III.C: Naya Daur - Marking the beginning of a new age

Iswar Sankalpa[24]

1. Problem Statement

According to the government, "Houseless Households" refer to families who do not live in 'census houses'/ homes with a roof, and are found on roads, pavements, under the flyovers, railway platforms and the like. Between the two censuses in 2001 and 2011, the numbers of these houseless households in urban India showed 37% growth (from 1.87 lakh to 2.56 lakh). This is majorly due to the unavailability of the various social schemes; most of which are meant for the ones in the rural areas. During the same period, West Bengal recorded an increase in the number of homeless households by 48% (from 19,385 to 28,647).

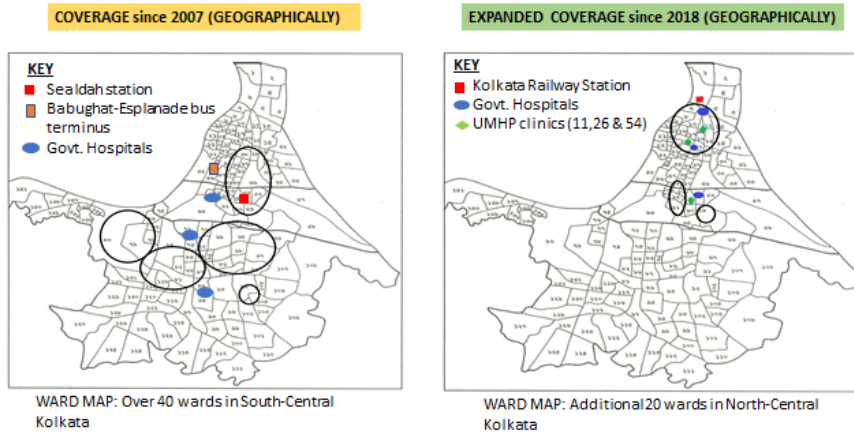

Figure 1: Ward maps indicating the coverage of our program

Sabuj (2014) in his study on the Homeless people of Kolkata, elaborates that, out of the 141 Kolkata Municipal Corporation wards, homeless people were found in 118 wards. These people had no safety (belongings got stolen), varied weather conditions made their life difficult, living conditions were

24 Contributed by Piyal Kothari

unhygienic and they were frequently evicted by the police or harassed and tortured by other community people.

Homelessness might lead to mental health issues or vice versa. They are two pervasive issues that societies need to urgently address, as both have a negative impact on the lives of individuals and communities (Kaur and Pathak, 2016). A couple of studies have been conducted to understand prevalence of mental illness in homeless population in developed and developing nations; one of them states that out of the 140 homeless persons admitted to the department of psychiatry of a North Indian medical university (Feb'05 - July'11), 90.7% were diagnosed with psychiatric illness and 55.7% had more than one psychiatric disorder. 84.3% of the total admitted[25] experienced mental illness before leaving their home and 54.3% left home due to mental illness. After treatment, it was possible to reintegrate 70% of the patients into their families. No treatment or inadequate treatment for the mental illness

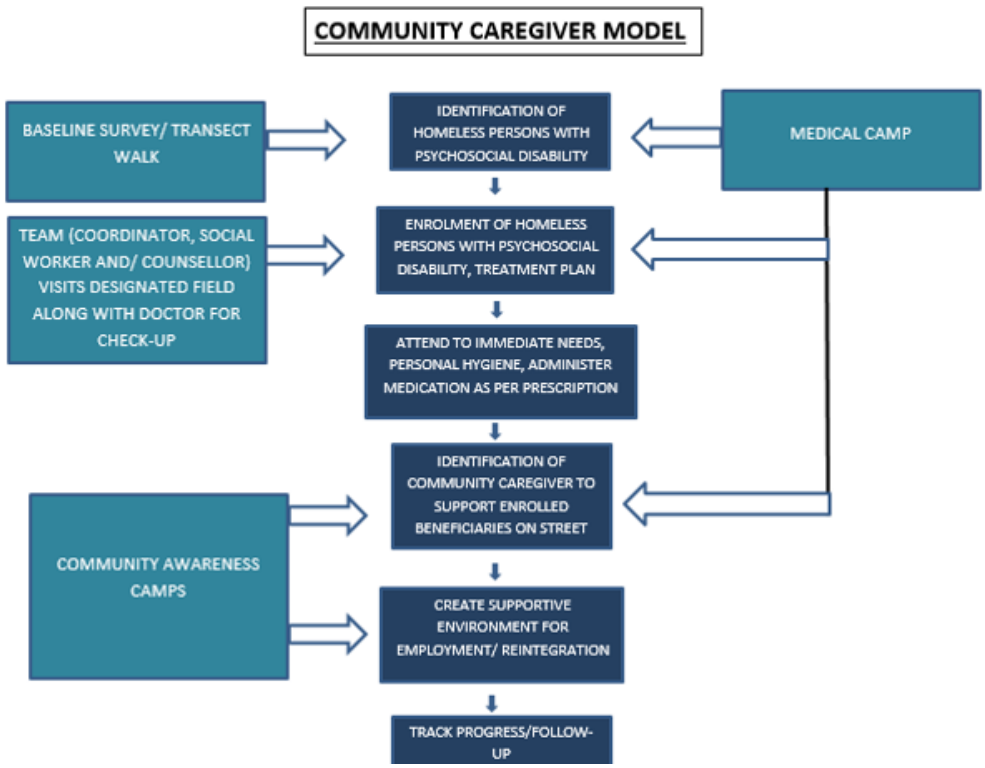

Figure 2: Community Caregiver model

25 Psychiatric illness is interchangeably used with mental disorder/ mental illness – no difference (it is an umbrella term) Psychotic disorder are severe mental disorders

was found to be one of the common causes for homelessness. Additionally, amongst the psychiatric illnesses in homeless persons with mental illness, 65% were found battling psychotic disorders, 44.3% were found to be in the grips of substance use and 12.9% were grappling with bipolar disorder/ mania (Tripathi et al., 2013).

In 2007, Iswar Sankalpa conducted a Baseline Survey of Homeless Persons with Mental Illness within the 141 wards of Kolkata. The survey, conducted over a period of 8 months, **identified over 466 persons in need of immediate medical treatment and psycho-social support.** The disorder profile of persons identified in the Baseline study is illustrated below in Figure 3:

Other findings include the following:

1. The majority of the people were 18-35 year.
2. 20% of cases had major physical ailments
3. 90% of the men had physical injuries
4. While women were the most vulnerable to sexual abuse and harassment, men were also subjected to physical abuse.
5. A large number, mainly men, were prone to substance addiction

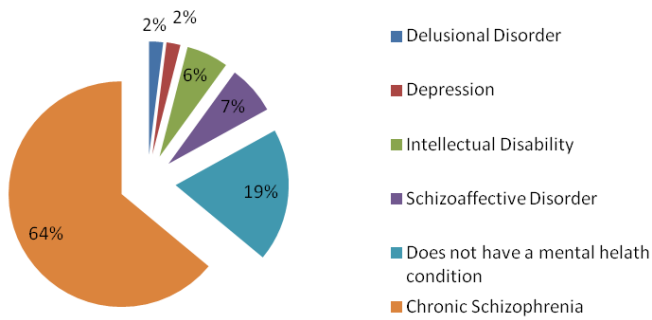

Figure 3. Disorder profile pie chart

There are about 400,000 wandering mentally ill persons in India. They are found battling mental distress and physical abuse especially in urban areas. They hail from economically poor and socially marginalized sections of the

society. Nine out of the ten have diagnosable and treatable mental health conditions and four out of five have co -morbid physical health issues. This picture becomes all the more complex given the fact that India lacks adequate supply of mental health services and the ones that exist, are inaccessible in majority of the cases. Homeless persons with mental illness are a special population, for they need to be picked up from the streets to be taken to the hospital, they lack an identity, no past history is available either due to memory loss and/ absence of a familial support and most of them suffer from severe mental disorder calling for a rehabilitation either through reunion with respective families or establishment of shelter homes (Singh, Shah and Mehta, 2016).

Unemployment and poverty have also been found to be intrinsically connected to homelessness and mental illness. While there is no causal link between poverty and mental illness, the two states can feed into each other – while poverty and its attendant stressors are a breeding ground for mental disorders, untreated psychiatric disorders can lead individuals and families into unemployment, social alienation and poverty. Poverty, homelessness, mental illness coupled with physical health issues forms a grim picture of persons living on the streets for years.

Civil Society Organizations in this field are few like *Health Initiative Group for the Homeless* (a joint initiative by the Institute of Human Behavior and Allied Sciences, *Aashray Adhikar Abhiyan,* and Delhi State Legal Services Authority), *Koshish* (by Tata Institute of Social Sciences in Delhi and Mumbai), *Adaikalam* by Banyan in Chennai (Lancet, 2016). The National Report on the Status of Shelters for the Urban Homeless (2014) outlines that the number of permanent shelters for the urban homeless is woefully inadequate in India and the allied services are virtually absent in the shelters. The accommodation capacity is far below the normative stated by the Supreme Court and the National Scheme of Shelter for Urban Homeless. In Kolkata (West Bengal) against a need of 44 shelters, there exists only 29 permanent shelters for the urban homeless, out of which only 14 are operational. Government agencies at both state and national levels fail to take responsibility and have no policy or planning for Homeless persons with mental illness in particular.

2. Naya Daur - Theory of Change

While we offer alternate forms of living and holistic care and support -it allows for individual choices, adapting the support according to individual preferences and needs *(The client's choice centres all decisions and interventions offered, starting from accepting food, to taking medicines, degree and manner of interaction with the team, sharing information about the families, engaging in employment…).* The belief that intervention, medical or otherwise, should be kept at the minimum level, with minimum disruption of a person's life ensures that treatment and support is provided to the extent that is desired and accepted by the person concerned, while trying not to subsume his or her existential self under the rubric of modern psychiatric and developmental discourse.

> ***By including neighbours and local communities as strategic partners in facilitating change, we aim to reduce the stigma against mental illness propelling not only 'clinical but also social recovery of the clients.'***

By including neighbours and local communities as strategic partners in facilitating change, we aim to reduce the stigma against mental illness propelling not only 'clinical but also social recovery of the clients.' By making institutional stakeholders, especially the government, take responsibility for the health and development of a vulnerable group of people, can make the desired change sustainable in the long term. Through a community-based model, we hope to elicit and understand the meaning of 'madness' in local cultural contexts, and bring them into its theorization and practice. We believe that a different concept of mind – its health, its pathology – born out of community experiences, and perceptions can help evolve a more viable and sensitive notion of community care in the field of mental health. In the long run, we hope to offer an alternative model of understanding (alternate to what is being taught and practiced in hospitals and extension clinics-contributing to pathologization and marginalization of human beings) of mental distress as well as caregiving for the distressed and that interventions need to be designed at every stage of the continuum: stress-distress- disorder-disability. (Refer to Figure 4)

3. Process Narrative

The Community Outreach Programme underscores the political stance of the organization – an attempt at development of an alternative pathway of community care for homeless persons battling psychological disabilities which will surpass the need of uprooting them on the pretext of providing care and treatment. The process of care thus follows the principle of minimal & necessary medical intervention with maximum community engagement.

This model of community-based treatment and care entails the following steps -

3.1. Identification, engagement with, and enrolment of homeless persons with psychosocial disabilities:

During the community survey conducted a decade back, the target areas for intervention were selected (having high concentration of potential clients) and social workers were allocated specific field(s) of work. Since then, identification of potential clients has been primarily through-

1. Observations and Rapport establishment:

   a. Social workers make notes (identification sheet) about potential clients (ones who are evidently homeless exhibiting signs of psychosocial disability) and keep them under observation for a minimum 15 days while deliberating upon their enrolment into the programme since service delivery would get hindered in cases of extremely wandering population.

   b. After identifying and before enrolling the potential client, the social workers undertake an arduous journey of rapport building with them to pave the path for reception of services.

      i. This process involves creating a sense of familiarity through regular visits, For example, During this phase, the outreach worker would visit the client every day with the mission to initiate a conversation – For example:

      “Would you want to have tea/biscuit/water”

      “What is your name?”

      “How long have you been here?”

      Then would proceed according to the pace and choice

of disclosure by the person and make consistent visits. The identified person would be made to feel that this meeting is desired and important too for the stranger/ outreach worker who is visiting without fail

ii. The outreach worker builds rapport with the person by talking to him/her about what s/he does during day, what s/he finds engaging in daily life casual conversations "My name is Ashish" - let him/her know their name, For example:

"What is your name?

"My house is in Badabazaar; where is your house?"-

"Do you have a friend here or someone who gives you food?"

"I will come again tomorrow, stay here only"

"Namaste!"

iii. The Social worker/Outreach worker creates a space of trust through loving gaze, caring words, a non-threatening touch, and provision of basic need- some food and water. The development of this therapeutic relationship is very crucial but not a time bound goal, calling for immense patience and motivation on the part of the front-line workers. This process on an average requires a month-long engagement till the client becomes comfortable with the social worker.

c. Once rapport is established, the Psychiatrist visits the site along with a psychologist/ counsellor for a comprehensive health assessment of the identified person(s); upon multidisciplinary team consensus and recommendation, the person(s) are enrolled into the programme for continued service. An individual care plan is drawn up too.

2. Mental health camps organized within the community: Apart from direct observation, the team also conducts mental health camps with the support of community organizations; these camps in the community spaces bring health services directly to the potential clients who otherwise wouldn't be able to access them (wherein they are assisted with bathing, provided food, fresh pair of clothes, basic materials for personal hygiene, counselor's meet-up and doctor's check-up)

3. At the time of enrolment, a thorough assessment of the client is carried out: their history is elicited by the counsellor and doctor, a quick overall physical health check-up, a mental status examination (General appearance of the potential client, Speech, Mood, Thought Content, Thought Process, Memory…are studied) and a baseline psychosocial assessment (standardised scales such as Indian Disability Evaluation and Assessment Scale, Life skills Profile are administered) is conducted

(levels of self-care, social skills and the like are gauged) and a provisional diagnosis is made. Based upon this, an individual care plans drawn up (Figure 5)

Figure 5: Program staff making individual plans

4. An important spillover impact of the enrolment process is that it 'visibilizes' the very 'invisible' population, establishing the fact that that they are approachable. A caring hand directly extended (physically and figuratively) to the apparently 'roadside mad' man/woman questions the prevailing public notions about them- that they are violent, a constant threat, a hopeless case and as good as dirt.'
Moreover, on witnessing the social workers interact, touch, bathe, feed and engage with them, quite a few community members get encouraged to join hands.

3.2. Providing Treatment, Care & Support to Enrolled Clients

The treatment regimen for the enrolled clients primarily involves planning modes of intervention along the following lines-

1. **Basic Health-care:** The clients are provided a one-time meal (if not available within the community) and encouraged and assisted to maintain their personal hygiene by the social workers on a daily basis. The social workers regularly visit to ensure the clients take a bath (usually at community *Sulabh* Complex), trim their hair & nails with the help of a local barber, and wear fresh pairs of clothes (provided). They are accompanied by the social workers as and when required. First aid service and hospitalization in cases of emergency is also provided.

Figure 6: Social worker helping the client to take a bath

2. **Pharmacotherapy:**
Social workers make efforts at obtaining consent of the clients for treatment. Once sought, they inform them about regular doctor consultation wherein the doctor would visit the client on

the street itself for check-up (usually every 15 days to a month) for free. The social workers then provide medicine(s) to the client directly everyday as per doctor's prescription barring weekends. (Refer Figure 7)

3. **Psycho-social care:** The enrolled clients are visited by the organization's counsellor once almost every two weeks for some caring and motivational interaction to expedite their social recovery. Daily communication with the client is goal-oriented in the way that it seeks to motivate the client to take decisions regarding their well-being, regain control of their life and develop hope for the future.These counsellors also administer psychometric scales every quarter to quantitatively record the overall levels of improvement since the time of enrolment-

   a. Indian Disability Evaluation and Assessment Scale (official tool used to assess disability in persons with mental illness and for their disability certification)

   b. Life Skills Profile: A measure to assess general functioning of the clients

   c. Positive and Negative Syndrome Scale: Scale used for measuring symptom severity in clients battling Psychosis

   d. Global Assessment of Functioning: A scale to understand how well a client is functioning in her/her daily life

Individual care plans (ICP) are prepared in conjunction with the client, who is supported to make every decision through a process of informed consent by the staff. ICPs are based on the clients' personal goals and an intervention is collaboratively developed with the Naya Daur team. The plan is revisited every quarter to assess the progress made and to change the goal/plan if required. The staff understand that clients may be unable to decide at a particular point in time, thus they continually check with clients. The multidisciplinary team holds case conferences, quarterly reviews and annual needs assessments for each client where clients' recorded will and preferences are incorporated into their ICP. Clients' voices and feedback are informally incorporated in service design and implementation.

3.3 Identification and engagement of Community Caregivers

The social workers at the time of enrolling potential clients try to mobilize the support of local community members too; i.e. they negotiate with them for co-facilitating the care and treatment process. On having observed the

clients for long the social workers learn about their sources of survival – the individuals in the community who may be providing tea, some water, food, clothes to them already. The social workers then approach these caring souls to partake in the treatment process. These caregivers anchor the care, treatment and recovery process of the clients in numerous ways.

Figure 7: Counselor providing medicines

Above all, they act as proxy families and develop as a source of emotional and social support for the clients in the community- someone who would pleasantly acknowledge the presence of the client through some daily interaction too.

The idea is to tap on this invaluable community resource (someone acquainted with the existential pattern of the client and someone who is a known face to the client) and channelize their inherent compassion towards the client's recovery. The negotiation to convince them to participate in the care and treatment process involves debunking the myths associated with homelessness and mental illness and assuring them of complete organizational support. The support offered by these caregivers is completely voluntary in nature and in majority of cases it is sustained by the palpable improvement observed in the client's overall health status. Additionally, they are invited to Naya Daur's annual caregivers' meet to encourage peer support.

3.4. Rehabilitation, Reintegration & Follow up

Progression towards this phase is the ultimate aim of the programme and it is usually slow and extremely difficult; the onset of this phase is dependent on client's improvement in overall functionality (reduction in symptoms, improvement in levels of self-care, communication, social engagement) Introducing to rehabilitative spaces & engagement in supported employment: The day care centres run by the organization are usually used as rehabilitation space for recovering clients wherein their personal hygiene is taken care of, they are engaged in vocational therapy (beading, making art and craft products…) and functional literacy classes. This also helps them get some

respite from the 'stony streets.' If for better outcomes street care is felt insufficient then the two shelters (for males and females) are also offered to them as options for continued care and development.

i. Usually, the caregivers engage the clients in their own small shops/ occupation when they find them improving (assisting in roadside eateries, selling small goods, cleaning stores are some of the odd jobs the clients are involved in). In other cases, they are encouraged to look for some opportunities too within the community wherein there would be reasonable[2] accommodation

ii. Alongside, the visiting counsellor offers motivational sessions to the concerned client to begin and sustain a more productive life. The social workers also negotiate with the caregivers to offer some monetary incentive to the clients in return for the work they do. The social workers follow up on the client's engagement in jobs.

a. Enabling Clients' Access to Entitlements: The team also advocates for client's access to identity markers (Aadhaar & Voter Id) and entitlements such as Disability Card since political recognition and benefits are crucial for sustaining client's recovery and rehabilitation.

b. Tracing their families and reuniting them: Usually as the clients regain cognitive functioning post continued treatment, they are able to recollect and share their family and home details. If the client wills, the organization's team follows up on the same to trace it. If located, families are informed about the client and made aware of the condition and future course of action. Once the client returns home, the team continues to follow up through phone calls, home visits (usually if within West Bengal) and OPD run by the organization to ensure after-care.

If the families cannot be located, or refuse to take the client back or if the client himself or herself refuses to return, then alternative arrangements are sought- reintegration into the community space itself with the help of their caregivers (in many cases the caregivers extend a roof over the client's head). It is only after 5 years of successful community reintegration (i.e. when the client is staying with his/ her family or within the community comfortably) that the follow-up is discontinued, marking the client's exit from the programme. However, their re-entry into the programme is always possible.

4. Challenges

4.1. The nature of the target population, mental health condition and the care & treatment space:

a. The target population (homeless persons with psychosocial disabilities) are a highly itinerant group and an extremely vulnerable population; attempts at bringing them into a care and treatment regimen (with their due consent) while upholding their right to freedom of choice is challenging for it results in drop-outs from the programme and supported employment (if present).

b. Even if they receive our care and treatment, the course of recovery while being on the streets is seldom linear due to the presence of myriad extraneous non-controllable variables such as lack of shelter, absence of familial support, presence of street predators, vagaries of weather, absence of identity documents, severity of mental health condition to name a few. In certain chronic cases, treatment and support may be required for the client's complete life -span. Moreover, even if the client exhibits signs of recovery, there always exists a risk of relapse due to a combination of physical, psychological, socio-emotional and socio-economic factors. Thus, even a small movement in the desired direction is a matter of celebration.

c. Above all, the very site of intervention- the streets, robs the organizational team of the power to channelize the care and treatment process in a particular direction (which is relatively easier in a closed setting such as a shelter/ a clinic). A lot then depends on their power to negotiate, build and maintain rapport with the clients and strong network within the community. This also means a relatively longer period of engagement before discernible changes are noticed in the client.

d. One of the other great challenges is addressing the target group's propensity for substance use for the drugs that are easily available on the streets. Rapport building process is highly challenged by (potential) clients who do not cooperate due to florid symptoms (anger outbursts, heightened suspicion…). Because it's a wandering population's difficulty to find them each at the same place and at the same time the social worker might have to do multiple visits.

4.2. The ignorance & indifference at the community level:

Even while the care model is based upon the idea of tapping compassion and care in community settings, there is lack of awareness and widespread ignorance with relation to persons battling mental illness and homelessness. The prevalent stigma and associated discriminatory practices often makes it hard for the team to garner cooperation from community members in pursuit of their goal. It is only the team's motivation and belief in the work which aids them to march ahead even in very hostile and unfavorable spaces.

4.3. Lack of political will to address the issue:

Homeless persons with psychosocial disability aren't featured in the developmental discourse since they are perceived as a public threat and the compartmentalization of government departments and services makes it extremely difficult to expect any meaningful result.

a. The State health department is reluctant to work with the said population for they are homeless, falling outside their purview of interest; and the State Social Welfare department too refuses to address the issue since the population is battling mental illness. This oscillation makes it extremely difficult for the team to ensure the rights of these individuals.

b. Additionally, fragmentation of general and mental health care services at the state level also compounds the existing problem. The organization is always at the risk of having to rebuild support of concerned government officials in cases when they leave, or are transferred or complete their term.

5. Formal and Informal Strategies

a. Organizing Community Awareness Camps: Social workers along with other team members also organize community mental health awareness camps in association with local community bodies to dispel myths around homelessness and mental illness, to encourage voluntary participation of the community in caregiving and to generate kind donations for the clients. This is usually to develop greater acceptance for the target population and enable their social inclusion.

b. Annual caregivers' meet: This is organised for the community caregivers so that they can meet each other and feel good about the work they are doing. They are also psycho-educated by the team- trained to provide services to the clients and this platform is also used to acknowledge their support. The caregivers are most often part of the informal economy themselves and do not have high economic security which can cause the caregiver to go through his/her own set of problems while taking care of our clients and burn them out. Meeting other caregivers, creates a sense of community and reinforces their belief in the work they do and also exchange ideas and strategies to provide better care.

c. Case conference every 3 months to track success: Every 3 months the client progress is studied based on the monitoring tools and observations made by the social worker, counsellor and the doctor. Based on this further steps of care provision are decided that are unique to every client based on his/her present progress.

d. Other important formal strategies are **networking and advocacy** with key stakeholders (government, hospitals, employers), use of **social media** to raise awareness and **psychoeducation of families** for greater acceptance.

6. Informal monthly ambulance strategies:

During the medical check-up every month, the social worker, counsellor and the doctor go around the field area to meet the clients and check their progress and decide few informal steps about how to proceed with the care and treatment process by incorporating clients' will and preferences. This is an interesting process because the ambulance is also a space where sociological knowledge about the client's health and well-being guides the medical knowledge and prescriptions. Thus upholding the foundational value of a community mental health care model.

The psychiatrist discusses the status of the client with the social worker and counsellor on these visits. The issues hindering the progress can be issues like the client not wanting the food given by the social worker and eating junk food, not taking up work, defaulting on their agreement on non-consumption of drugs or alcohol etc. The team reasons with the client and asks him/her as to what difficulty they are having? Why don't they like the food? what kind of work they want to be engaged in? Why did he feel like smoking or drinking the other day? Because the team has established a good rapport and trust, clients often confess their non-compliance and seek help.

The process of counselling the client, negotiating with the client and making sure he follows the individual care plan is a long and seemingly never-ending process but the team believes in strengths based approach and providing supportive/motivational counselling. Moreover, the programme is developed in a way that it does not see faltering of the client as a problem but as part of the progress itself. Thus the care and treatment is rooted in the social location and environment of the client and not in their medical diagnosis.

A New Lease of Life: Bijon's Story

A nameless, homeless, fierce looking man in his 30s in tattered clothes roamed around *Bijon Setu*, the *Kasba* flyover near *Ballygunge* railway station –triggering fear, disgust and sometimes sympathy from the locals and the passersby. His long-matted hair and beard, unwashed body and malnourished frame showed signs of living on the unkind streets for many days. Yet he was oblivious to his physical state and challenged the world with his angry eyes. One kind hearted lady, who often passed him by on her daily commute, was deeply concerned. Her path crossed with Iswar Sankalpa (IS) and she alerted us about the man. The man's story of change started on a day in July 2014 when an IS outreach social worker of the Ballygunge field, *Swapan* visited him. It was not an easy task to win his trust. He wouldn't accept food or water, or even speak to *Swapan*. Daily visits and caring gestures, finally made him respond to his negotiations after a few weeks. Once he gave consent for intervention, IS psychiatrist checked him and found him battling severe mental health conditions. *Swapan* involved the local community members- *Sunil babu* ran a soft drink vending stall and *Kanan Biswas* was a tea stall owner under the flyover. Both came forward to help the man willingly. In absence of a name, he came to be known as *'Bijon'* named after the flyover where he usually roamed.

Psychosocial interventions from Iswar Sankalpa helped *Bijon* become clean and calm. He accepted medicines, hygiene care, food and counseling therapy and slowly started regaining his memory. He remembered his real name as *'Md. Ashif Iqbal'* and that he lived at his maternal uncle's home in *Rajabazar.* A visit to his home by the IS restoration team revealed *Bijon's* past. He had lost his mother at an early age, he was left at his uncle's home by his father who moved on to start a second family. Uncared for, he befriended local boys who introduced him to drugs which deteriorated his mental health

condition. The neighbors and family members were troubled by the nuisance created by *Bijon,* they beat him brutally. Physical, mental and social abuse made his mental health condition worse and he often wandered away.

Overtime he recorded stark improvement. He continued to dwell at the flyover, as he wasn't ready to go back home. His memories of past experiences of brutal abuse and neglect haunted him. He happened to like his new friends *Swapan, Sunil babu* and *Kanan Mashi* and found a new home in the caring community around the flyover. *Anirban,* a volunteer at IS visited him regularly, motivating him to engage in work. *Bijon* helps *Sunil Babu* sell the drinks. IS continues to strengthen the community network of support, care and love around *Bijon* as the final step of community-based rehabilitation for him.

Bijon's story is a significant example that mental health care can be facilitated outside the boundary of institutions. In the cradle of community care, *Bijon* has had a second chance at life as a functional, productive human being who can sustain himself with the basic dignity that all citizens are entitled to.

Naya Daur is focused on allowing its clients to recover and feel healthy at their own pace. Here are two cases of Abdullah and Ashok and their timelines to show that every case takes its own time.

Abdulla's treatment and resettlement timeline

August 2007	Abdullah, aged around 60, was found at the Hastings in a poor hygienic condition, sitting in the dark covered with garbage. He was sitting in the posture of offering namaz. He did not speak at all when we met him. After a few days through gestures he expressed that Allah ordered him not to talk to anybody. Our field workers brought him to one the health camps.
August 2007	Mohamad Nihal, a grocer volunteered to take care of Abdulah. He started providing him food, clothes and helped maintain personal hygiene. After regular treatment and medication he showed improvement in selfcare, hygiene. Within a year he started working at Nihal's shop, started communicating. He could speak english and informed us that he was from Maharashtra and his name was Suresh Kambli. He previously worked at Nanavati hospital (Mumbai) in the Radiology department.
September 2008	Initially He earned around Rs.1500 per month, then started securing about Rs.3000 per month. Nehal continued to support him with food, clothes and other items.

October 2016	Ishwar Sankalp withdrew all the services from Abdullah (Suresh) as he started living with his caregiver Nihal who had embraced him as his own. For further care and treatment, he was tagged to a government hospital. He was the first community resettled in the case of IS.
October 2018	Abdullah (Suresh) participated in workshops and conferences of IS and shared his story with people. On 26th October'18 he along with IS secretary Sarbani Das Roy participated in 'Kaun Banega Crorepati' television reality show.
June 2019	The turning point in Abdullah's (Suresh) story was when the reintegration team traced his family after almost a decade through his daughter who worked as a nurse in a private hospital in Mumbai. His family willingly received him after he went missing for the last 32 years. There was a history of mental illness in Suresh Kambli's family.

Ashok's treatment and resettlement timeline

January 2019	A person aged around 32, was identified at *Sealdah* station, South Area. Initially he could say only his name - Ashok. He was in poor hygienic condition. He wore multiple clothes and was non-communicative but was co-operative and could follow instructions.
March 2019	Due to severe anemia he was treated at a government hospital and was eventually taken to a private facility. During this perios he revealed details of his family members and his home.
April 2019	He desired to return to his home at *Samastipur,* Bihar. His family was traced and he was handed over to his family with whom he reunited after 5 years.

Key Achievements - Facts and Figures that matter

The community mental health programme has brought about small but significant changes in the lives of the clients, that of their voluntary caregivers, families (in cases of reunion) and evoked State response too.

1. Over **3500 lives** have been touched and transformed through street care in the last 13 years of working in over 60 wards of the city; all of them were guaranteed basics of life- food, clean clothes, health care and human touch

2. Each year nearly **200 homeless persons battling psychosocial disability** are found under regular care and treatment process

3. **60+ Medical camps, and 250+ Mental Health Awareness camps** have been organized in the communities **reaching out to over 4000 people** since the beginning

4. The care network has been widened in the last decade to include **250+ voluntary community caregivers** who have not only extended care but also referred potential clients to the social workers

5. **7% of the total active clients usually get absorbed in odd jobs** in the community through caregivers every year

6. **120 street clients** have been reunited with their respective families across Indian states

The team has worked relentlessly to enable clients' access to entitlements:

Entitlement	Frequency
Gratuity Relief Scheme Benefit	16
Aadhaar Card	40
Disability Card	7
Bank A/c	4
PAN card	9

Dedicated field work and advocacy enabled street clients' access to government hospitals for treatment which was earlier denied to them. Additionally, the organization was successful in getting a space within a police station to run a day care centre for them in 2009; this was a breakthrough since they were perceived as a threat by the guardians of law and order.

In the year 2017-18, 66% of the 137 total active enrolled clients who were recipients of direct service recorded an improvement in their overall levels of functionality as per their IDEAS (Indian Disability Evaluation and Assessment Scale) global score, a scale which measures the current status of the clients across 4 major domains: self-care, communication and understanding, interpersonal relationship & work.

Key Learnings - Evolving through experiences

The organization has never romanticized its maiden mental health care model or endorsed it as "the approach" to meeting health care needs of homeless persons with psychosocial disabilities for it was realized early on that the care model fell short in cases of extreme vulnerability- for homeless women battling psychosocial disability in particular, for persons with severe co-morbidities, physical health conditions and for persons addicted to hard drugs. These experiences compelled the organization to develop a multi-pronged approach to address the issue at hand. As a result of which, the birth of the following programmes took place to meet the individual needs of the clients-

Response of the organization to the needs of the target population

1. Naya Daur (2007): An outreach intervention wherein the team along with the community caregivers provide health and allied services to the urban adult homeless persons with psychosocial disabilities on the streets itself

2. Sarbari & Morudyan (2010, 2015): Special shelters for urban homeless women and men battling psychosocial disabilities respectively; providing a safe space for their recovery and rehabilitation; Thus, the maiden programme while continuing to serve the street clients also evolved as a crucial gateway of identification and referral of those in need of sheltered care for better clinical and social outcomes.

3. Day care centres (2009): There are two of them, one within the premises of Hastings Police Station and the other in the community. These centres offer therapeutic space for rest, focused activities and recreation for the target population.

4. Urban Mental Health Programme (2012): It is the mental health clinics run in 5 ward health units of the city in collaboration with the Municipal Corporation with the objective of integrating mental health care with general health care and to make the former accessible to underprivileged population

5. Reintegration: It mainly has three focus areas; Vocational training and supported employment, reuniting clients with their families and enabling their access to entitlements

6. Nayagram (2016): Assisted community living programme in Kashipur, South 24 parganas for those homeless women with psychosocial disability who have become much functional but for whom returning home is not an option. It is to build a home away from their home and enable them to (re)gain financial independence.

7. Crust & Core (2018): A training unit cum cafe to help the clients attain a sustainable source of income and respectable position in society.

The need for continuing the *Naya Daur* programme emerges from the understanding that the evidence generated before the eyes of the community is irrefutable and way greater than one which takes place within the confines of the shelter – that when the community witnesses changes in the 'roadside mad,' their belief in the possibility of change augments and stigma associated with homelessness and psychosocial disability reduce. Thus, in 2018, a decision was taken to expand the programme and apply a decade's experience to 20 new wards in North-Central Kolkata.

One of the other great lessons learnt is that fact that 'restoration of the family unit' will not necessarily be the answer to a successful reintegration for there could be cases wherein the families may not get traced and even if they do get traced, the members wouldn't be ready to take the client back into the family due to various reasons (financial constraints, misperceptions around mental illness…). There are cases where the client doesn't wish to return to their families too. Thus, alternative living arrangements for recovered clients are being thought of; in some cases the community caregivers have offered spaces to dwell safely within the communities. In 2016, Assisted Community living programme was started by the organsiation in Kashipur, a bucolic village in West Bengal to help female recovered clients start their life anew.

It is long realized that thrust has to be laid upon finding alternative solutions for the ailing and aging homeless persons with psychosocial disabiltiy since the option of engaging them in economically productive options in the community is ruled out and they would need constant care and support.

Plans to continue the Change (Building sustainable pathways of care)

a. Community Caregivers: The programme aims to conduct capacity building sessions for community caregivers to gradually make them recognize the importance of their contribution, retain them and enable a more focused service delivery. It aims to make them models of inspiration to absorb many others from the community into the care network. By building and strengthening this social support system in the community for the target population, the foundation for its sustainability will be laid. Plan is to institute a 'caregivers' committee' as well which will stir the community work in the desired direction; exercising their responsibility towards fellow vulnerable citizens.

   Currently, the focus is on also facilitating community awareness and training for effective participation of the community members in the programme. This is to widen the community care network: enlist their support as caregivers of the clients. It is expected that the community will continue to extend support to the programme through donation in cash and/ kind (food, clothes, materials for maintaining hygiene and the like) and also make referrals for treatment. Community ownership and stake in the programme will enable the programme to sustain financial support beyond current funding. The aim is thus to raise community resources to reduce direct programme costs.

b. Involvement of State Bodies: In the long run, the aim is to tag almost all the clients to government hospitals and the ward health units of the government for physical and mental health care treatment. Iswar Sankalpa (under its Urban Mental Health Programme) is currently running five mental health clinics in partnership with the Kolkata Municipal Corporation(KMC) by integrating with primary health centres in wards 74, 82, 11, 54 and 26 of the city. By offering capacity building support and partnership with KMC, the organization wants to move mental health care from professionals to general medical practitioners with the aim to help them provide services at these wards. The health workers will use their skills to identify prospective clients and provide basic counselling support. Thus, gradually, the clients will be availing health services from these centres, creating a shift in the responsibility: the interventions by the organization will reduce, concurrently increasing those by the government. Eventually, as per the National Urban Health Mission, all the 144 wards of the city will have a mental health OPD. The community caregivers are being encouraged to help the street clients receive treatment from these facilities by accompanying them.

c. Developing as a Technical Resource and Decreasing Direct Service: The ultimate aim is to develop as a technical resource for other NGOs and state-run bodies to help them identify and address the needs of homeless persons with psychosocial disability. SOP (Standard Operating Procedure) of the organization's programmes have been prepared to be shared with relevant stakeholders to enable them to replicate the programme (if at all) in future. Thus, the onus would not lie with the organisation solely to address the problem at hand. It will be a collective effort towards addressing the same.

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[1] Psychiatric illness is interchangeably used with mental disorder/ mental illness – no difference (it is an umbrella term) Psychotic disorder are severe mental disorders

[2] Any change to a job, the work environment, or the way things are usually done that allows an individual with a disability to apply for a job, perform job functions, or enjoy equal access to benefits available to other individuals in the workplace.

About Iswar Sankalpa

Iswar Sankalpa is a non-profit organization started formally in 2007 with the hope of reaching out to the 'forgotten' and 'untouchable' population – the homeless persons with psychosocial disabilities on the streets of Kolkata. Today

we are a multi-pronged service delivery organization providing intervention for both the homeless and urban home-based poor population in Kolkata battling psychosocial disability.

Our work is rooted in the vision and mission: "To ensure dignity and holistic well- being of persons with psychosocial disabilities, particularly those from underprivileged sections of society, and to do so in a humane manner, in addition to empowering them in attaining their rights."

We are a dynamic organization, upholding our clients' Right to Life while working in conjunction with the community, government and other stakeholders. We undertake a complete journey with the clients: right from extending mental health care and allied services to enabling them to re-integrate into the society. We consciously refer to our target population as 'clients' even though there are numerous terms such as service users, beneficiaries etc. We choose to use the term 'client' because it connotes a partnership, a transaction wherein both are equally responsible.