed the personal profiles of the chief functionary and care providers and their orientation to mental illness. Chapter 6 delineated the profile of the residents and the rehabilitation outcomes viz. patient satisfaction, quality of life and level of functioning. This chapter also covered relationships among various variables.

7.2 Profile of Rehabilitation Facilities:

The findings of questions related to profile of the facilities revealed that all centers possess status of registered organisations as trust or society and none of them are registered under the regulations of Mental Health Act (1987). The centers rely heavily on income from
public donations and a very few receive support from government and International agencies. The centers worked as charitable organisations and none of them charge any fees for their services. These centers have become solace for many mentally ill who are homeless and persons with mental illness from poor resource backgrounds. The results also revealed that the centers catered to an average of 99 clients of which 91 were having severe and persistent mental illness.

The reports of National Human Rights Commission (NHRC, 1999, 2008) and other health review committees (Bhore Committee, Mudaliar Committee) consistently reported the scarcity of infrastructural and human resources for mental health care in India. The reports also discussed the limitations of the facilities for caring the mentally ill. The WHO, Mental health Atlas (2005) reported that the psychiatric beds in India is grossly inadequate for the care of persons with severe mental illness. The relevance of these centers is discussed in this context of limited rehabilitation facilities and inadequate care facilities for homeless mentally ill in the country. The voluntarism of a group of individuals for mental health care of the homeless mentally ill, the most vulnerable section among the persons with severe and persistent mental illness is commendable.

The major discussion with regard to these organizations is, their non-compliance with Mental health Act (1987) especially in the context of post Erwadi observations of the Supreme court (Orders of the Supreme Court in Civil Writ Petition No 334/2001 & 562/2001). The
comments about establishment and maintenance of private psychiatric hospitals are noteworthy in this context.

“MHA is a proactive legislation to achieve the ideal minimum standards of mental hospitals but is difficult to implement pragmatically because of acute shortage of human resources” (Suresh, B.M., Nagaraja, D., 2008).

The mental health act has not given much emphasis on rehabilitation centers but mentioned on convalescent homes and the policy implies that the minimum standards applicable to psychiatric hospitals which deal with acutely disturbed patients with severe illness also apply to convalescent homes, where the focus is on rehabilitation and reintegration into the community. This has lead to a great deal of concern among private convalescent homes and rehabilitation centers operated mainly in the nongovernmental sectors whose aims and functions are distinct from psychiatric hospitals. It is a matter of debate whether these organizations should be brought under the purview of the Mental Health Act, or whether their monitoring should be brought under alternative Acts like the Rehabilitation Council of India Act. This also looks at the possibility of an amendment in the Mental Health Act to include this unrepresented group in the purview of rehabilitation of mentally ill, specifically the homeless. Further, a state policy for care and rehabilitation of homeless mentally ill could be developed considering the local realities.
The centers are again relevant based on the comment “The MHA sets minimum standards for institutional care. Lack of standards and monitoring mechanisms can give rise to disasters, best exemplified by the horrific incident at Erwadi in Ramanathapuram. Ensuring adequate standards of care both in institutions and in the community requires active public-private linkages, as only governmental agencies cannot comprehensively shoulder the responsibility of the care of the mentally ill (Suresh, B.M., Nagaraja, D., 2008).

However, the standards of care need to be set and ongoing quality monitoring is to be facilitated by the state government and state mental health authority. The concerned bodies could guide the operations of such centers through developing an operational guideline.

7.3 Resources and Rehabilitation Processes:

Majority of the centers operate in a building owned by the parent organisation usually built on the personal property of the chief functionary. The centers have one room per thirteen residents and one toilet for twelve residents. Majority of the residents were satisfied with the facilities. The centers also had facilities like television, vehicle, telephone, audiovisual facilities etc.

The centers operated with the support of volunteers and recovered patients. The centers had an average of five volunteer staff and ten recovered patients. The psychiatric care is performed by Psychiatrists. None of them employ occupational therapist and a very
few had a psychiatric social worker in their roles. Some of them sought support of volunteer consultants from these fields. It was noted that the volunteer staff had average levels of satisfaction with their knowledge on psychiatric disorders and psychosocial rehabilitation, and majority of them were satisfied with their skills in working with the mentally ill. The chief functionaries also expressed similar levels of satisfaction with the knowledge and skills of the personnel.

95 percent of the centers admitted wandering homeless mentally ill either brought by police or public. Even when, they were brought by police, official procedures for admission like reception order were not taken for the admission. Most of the centers gave priority to providing basic care to the residents’ viz. food, accommodation, and clothes along with basic medical and psychiatric care. All the centers assumed the status of a long term rehabilitation center and none of them offer day care or night shelter services.

This situation clearly draws the social relevance of such centers for the care of homeless mentally ill. The centers support the necessary basic needs of the homeless persons. NHRC (2008) commented after reviewing the mental health facilities in the country, Non-government Organisations play an extremely important role in the absence of a formal or well-functioning mental health system, filling up the gap between community needs and available community services and strategies.
Nevertheless, the increasing need for such centers call upon efforts for formalising these services through setting quality standards and legalising the admission and discharge procedures. These centers need to be developed as transitional centers to community reintegration, more than their current status of long term rehabilitation centers, which in long run would fail to meet the demands of more homeless persons due to saturation of care facilities available. This could be developed through well planned rehabilitation processes and scaled up community reintegration processes.

Most of the centers had insufficient planned rehabilitation activities. None of the centers performed rehabilitation assessment and planning. Though not very planned, majority of the centers utilized the services of the residents for the day to day functioning and routine activities. The vocational activities performed are largely natural like dairy, poultry, goat and cow rearing and agricultural activities. The advantage noted was that most of these activities did not require extensive supervision and highly skilled instructors. This also helps in translating their skills into their life context after discharge from the center. This is highly relevant as stated in the principle of psychosocial rehabilitation suggested by IAPRS “Psychiatric Rehabilitation practices help people re-establish normal roles in the community and their reintegration into community life”. (IAPRS, 1998)

Only a quarter of the centers had structured schedule for all the residents and 55 percent of the centers were able to involve all the
capable residents in structured activity. The emphasis on recreational activities for the residents was meagre in most of the centers. The centers vary highly in their operational procedures. This point to the need for developing unified operational guidelines for enhancing the functioning of these centers.

The deficit in planned rehabilitation activities were attributed to absence of trained human resources, absence of an operational guideline for the functioning, poor skills of the existing staff and resource deficits for employing more staff. This circumstance again calls for capacity building of the staff available and developing clear operational guidelines for guiding the operations.

Most of the centers attempted to discharge the patients to the family and are not very successful due to non-availability of address of the residents and unwillingness of many families to take the resident back.

90 percent of the centers maintained case files for each resident. However, the rating on quality of recording reveal that 80 percent of the recording are satisfactory to very poor range. The data available is restricted to the basic data entered at the time of admission and no serious efforts were taken to update the progress in the case files. In the overall rating of patient care services 45 percent of the centers have scored excellent to very good scores.
90 percent of the centers receive very good support from the public. 25 percent of the centers take conscious efforts in sensitising the public.

The preceding section throw light to the fact that the centers are highly successful in the areas of infrastructure and basic care and has gross deficits in professional activities like rehabilitation processes, documentation etc. The necessity for ensuring minimum standards (Agarwal et al. 2004) of care has been discussed in the previous section. The major hindrance to these efforts in the centers is lack of adequate human resources and poor skills of the available personnel. There is an urgent need for equipping the personnel towards quality care in rehabilitation and an attitude of thinking beyond the basic care. The voluntary consultancy support of mental health professionals also needs to be explored.

7.4 Profile of Chief Functionaries and Care Providers:

Majority of the chief functionaries were married and were staying in premises of the center. Majority of the care providers were singles. Most of the chief functionaries and care providers were motivated by the personal experiences and religious beliefs. It is also noted that a good number of the care providers offer their services as volunteers and did not receive any payment for the work.

Majority of the chief functionaries and care providers were not formally trained in mental health and psychosocial rehabilitation.
However, they were highly satisfied with their skills in dealing with the mentally ill.

While assessing the care providers’ orientation to mental illness in four domains viz. causation, perception of abnormality, treatment and after care, it was found that the care providers in general have favourable orientation to mental illness in all the domains. This showed that the attitudes of the care providers were positive and they could be supported with organised capacity building programmes for enhancing their efficiency and effectiveness in working with persons with mental illness. The capacity building programmes would supplement in enhancing the quality of patient care services, which in turn would enhance the quality of life of residents.

7.5 Profile of the Residents:

The mean age of the residents was 38.6 and they had an average of 3.83 years of stay in the rehabilitation centers. This indicated that most of the patients were chronically ill and the centers operate mostly as long term rehabilitation centers. The centers contribute significantly to the quality of life of the residents, as they provide shelter to 85 percent homeless or marginally housed people.

The residents did not perceive their roles in planning the treatment and it is also found that none of the centers practiced clear rehabilitation processes including rehabilitation assessment and planning. Majority of the residents were satisfied with the facilities and staff of the centers.
The QoL scores of the residents showed moderate levels of quality of life in all domains of the QoL. The results are consistent with many other studies on QoL of mentally ill. The studies showed significant differences in quality of life of clinical and non-clinical groups (Murphy, H. and Murphy, E.K., 2006), greater QOL variability in patients with low function scores compared to those with medium and high function scores (Becker, T., et al., 2005), quality of life was associated with decreased psychotic and depressive symptoms, reduced substance abuse, fewer days of homelessness, and increased social support, income, employment, and service use (Lam, J.A. and Rosenheck, R., 2000).

An evaluation study of The Banyan conducted among the resettled homeless mentally ill residents showed below average quality of life in psychological, social and environment domains (Kumar, Sekar, Murthy, 2003). The quality of life was highly related to health of the person and duration of illness.

Level of functioning is found to be within normal limits in physical functioning and dangerous behaviour and is low in psychological functioning and very low in interpersonal relationship and community living.

The research evidences substantiate these findings. Patients with schizophrenia had significantly greater disability than the normal subjects according to total scale scores as well as the communication, transportation, finance and shopping sub scale.
scores (Klapow, et al., 1997), functioning of mentally ill lower compared to general population (Goering, Paula, Lin, et al., 1996)

The residents with greater levels of functioning displayed higher quality of life. This indicated the need for focusing on enhancing functioning as an important goal of rehabilitation. Concerted efforts to enhance the functioning would in turn enhance the quality of life of the homeless mentally ill. Further, the quality of patient care services is related to better functioning and quality of life. The recommendation to centers is on the quality of patient care services. The centers could take necessary steps to enhance the quality of services with the goal of fostering the quality of life of the residents.

This scenario draws our attention to more concerted efforts to enhance the functioning of the homeless mentally ill. Seriously planned rehabilitation activities with evidence based protocols needs to be utilized as evidenced in, Sullivan, G., et al. (2000) that interventions most likely to improve the quality of life of homeless persons with mental illness, include those that stress maintenance of stable housing and provision of food and clothing and that address physical health problems and train individuals to minimize their risk of victimization.

Deborah Bybee, Carol T. Mowbray, Evan Cohen (1994) commented that providing housing alone is not sufficient. Supportive assistance to maintain housing is a necessity -- persons with severe
Discussion and Implications for Practice

Mental illness who have experienced homelessness are likely to again become unhoused unless there is continuity of needed services, because of the unpredictability and variability of their illness. However, due to the heterogeneity and diversity of this population and the multiplicity of their problems, a range of interventions and a variety of service providers are required, tailored to individual needs.

The functioning of the centers was analysed based on the principles of psychosocial rehabilitation (Disability Services of Victoria Inc., VICSERV, 2008) Flexibility of structure and service models, Support for mobility and choice of service options, Active participant involvement in services, Support for participant decision-making, Concentration on quality of relationships and interactions between participants and staff, Encouragement of peer support, Responsiveness to participants' needs, Provision of most 'normal' environment, Utilisation of a broad range of skills, Active community education function and advocacy function, Cost-effectiveness: both operational and preventative. The centers fulfil the principles of quality services viz. quality relationships, provision of normal environment, peer support and peer leadership, utilisation of skills, and cost effectiveness. They need urgent efforts directed to provision of service options, and more participation of residents in decision making. This provides the implications for strengthening practice of rehabilitation in the centers of homeless mentally ill.
7.6 Implications for Practice:

This research has documented a low cost innovative rehabilitation model for homeless mentally ill. This has added knowledge to psychiatric social work literature on viable psychosocial rehabilitation process involving non-professional community volunteers. The study brought out the strengths and limitations of such centers and drew the relevance of such models in the context of low resource in the country, for rehabilitation of persons with persistent and severe mental illness. This has contributed to social work profession and psychiatry for developing programmes for homeless persons with severe and persistent mental illness.

This has further identified limitations of existing policies on fostering such initiatives and discussed possible changes in the existing policies on mental health care. The study also suggested possible ways of involvement of social workers and schools of social work in these endeavours. The study being the first in the documentation of these unique rehabilitation facilities opened several new areas of research in this area of psychosocial rehabilitation. The findings also provided viable guidelines for the centers for care and rehabilitation of homeless mentally ill.