



## HOME AGAIN : A RIGHTS BASED APPROACH

Housing with Supportive Services for People with Psychosocial  
Disabilities Experiencing Long-Term Care Needs





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## Partnering for Change

Hello. Welcome aboard as a fellow traveller in this journey for change. A long journey to restore the right to dignity, wellbeing and social and economic inclusion of marginalised people with mental illness. You may be prompted by many things – a passion for equity, a strong sense of empathy, a personal or observed experience as a user of mental health services or a career. Or you are a professional who wants to do a more informed, nuanced job. Whatever the case, we hope to provide you a better understanding of the issues involved and a way forward.

Make no mistake, the problem is huge. About 3% of the Indian population suffers from severe mental disorders. The next time someone downplays the prevalence of mental illness, ask them to visualise two cities the size of Mumbai and Delhi, filled with people. That's the size of the affected population. And draw them yet another mental image: According to the World Health Organisation (WHO), 75-85% of those with severe mental health disorders in low- and middle-income countries (LMICs) have simply no access to treatment. That's us. A LMIC.

The WHO has more alarming numbers. Globally, mental health conditions account for 13% of the total burden of disease and 31% of all years lived with disability. By 2030, depression will likely be the single highest contributor to the burden of disease. Not HIV/AIDS, not heart disease, not road accidents. Just depression. Further, more than 80% of the global burden of disease due to mental health conditions are in LMICs. The Indian subcontinent is particularly vulnerable with neuro-psychiatric disorders in India, Nepal and Sri Lanka alone contributing to 34.1% of the global burden of disease (WHO, Mental Health Atlas 2011).

So, is the situation dire beyond belief? Well, not really. For one, there are people like you. People who have been working to highlight the vulnerability of this population and forge ways to make a meaningful and sustainable impact on their wellbeing. Governments are passing laws that are huge improvements, that are sensitively nuanced and consider the real-world needs of people with mental illness.

Though the challenges are immense, there is enough good intent and momentum to capitalise upon. At The Banyan, we have over 28 years of experience in providing integrated mental health services for marginalised persons. In this time, we have developed many approaches in response to the diverse recovery aspirations of such individuals. Starting as a transit care centre for homeless women with mental health issues, we have journeyed from overseeing their rescue and recovery to reuniting them with lost families, and then further on to providing community-based curative and preventive services. We are principally inclined towards the restoration of the ability to exercise freedom and choice for those affected by mental health issues. And we've seen this work successfully, again and again.

We recognise that there is a huge gap in treatment for mental disorders in India and elsewhere. Studies here indicate that only 40% of people with schizophrenia, 12% of people with common mental disorders and 10% of people with dementia receive care. Globally, annual spending on mental health is less than USD 2.50 per person per annum and less than USD 0.02 per person in low-income countries (WHO, Mental Health Atlas2017)<sup>1</sup>. A third of the countries have no budget for mental health services and one-fifth spend less than 1% of health budget on mental health services. The latter includes India.<sup>2</sup>

Why is there such an inadequate response in the face of the stark statistics, you may ask? Leaving aside the fact that this is a highly inequitable world, and government and public response to problems is usually inadequate, there is the problem of intentions not matching implementation. Policy mechanisms introduced to ensure care in India, such as the District Mental Health Programme (DMHP), have remained largely on paper, and when implemented, has often taken the form of overburdened and isolated camps simply dispensing medication. Besides there just aren't enough people to offer mental health services. As per data from a 2002 nationwide survey, India has only 2 psychiatrists, 1.5 clinical psychologists and 2 psychiatric social workers per 100,000 population. And these few are not entirely equipped or trained to deal with the complex economic and social realities that underpin the experience of illness for most Indians. Quite simply, the infrastructure to deliver mental health care is strained, crumbling and often far removed from what people need. In a resource scarce country, the best way to address these issues resides in a key term – decentralisation. This means changing the way government and the public think about health care. And to ask questions like – does a mental health care programme have to depend so much on highly trained psychiatrists and psychologists, of whom there are just a few? Does care have to be centred around large mental health institutions and hospitals? Does care have to centre around prescribing medicines? (There is a good reason the word “care” is attached to health.) Does the community have a greater role than simply banishing affected people from their midst into the invisibility of institutions and waiting for them to get better or not? And most importantly, who needs to be at the centre of any mental health policy or service? The state, the medical professional, the carer, the user?

At The Banyan we began engaging with mental health through a humanistic response to the plight of mentally ill women rendered homeless and vulnerable on the streets. There is a 360-degree connection between poverty, homelessness and mental illness. Poverty and homelessness or other adverse events can trigger mental illness and conversely mental illness can lead into a downward spiral of loss of support systems, homelessness and poverty. This was our entry point into the field of mental health and we continue to work at the intersection of mental

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1. <http://apps.who.int/iris/bitstream/handle/10665/272735/9789241514019-eng.pdf?ua=1>

2. Mental Health, not a priority, fiscally - Health Analytics AsiaHealth Analytics Asia (ha-asia.com)





illness and homelessness. In our early days of rescue and crisis intervention we asked questions like how did she get on the streets? Can she recover? Can we find her family? Can they be reunited? Can she be rehabilitated in society? Can she stay stable and well after rehabilitation? And we found that the answers to all of that was mostly a resounding 'yes'. In total, 1409 of the 1855 women who came through our doors have been reintegrated with their families. While some others have shifted to other NGOs, around 10% - 12% do not or are unable to leave. Most are those with high clinical needs and/or concurrent intellectual disability who cannot remember or identify their families, while some have no family or simply choose not to leave.

Again, we asked questions, both of us and of the women. Questions like what do you need to recover a sense of agency? Does an institutional setting work for you? What do you need to survive outside an institution without family support? The answers circled back to inclusive living spaces with a range of supportive services, such as housing, employment opportunities, helping access government welfare entitlements, providing trained but non-specialist assistants for those with higher personal needs, supporting socialisation, leisure and recreation, among others. Through the Home Again approach, these individuals form affinity groups and re-enter a real village (or urban equivalent community) living in a shared home and forming a unit that mimics a familial environment.

In a long cycle of evolution, we have arrived at a point where we are taking mental health care back into the heart of the community, from where it was traditionally banished. On the one hand, we provide stable shelter and supportive services to ground the women who need long term care. On the other, we believe that taking them out of an institution into the midst of a regular community, creating family like units, enabling employment and leisure, promoting independent living and social interactions, can improve their quality of life, mental health outcomes, community functioning and promote human rights.

We are excited to have you join us in this stage of the journey. As partners, we aim to build a coalition that can demonstrate shared housing as a viable option that can inspire social inclusion through large scale social contact, create ecosystems of care and living, and in the longer run, transform institutional mental health care.

In the following section, you will find tools and information to help you arrive at a legal, theoretical, ethical and practical understanding of the issues at hand – a brief primer on mental health and illness, legislation and movements that support recovery and rights, the mental health scenario in India and a brief overview of The Banyan and its approach to long term care needs. In the subsequent section, you will find a detailed protocol for the implementation of the Home Again model. We hope you will find this a useful blueprint for replication. Good luck and look forward to partnering with you.

**Team Banyan and The Banyan Academy**



## Section 1: Focus on Neurodiversity, Social Mixing and the Social Determinants of Mental Ill Health

### A. Mental Health and Mental Illness

The World Health Organization (WHO) defines health as a “state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity”. (WHO, 2001b: 1). Mental illness undermines many aspects of health, wellbeing and personal contentment. Mental ill health is distressing by itself. In combination with poverty and homelessness, its effects are devastating. Over the years, causative factors for mental ill health have been studied extensively, originating in discussions centred around the brain and biochemistry, and increasingly expanding to include broader themes of ecological systems, social capital and adversity (De Silva et al, 2007).

New research is needed to investigate mental ill health and to design effective health systems. Current studies are not drawing the attention they should, resulting in limited change. While newer trends and methods of alleviating the distress caused by mental ill health have emerged in the form of medications, science, neuroscience and therapeutic and development practices, outcomes have not improved significantly in many parts of the world, including in India. Mental health is affected by a complex set of factors such as poverty, homelessness, marginalisation, violence, sexual abuse, trauma to name a few. Pharmacology, based on various hypotheses that look towards an imbalance in neurotransmitters in the brain, is useful in muting symptoms that may disrupt a person's safety, ability to function and express volition.

### B. Mental ill Health and Neurodiversity

The experience of a disorder in mental health cannot however be reduced to a disease of the brain. The body is not the person; the brain is not the mind. In The Banyan's experience of running Emergency Care and Recovery Centres for homeless persons with mental health issues, many clients return to daily routine without necessarily displaying reduction in symptoms. The reduction of symptoms is counterproductive if the medications disallow a person from carrying on everyday activity or disrupt participation in economic, social and cultural activity.

Practice of pharmacology that disregards factors beyond elimination of symptoms borders on biomedical hegemony. Studies suggest that many may do better with no or less medication than is required for optimal reduction of symptoms. Recovery from a mental disorder, is not mere absence of symptoms, but the restoration and sustenance of wellbeing. The goal is to achieve a minimum state that allows a person to discover personal recovery – reclaim identity, relationships, dignity and independence. This would constitute management of

symptoms, adherence to continued treatment ability to care for self and perform activities of daily living, work participation and occupational functioning, qualitative improvement in social relationships and social role fulfilment, economic wellbeing and ability to express independence and interdependence.

### C. Mental Health, Poverty and Homelessness

People living in poverty are much more vulnerable to developing mental health problems, including both severe mental illness and common mental health disorders. The 2011 World Disability Report considers that the poorest worldwide are persons with disabilities, including psychosocial impairments (WHO and World Bank, 2011). Furthermore, depression is 1.5 to 2 times more prevalent among low-income groups (Patel, 2001). Hunger, debt, overcrowding, poor or inadequate housing, poor education and unemployment correlate with higher estimated prevalence of common mental disorders (Patel et al, 1999, 2001).

Poverty, coupled with inadequate and inaccessible health care and support systems, can render persons with mental ill health homeless, and susceptible to rapid deterioration, placing them in an environment of conflict, distress and heightened vulnerability. In many LMICs, this deterioration is exacerbated by ineffective policy, planning and legislation; weak development intent; poor governance and leadership; implementation gaps; and a divided, apathetic society. In this context, the 65th World Health Assembly in 2012 has called for convergence between the social and health sectors to address mental health issues in a more integrated manner (WHO 2012, Atun et al, 2013, Townsend, 2013).

Provision of mental health care in India, as in many other LMICs, faces a number of serious challenges. A strong public health system is the backbone of an effective mental health system but public health is making slow progress in India. Health systems and health budgets are both inadequate as are human resources both in terms of quantity and quality. As a result, out of pocket spending on health is significant, driving people into further distress and poverty. And this is a huge at-risk population given that almost 70% of Indians continue to live on less than USD2.00 per day while some 1.77 million persons are homeless (a figure known to be a gross under representation).

Poverty is seen as a predictor of ill health at individual and population levels (Fiscella and Franks, 1997; Subramanian et al, 2002; WHO, 2000a), while health improvement is linked to poverty reduction and development. Despite widespread knowledge of these links and participation of many stakeholders at global and national levels, the rising tide of homelessness and mental ill health has not been curtailed or reversed in over three decades. So, mental health activists can expect a continued rise in morbidity.



## D. Mental Health Legislation

Increasing attention is being paid to violation of rights of persons with mental illness in communities and hospitals. This is part of a global trend where prominence is given to the human rights-based approaches to mental health, owing to progressive legislation and frameworks. It is good news for the mental health stakeholders as disability rights are now in the spotlight.

One such initiative is the UN Convention on the Rights of Persons with Disabilities (CRPD) that came into force in 2008. The CRPD was unique in that it focussed explicitly on the rights of those with disabilities, including their right not to be discriminated against on the basis of disability and their fundamental right to live in communities, rather than being confined in institutions. It also emphasised the importance of mainstreaming disability issues as an integral part of relevant strategies of sustainable development. It further recognised the diversity of people with disabilities, and that the majority lived in conditions of poverty, which therefore led to a critical need to address the negative impact of poverty. Most importantly, it enjoined all countries to adopt all appropriate legislative, administrative and other measures for the implementation of the rights of the disabled.

India's Mental Health Care Act of 2017 is another progressive step forward. It recognises access to mental health care as a right and puts the user at the centre of the legislation. Refreshingly, it places accountability on the state and the public health system to deliver a spectrum of services that it considers essential to wellbeing, including provision of medicines and rehabilitative services through the establishment of a Central Mental Health Authority represented in each state by a State Mental Health Authority. It makes the state responsible for ensuring full coverage. In a country like India, where access to healthcare is poor and high out-of-pocket spending pushes people further into poverty in the case of an illness, this is a much-needed relief.

Despite progress in the right direction in terms of legislation and rights, the ground realities remain unchanged. There is evidence of widespread abuses of human rights in India's 43 mental hospitals (Murthy, 2011). Following the Erwadi incident in Tamil Nadu where 28 people died chained to their beds in a mental hospital, the National Human Rights Commission carried out reviews in psychiatric hospitals. The results revealed numerous violations of rights in facilities providing mental health care throughout the country. This prompted changes at the national level with increased budgets and upgrading of mental health facilities in the last decade (Murthy, 2011). But there is still a long way to go

## E. Mental Health Care Scenario in India

In principle, India follows the policy of integration of mental health care into primary care through training of general health practitioners and other para medical staff. In practice, the results are inadequate. The National Mental Health Programme (NMHP) launched in 1982, mandated delivery of mental health services to administrative units (villages, blocks, districts and towns) through the District Mental Health Programme (DMHP) which was launched in 1996. As of 2019, DMHP operates in approximately 655 of the 692 districts. The DMHP has shown mixed results: some goals have been met in some regions, while many remote rural areas remain under-serviced (van Ginnekin et al, 2014). Similarly, the goal of integrating mental health into public health has also not been accomplished (Khandelwal et al, 2004; Thara et al, 2004). Services provided under the DMHP are grossly inadequate to meet the needs of the majority of persons who live in resource poor circumstances and are unable to afford private, paid services, hindering early identification, treatment, stigma reduction and recovery.

In addition, the DMHP addresses mental illness from a disease perspective, ignoring the context of complex economic, emotional, social and cultural problems. This presents challenges given that mental illness is strongly linked to widespread poverty and homelessness. Another problem for the DMHP is quality of resources. A mental health service relies on the competence and motivation of its personnel to promote mental health, prevent disorders and provide care. (WHO, 2005: 1). The paucity of good quality human resource is an enormous challenge in India. We know that for every 100,000 persons, India has 0.4 psychiatrists, 0.02 psychologists and 0.02 social workers, most of whom are in urban areas (WHO, 2001). But poor motivation to work in under-resourced regions, over extended periods of time, results in an estimated 40-45% rate of absenteeism among doctors posted at public health centres (PHCs).

From a competency point of view, doctors posted at PHCs are not equipped to treat mental illnesses, and rely almost entirely on the six-day training that the DMHP proposes to aid in clinical judgement. Current undergraduate medical curriculum places little emphasis on mental health disorders with just a two-week posting in psychiatry. The duration of training and exposure in general for doctors to mental health in India appears inadequate to equip them with the confidence to take decisions involving Schedule H drugs in a span of 5-10 minutes - the examination time possible with caseloads in India. Studies show that about 0.6 to 7.3 % of the Indian population needs mental health care but not everybody gets the care they need (Shields, 2013). This is called the treatment gap and is estimated to be 90%, which is similar to other LMICs (Patel, 2009; Demyttenaere et al., 2004). The treatment gap symbolises the proportion of people who need care related to the proportion who receive care (Kohn et al., 2004). It is in this space that The Banyan and other organisations attempt to bridge the treatment gap and evolve meaningful, context specific and replicable models of care.

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<https://newsvibesofindia.com/national-mental-health-scheme-being-implemented-in-655-dists/>



These gaps in necessary support for people with psychosocial disabilities burden them disproportionately with liabilities, such as the risks for early mortality, poverty and homelessness. One of the most profound manifestations of social exclusion of people with mental illness is the phenomenon of long-stay, service users spending their entire lives within the confines of acute care settings or in some countries, prisons - segregated and removed from the outside world. A national level survey of service users in 43 state psychiatric hospitals in India, conducted by a multi-stakeholder group set up by The Hans Foundation, across 24 states shows that 4,953 people have lived within the confines of these facilities for one year or more (Narsimhan et al., 2019)<sup>5</sup> The median duration of stay was 6 years; 1 in 10 had lived within these psychiatric facilities for 25 years or more, including one person who had spent all of 62 years of her life inside an institution. Over three-quarters were living in closed wards – that locked spaces with no time outdoors; at the time of survey 47 participants were living in solitary confinement in cells. About half has possible histories of homelessness; in most psychiatric facilities there were more women than men among long stay. Profound social isolation was experienced, 9 in 10 had never stepped outside these facilities or received a visitor in all the years they had spent in these institutions. The majority did not need to be in tertiary psychiatric facilities, not requiring acute care. The majority wanted to move out of these facilities. About 8 in 10 require none to moderate support to live by themselves.

The Banyan

Since 1993, The Banyan has worked with individuals and families with lived experiences of mental illness, homelessness and poverty. We offer comprehensive mental health services in a range of institutional and community settings in the states of Tamil Nadu, Kerala and Maharashtra servicing a population of 1 million low-income households and homeless people through a range of approaches that include hospital-based care, housing in rural and urban neighbourhoods and community and clinic-based mental health solutions. Our focus is on transformative social justice. We work to ensure that people with mental health conditions living in homelessness make journeys back to families and communities of choice, re-enter work, reclaim social relationships and pursue lives of their choosing.

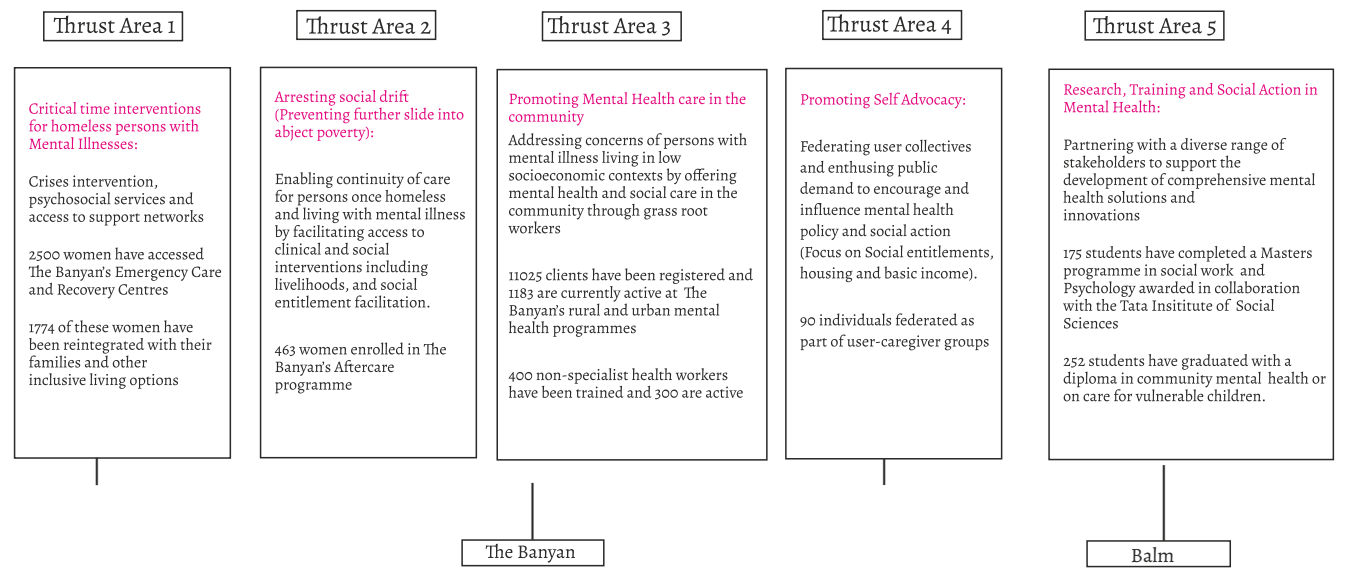
The first, the Emergency Care and Recovery Centres (ECRCs), offers acute care services for HPMI taking into account backgrounds of deprivation, disadvantage and intergenerational distress. Over 2500 persons have accessed this service, with over three quarters having successfully re-joined their families. Goals of personal recovery, meaning making, interdependence, and hope influence the approaches of care that the ECRCs have developed. In 2017, the Government of Tamil Nadu through the National Health Mission recognised this model as one with the highest efficacy in aiding HPMI and since has scaled up, in partnership with district level annually.

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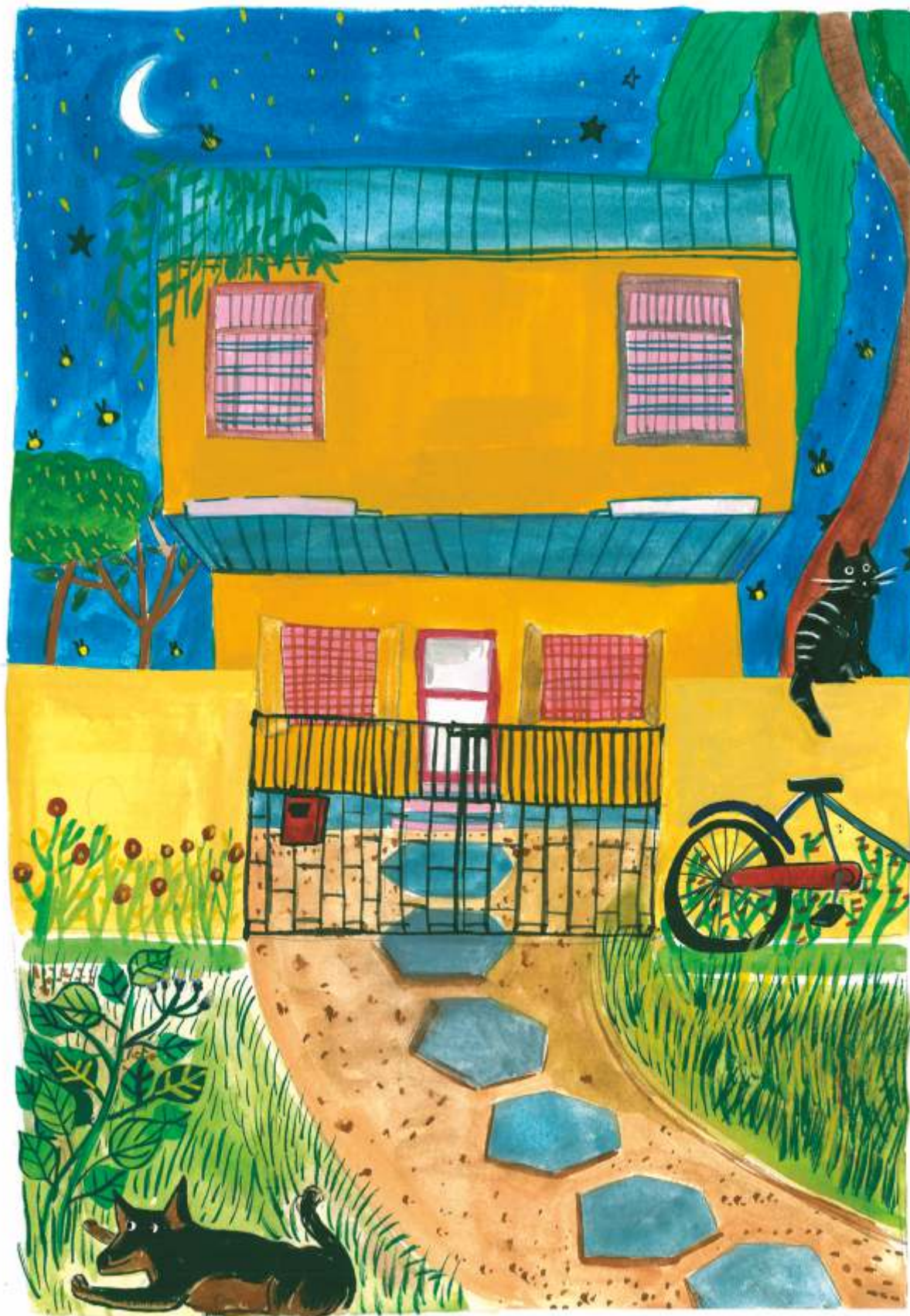
The Hans Foundation National Strategy for Inclusive Living and Community Based Living for Persons with Mental Health Issues, 2019

NALAM' is a well-being oriented, community based mental health care programme driven by grassroots workers who offer multi-tiered, multi-interventional packages of mental health care delivered through grassroots mobilizers. Services offered range from tracking progress on symptom reduction and securing economic stability, to pursuing personal aspirations. NALAM mobilisers work in coordination with the Health and Wellness Centres (HWCs) across rural and urban spaces and community resources or agencies, identifying gaps in accessing immediate, customised and thorough care. They identify psychological distress, offering referrals, counselling, clinical care, home visits, home-based care and social entitlements such as citizenship documents, loans, pensions, employment, etc. Simultaneously they work with children living with parental mental illness and at-risk children receive support annually to break intergenerational cycles of deprivation.

In 28 years, 2537 homeless persons with mental illnesses have been serviced by the Emergency Care and Recovery centres located in two states in India, Kerala and Tamil Nadu. Of these 1727 have been successfully united with their families and 413 of them, not having access to local mental health resources, are part of the aftercare programme which delivers care through outpatient clinics, postal and tele-medicine. 243, without an exit option from institutions, have opted for inclusive living options in the community through the Home Again programme in 3 states. 5000 clients have registered for the outpatient service in Chennai city while 3500 have registered in rural Tamil Nadu and Maharashtra. Over 1000 outpatient clients are currently employed while 33% of the clients within the inpatient facility are employed by The Banyan in various functions ranging from health care provision to security to housekeeping or tailoring. 54 peer leaders have formed a group that involves in advocacy, self-help and helping others with mental health issues. Over 2000 children from disadvantaged backgrounds have registered to participate in our after-school programmes and summer camps and 12 children with parents living with mental illnesses are supported for their education and living expenses.







## Section 2 Home Again: Inclusive Living Options for Homeless People Living with Mental Health Issues

Home Again (HA) as an innovation enables people to come together to form affinity groups and live in homes in a community, creating a shared space of comfort, that mimics a familial environment. Along with housing, the intervention features allied supportive services including social care support and facilitation (opportunities for a diverse range of work, facilitation of government welfare entitlements, problem solving, socialisation support, leisure and recreation), access to healthcare, case management (detailed biopsychosocial assessments and personalised care plans), and onsite personal assistance.

The innovation is executed by a multidisciplinary team, the majority of whom are non-specialist personal assistants. A typical home has 4-5 residents with 1-2 onsite personal assistants visiting or living with them based on need. Access to community resources in a vibrant neighbourhood such as varied work and recreation options, banks, and such utilities are essential. Home Again was initiated by The Banyan through research grants from the Grand Challenges Canada (GCC) and is supported currently by The Rural India Supporting Trust and Bajaj FinServ and previously by The Hans Foundation, Paul Hamlyn Foundation and Azim Premji Philanthropic Initiatives. The intervention has been implemented in neighbourhoods in Chennai, villages in Trichy and Kancheepuram districts of Tamil Nadu; Malappuram and Thrissur in Kerala; Thane and Ratnagiri in Mumbai and Guwahati and Boko in Assam with a partner, Ashadeep. Currently 243 people live across 49 homes in Tamil Nadu, Kerala and Maharashtra. Additionally, 30 people live as part of homes offered by our partner Ashadeep. Operating with a strong focus on personal recovery and individualized support of participants, the innovation seeks to operationalise community-based living while expanding relationships and infusing a sense of broader inclusion.

Replications with the Governments of Kerala and Maharashtra aimed at reducing the incarcerated count at state mental hospitals and the needs of those who continue to remain in psychiatric facilities for over a year or more. These approaches have been featured as successful models in the Lancet Commission on Global Mental Health and Sustainable Development and more recently, in 2021 as part of four models published by the World Health Organisation in their document titled 'Supported living services for mental health: promoting person-centred and rights-based approaches' and one of 24 models that featured good practices from across the world.

Vikram Patel, Shuiyuan Xiao, and others, "The Magnitude of and Health System Response to the Mental Health Treatment Gap in Adults in India and China," *The Lancet*, 388.10063 (2006), 3074-84 <[http://doi.org/10.1016/S0140-6736\(16\)00160-4](http://doi.org/10.1016/S0140-6736(16)00160-4)> Supported living services for mental health: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (Guidance and technical packages on community mental health services: promoting person-centred and rights-based approaches). Licence: CC BY-NC-SA 3.0 IGO



The innovation works on three levels.

### Promoting participation and equal opportunity

By offering an environment that fosters engagement with self and others around, with the necessity to manage one's daily choices (experiences, schedules and so on), assume responsibility in the familial unit and contribute to running a home, form relationships, pursue work of one's choice and pace, participate in cultural activities, and liaise with local community, the intervention nurtures individual capabilities, promotes spatial mobility, increases social and economic transactions and enables organic changes directed by users. <sup>5</sup>

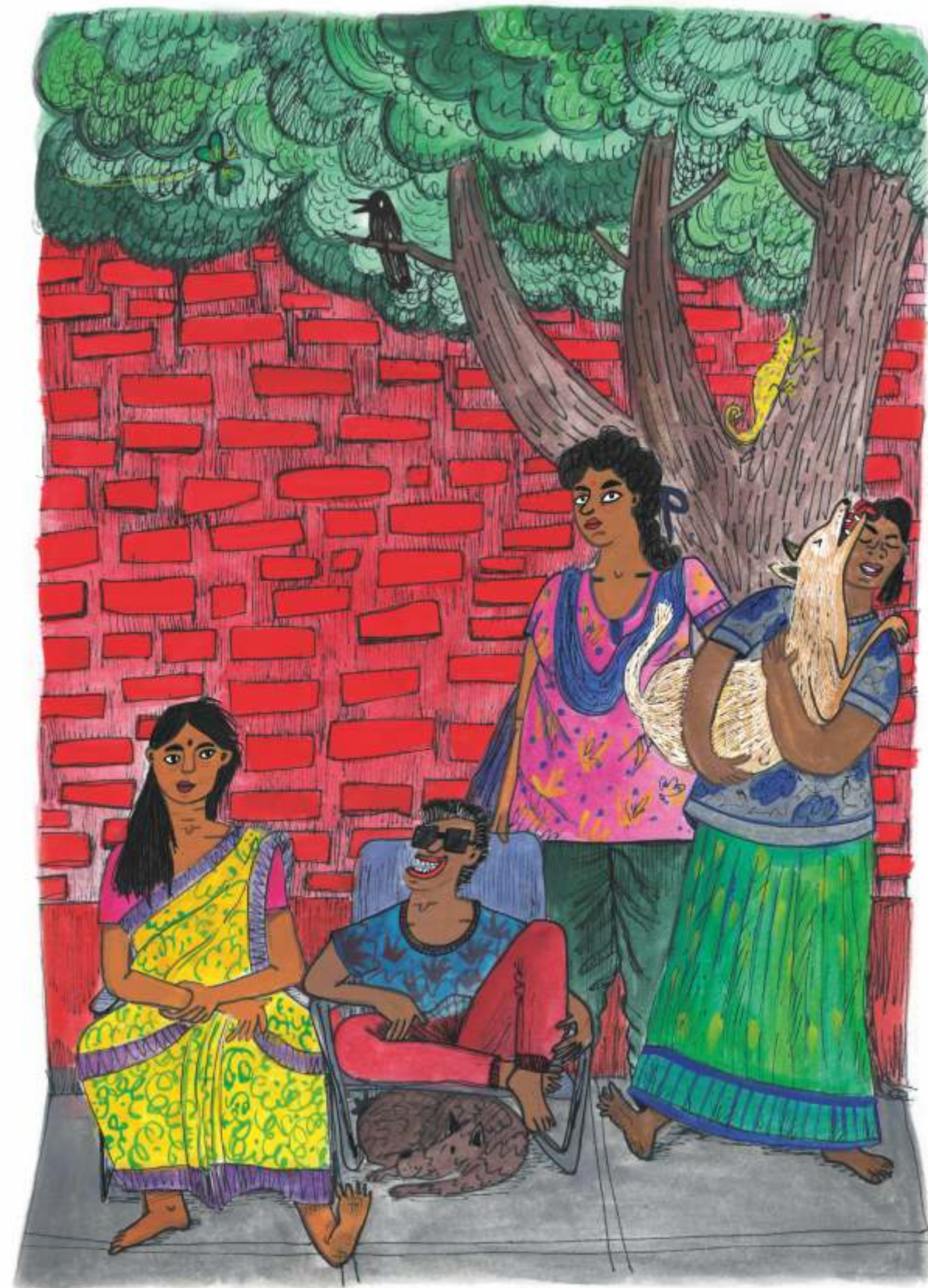
### Reframing social and mental ill health narratives and catalysing social mixing

Through the placement of housing within an ordinary neighbourhood and consequent engagement of people with mental illness with the wider community, the innovation offers the opportunity to reframe personal evidence regarding mental health for people living in such neighbourhoods. Stigma and discrimination, indicated by both attitudes and behaviours of three groups – the user, the onsite personal assistant and the community – may be influenced. The opportunity to study this process may inform a framework for campaigns to address widespread stigma and discrimination against mental illness.

### Transforming institutional mental health care paradigms

The innovation has the potential to transform institutional mental health care in the long run, by offering the opportunity to incisively invest resources in acute care; and by re-orienting mental health services to focus on responsible transitions out of the institution through appropriate community support. The approach is led by user perceptions of wellness and recovery, and proactively engages the user in the planning of individualised care packages. The initiative also seeks to reduce the stigma related to mental illness to organically minimise social distance by encouraging opportunities for social mixing, and thus spurring participation and inclusion.

*Animals form a veritable part of our ecosystem. They saunter across homes in geographies and form significant relationships with those around. This is a recurring theme which has been observed in different phases of Home Again. For instance, in a shared home located in the coastal countryside of Thiruporur, people expressed feelings of inevitable alienation during early days of moving in. Questions of belonging or estrangement loomed large because of the newness and implied strangeness of the space. Some were yet to get accustomed to ways of living here which were starkly different to their individual journeys. The historicity to their experiences of poverty, homelessness & mental illness and profound social disadvantages alongside irreconcilable trauma were other factors. The fact that the community was primarily rural and viscerally quieter added to people rallying around allied thoughts leading to an impasse of sorts.*





Consequently, at a point when the desire to move out was being vocalised, the ambiguous animosity in the air vapourised for reasons unknown and people chose to stay back. It was later realized that without warning, perspectives had gradually shifted, because residents had begun to forge lasting friendships in the neighbourhood (primarily with dogs). They would care for their animal friends, perhaps offer them a bite to eat, undertake long aimless walks on cobbly lanes of the neighbourhood and care for them while navigating everyday life. This consequently led to a greater sense of purpose for some, easier conversations and furthered relationships with children, young people and older neighbours of the larger community.

Looking forward to the carefree companionship brought about allowed people like Veni to live normal days peppered with random joy and find the grit to provide support to those who live with her. When in June of 2020, Veni decided to join as a Personal Assistant in Home Again having unofficially assumed a similar role for quite some time as a fellow shared home resident, she fulfilled a long-term desire by using her savings to buy a phone. Her first act was to photograph her best friends Rowdy and Salim. This was a clear indication to us that for integration, reaching an organic sense of cohesion was a substantive goal to work towards; the answer to which lay in critical elements revolving around intimate connections.

The deep bonds fostered between pets and the people of shared homes also reiterate central capabilities of people to segue their way into relationships, and the importance of creating opportunities to engage in warm social transactions. Seen here are whimsical illustrations of Veni, Rasathi and Laila captured with Rowdy in their elements. Says Veni - “I relate to dogs better than I do with people. There is a sense of comfort that I derive from Rowdy. I don't have anyone but him, neither does he.”

The key features of the Home Again model are illustrated below

Housing + Supportive services Stimulating an environment of home that promotes spontaneity, shared responsibilities, equal opportunity, organic relationship formation, development of individual capabilities and social mixing						
Housing Options	Experiences that have personal meaning	Work Options	Social Ties	Economic Transactions	Health Services	Onsite assistance with daily living if necessary

The supportive services include, but are not limited to:

- 1. **Onsite personal assistance and access to supportive networks:** To aid each individual in reclaiming her identity, navigating the illness and social context and fulfilling her potential to the fullest possible extent.

How do we do this? We extend support when needed towards activities of daily living. In addition, we offer problem solving and handholding assistance (as and when requested).

- 2. **Encouraging self-reliance and aspiration and enthusing hope:** The World Health Organisation (WHO) defines mental health, as 'a state of wellbeing in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

In keeping with this ideology, this programme seeks to create opportunities to access a diverse range of work options, and through that, catalyse a sense of purpose, meaning, and financial and social security.

- 3. **Social care facilitation:** Social care can be defined as 'the provision of social work, personal care, or social support services to children or adults in need or at risk, or adults with needs arising from illness, disability, old age or poverty. The aims are largely to: protect individuals who use care services from abuse or neglect, prevent deterioration of (and to promote) physical and mental health, promote independence and social inclusion, improve opportunities and life chances, and to strengthen families and protect human rights in relation to people's social needs. The Home Again programme subscribes to this philosophy, and has integrated social care services across all aspects of the programme. These include:

- a. Facilitation of government welfare benefits, particularly access to disability pensions, and housing and food subsidies.
- b. Promotion of citizenship rights and financial inclusion: Facilitation of identity documents (voters IDs and Aadhar cards) bank accounts, and PAN cards. This ensures civil and political participation, also critical to living a full and well life.





c. Co-planning of leisure and recreational activities: Creating opportunities that enable the pursuit of experiences that infuse a sense of joy, stimulate hope, and inspire a sense of optimistic wonder and curiosity regarding their future.

4. **Care coordination facilitation:** Care coordination (formerly referred to as case management) as an approach ensures uniformity and consistency in care provided to each individual in the programme. It focuses on orienting the team and all members involved in the programme to both programmatic and individual level values and goals. To do so effectively, it uses structured and unstructured methods and therapeutic interventions including focus group discussions, client level audits and feedbacks, bio- psychosocial assessments and formulation of individualised care plans when needed. It also offers supervisory support to personal assistants and guides them through some of the everyday negotiations they may be involved in, training them in methods that help problem solve, motivate and enhance support networks and social mobility.

#### *What do we mean when we use some of these phrases? (Operational Definitions)*

Words and concepts can be interpreted in multiple ways by different people based on their cultural and educational backgrounds, socio-economic status, levels of exposure, and personal opinions and views. The Banyan and hence the Home Again approach operates on the paradigm of promoting social justice and well-being, and thus views mental health and vulnerability using this lens.

Below is a list of often used phrases in our programme and ways in which we choose to understand / interpret these concepts.

Fundamental concepts	
Affinity groups	An affinity group is a group of people who share interests, issues, and a common bond or background, and offer support for each other. These groups can be formed between friends, or people from the same community, workplace or organization. Affinity groups can represent a narrow or broad definition of a dimension of diversity: including individuals from varied races, castes, classes, sexual orientations, persons with disabilities, and / or other vulnerable groups ( <i>Bernard Hobes Group, 2004</i> ).



Agency	Agency refers to the thoughts and actions taken by people that express their individual power. It is the power people have to think for themselves and act in ways that shape their experiences and life trajectories. Agency can take individual and collective forms ( <i>Stanford Encyclopaedia on Philosophy</i> ).
Capabilities	<p>Martha Nussbaum uses the term 'basic capabilities' to refer to “<i>the innate equipment of individuals that is necessary for developing the more advanced capabilities</i>”, such as the capability of speech and language, which is present in a new born but needs to be fostered.</p> <p>Nussbaum (2000) frames these basic principles in terms of 10 capabilities, i.e. real opportunities based on personal and social circumstance. She claims that a political order can only be considered as being decent if this order secures at least a threshold level of these 10 capabilities to all citizens. Nussbaum's capabilities approach is centered around the notion of individual human dignity (<i>Nussbaum, 2000</i>).</p>
Care	The provision of what is necessary for the health, welfare, maintenance, and protection of someone or something ( <i>Oxford Dictionary</i> ).
Discrimination	Enacted stigma comprises events of negative discrimination, whereas felt stigma includes the experience of shame of having a disorder and the fear of encountering enacted stigma, and is associated with lower self-esteem ( <i>Thronicroft, 2009</i> ).
Diversity	It means understanding that each individual is unique and recognizing and accepting individual differences. These can be along the dimensions of race, ethnicity, gender, sexual orientation, socio-economic status, age, physical abilities, religious beliefs, political beliefs, or other ideologies ( <i>University of Oregon</i> ).

Formed Families	A formed family is widely defined as a family that is created through fostering, adoption or kinship. In the context of home again we consider the non-traditional set up of a group of adults with special needs living together as a family that supports one another where each plays a role and familial bonds are laid. In the Tamil Nadu project, we are attempting to formalise this by recognising the family through a ration card that will give them access to the public distribution service.
Home	<p>A home is a dwelling place of an individual; may be permanent or semi-permanent. However, the meaning of home is complex, interpretational, and unique. It is also subject to our aspirations, beliefs, and historical experiences. Whatever it is, the meaning of home is a way of organizing and understanding the space within ourselves and the way the world is constructed around us.</p> <p>It is defined by memories, contents, and people as much as it is by physical form. It is an evolving idea that continues to change as memories and inhabitants come and go. For a home to function well it needs the basics of threshold, sanctuary, space-to-be, and space-to-share.</p>
Identity	Identity is the conception, qualities, beliefs, and expressions that make a person ( <a href="#">self-identity</a> ) or group (particular social category or <a href="#">social group</a> ). Identity is thus best construed as being both relational and contextual, while the act of identification is best viewed as inherently processual ( <i>Stanford Encyclopaedia of Philosophy</i> ).
Individual autonomy	Is an idea that is generally understood to refer to the capacity to be one's own person, to live one's life according to reasons and motives that are taken as one's own and not the product of manipulative or distorting external forces ( <i>Christman, 2008</i> ).



Intuition	Intuition is a process that of knowing something directly without analytic reasoning, bridging the gap between the conscious and nonconscious parts of our mind, and also between instinct and reason ( <i>Cholle, 2013</i> ).
Kinship	<p>In anthropology, kinship is the web of social relationships that form an important part of the lives of most humans in most societies. Kinship can refer both to the patterns of social relationships themselves, or the study of patterns of social relationships in one or more human cultures.</p> <p>Anthropologists refer to the study of kinship as 'the study of what man does with the basic facts of life - socialisation, mating, gestation, parenthood, siblingship - to name a few'.</p> <p>In a more general sense, kinship may refer to a similarity or affinity between entities on the basis of some or all of their characteristics that are under focus. This may be due to a shared ontological origin, a shared historical or cultural connection, or some other perceived shared features that connect the two entities.</p> <p>Fictive kinship is a term used by anthropologists and ethnographers to describe forms of kinship or social ties that are based on neither consanguineal (blood ties) nor affinal ("by marriage") ties, in contrast to true kinship ties (<i>Scott 2012</i>).</p>
Mental health	Mental Health as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community ( <i>World Health Organisation</i> ).
Mental health user / peer	The language used to describe service users is perhaps more varied in mental health than in any other sector of health and social care. Users are most frequently portrayed as patients – as objects of the clinical gaze of mental health professionals ( <i>Pilgrim &amp; Rogers, 1999</i> ).

Mental Illness	“Mental Illness” means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life ( <i>Mental Health Care Bill, 2016</i> ).
Personal recovery	A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness ( <i>Anthony, 1993</i> )
Self-advocacy	Self-Advocacy is, '[...]one form of advocacy, occurring any time people speak or act on their own behalf to improve their quality of life, effect personal change, or correct inequalities' ( <i>Concunan-Lahr and Brotherson as cited in Brown, 1999</i> ).
Self-expression	<i>Self-expression is a display of individuality whether it's through words, clothing, hairstyle, or art forms such as writing and drawing. Being self-expressed means that people will see your spirit and true character; they will see the totality of who you are. And sharing of one's “self” fully is the ultimate in generosity and is vital for peace, happiness and fulfilment.</i>
Social exclusion	<i>Exclusion consists of dynamic, multi-dimensional processes driven by unequal power relationships interacting across four main dimensions - economic, political, social and cultural - and at different levels including individual, household, group, community, country and global levels. It involves the lack or denial of resources, rights, goods and services, and the inability to participate in the normal relationships and activities. It affects both the quality of life of individuals and the equity and cohesion of society as a whole (Sorokin, 1959).</i>



Social inclusion	Social inclusion describes how a society values all of its citizens, respects their differences, ensures everyone's basic needs are met, and welcomes and enables full participation in that society (Westfall 2010, pp 7).
Social Mixing	Social mix is the diversity in the levels of income, tenure and social class within a given neighbourhood. Social mixing is scene is a measure to stimulate social cohesion and build social capital thereby increasing the opportunities available to those who live in the margins. <sup>8</sup>
Social mobility	Social mobility is the degree to which, an individual's social status can change throughout the course of his or her life, or the degree to which that individual's offspring and subsequent generations move up and down the class system, in a given society ( <i>Sorokin, 1959</i> ).
Stigma	The term stigma refers to problems of knowledge (ignorance), attitudes (prejudice) and behaviour (discrimination). Stigma produces changes in feelings, attitudes, and behaviour for both the person affected (lower self-esteem, poorer self-care, and social withdrawal) and family members ( <i>Thornicroft, 2007</i> )
Wellbeing	<p>Defining and achieving a state of wellbeing has been the primary task of philosophers since the time of Aristotle, given that it is the essence of the human condition in many respects. Recently it has moved to the realm of science from that of philosophy.</p> <p>The science of 'subjective well-being' suggests that as well as experiencing good feelings, people need:</p>

	<p>1.a sense of individual vitality</p> <p>2.to undertake activities which are meaningful, engaging, and which make them feel competent and autonomous</p> <p>3.a stock of inner resources to help them cope when things go wrong and be resilient to changes beyond their immediate control.</p> <p>Wellbeing is most usefully thought of as the dynamic process that gives people a sense of how their lives are going, through the interaction between their circumstances, activities and psychological resources or 'mental capital' (<i>Sarvimaki A, 2006</i>).</p>
Service Providers	
Care Coordinator (formerly referred to as Case Manager)	A professional responsible for managing an assigned caseload of clients having long term mental illness and for assessing client needs, developing, implementing and reviewing service plans, and working with other community resources in meeting/achieving client service needs ( <i>Clark, 2013</i> ).
Mental health professional (As defined in the Mental Health Care Act, 2017)	<p>The Mental Health Care Act refers to a Mental Health Professional as:</p> <p>(i) A psychiatrist (<i>definition provided below</i>); or</p> <p>(i) A professional registered with the concerned State Authority under section 55; or</p> <p>(iii) A professional having a postgraduate degree (Ayurveda) in Mano Vigyan Avum Manas Roga or a postgraduate degree (Homoeopathy) in Psychiatry or a postgraduate degree (Unani) in Moalijat (Nafasiyatt) or a postgraduate degree (Siddha) in Sirappu Maruthuvam.</p> <p>(iv) A professional with an M.Phil or PhD in social work or psychology.</p>



Personal assistant	The personal assistant assists in all activities of self-care and daily living including grooming, home maintenance, food preparation and intake, negotiations around work and interpersonal relationships ( <i>The Banyan</i> ).
Psychiatrist	A psychiatrist is a medical doctor (M.D. or D.O) who specializes in mental health including substance use disorders and are trained/qualified to assess both mental and physical aspects of psychological problems ( <i>APA, 2016</i> )

Who does the Home Again approach serve best?

The Home Again approach is aimed at offering mental health care and social care services for persons with severe mental health issues, who have been stuck in institutional spaces over an extended period of time. Typically, these settings include mental hospitals, Government run rehabilitation homes, beggars' homes, shelters for homeless persons, and not for profit organisations offering inpatient mental health care. Thus far, only individuals who have managed to attain a clinician rated notion of recovery, i.e., being symptom-free, or enjoying high levels of functionality and low levels of disability have been able to exit institutions. For those with more profound impairment and disability, there are very few options (if at all). Central to the Home Again approach is the philosophy that there are no conditions on 'recovery'.

As much as we believe anybody should be able to live in the community, equally we have to understand the individuals' keenness, enthusiasm and need. If the transition compromises the safety of the individual, either from a social / physical or psychological health point of view, then it is responsibility of the team to confer with the individual, her support networks, and other peer advisors to the programme on whether she should move back into a service that may better cater to her needs.

We hypothesise that a shift in the social architecture, to a space that offers care in a personalised manner, in an intimate setting, that is reminiscent of home will improve prognosis, functionality, and one's quality of life, reduce disability, improve functionality, and most importantly create inroads into the community such that social mixing is encouraged and participation and inclusion promoted. As illustrated in the vignettes above, each individual in most cases continues to experience mental health issues through the presence of either positive or negative symptoms, but is also progressing steadily towards a state of personal recovery / wellbeing.





Ms. L	<p>Visitors to Ms. L's house are reliably greeted by her cheery call of, "Come in!"</p> <p>Only 18 months earlier, Ms. L—mid-forties, petite, bright-eyed—was largely uninterested in the world of people. She would make eye-contact, even, only with a select few. Ms. L, diagnosed with psychosis comorbid with an intellectual disability, has accessed care at The Banyan for approximately ten years. Eighteen months ago, she moved from the Emergency Care and Recovery Centre to a home in Kanchipuram.</p> <p>Today, Ms. L engages eagerly with those around her, is expressive about her preferences, and is fond of visitors.</p> <p>Her levels of disability have decreased by two points (6 to 4). Her psychiatric symptoms have stayed constant.</p>
Ms. M	<p>Ms. M shares a home with four friends who understand that she has good days and hard ones. Fifty years old, quick-witted, and sharp-tongue, Ms. M was diagnosed with a schizoaffective disorder when she first came to The Banyan over 7 years ago.</p> <p>On her good days, Ms. M is highly functional, independent and very self-directed. On more difficult days, she hears voices that leave her feeling agitated, harassed, and unlike herself. In the latter case, she often requires additional support, including on occasion returning to the Emergency Care and Recovery Centre.</p> <p>The quiet of the ECRC, and the more intensive care, help her as the hallucinations subside. And when they do, she comes home again.</p> <p>Ms. M has had a dramatic reduction in psychiatric symptoms and disability with her BPRS scores coming down by almost 15 points (72 to 57), and her WHO-DAS scores coming down from 5 to 2.</p>





Ms. A	<p>Ms. A has bright silver hair and a warm, gracious smile. She lives in a home with two friends in a fishing village in Kanchipuram District. She's known for her perfect cooking. She provides care for two children whose mothers have mental health challenges and who require childcare support, <i>and</i> she helps manage the home.</p> <p>But on rare, bad days, Ms. A hears her dead father's voice. He issues her commands. She slips away from her own reality. Her self-care dips severely, as does her ability to manage the home and care for the children. Through these days, the personal assistant steps forward with intensive support. If required, Ms. A returns to institutional care until she feels like herself again.</p> <p>When she arrived at The Banyan eight years ago, Ms. A was diagnosed with schizophrenia and was floridly psychotic—she heard voices and saw visions. While her levels of disability fluctuate, Ms. A's WHO-DAS scores have reduced from 7 to 4.</p>
Ms. M	<p>Ms. P needs no help taking care of herself. She gets through her chores independently, bathes and cleans self-reliantly—she rarely asks for help, and rarely needs to. Actually, Ms. P barely starts conversations at all. Ms. P lives in a quaint, small home in a village in Kanchipuram, with house-mates. Her hair, even at 50-years-old, is thick, black, and flows down to her hips. She came to The Banyan six years ago and was diagnosed with schizophrenia, and she continues to have residual negative symptoms. Her BPRS scores indicate an increase in psychiatric symptoms by 9 points (particularly negative symptoms).</p> <p>With respect for her introversion and personal space, the personal assistant tries to engage with her conversationally, in attempts to enable her social participation.</p> <p>Recently, Ms. P opened up in joyous reminiscence about the sweet <i>payasam</i> she used to make at home, back when she was younger, before she felt unwell.</p> <p>Ms. P's level of disability has decreased from a 25 to a 9 WHO-DAS score</p>

Ms. R	<p>Ms. R has been house-hunting. She plans to move out of the home she shares with four friends, into a new home that she'll share with just one. Rent will be a considerable cost, but she's been saving up for months. And she's been working for even longer. Ms. R is now a sales assistant (a role she enjoys greatly), and in the past few years has worked as a security guard, an idli batter vendor, and a worker in the vocational training unit.</p> <p>At 45, Ms. R carries the enthusiastic, energetic air of someone who's just getting started. She's driven, resourceful, entrepreneurial and independent. She loves her work and she loves her independence—perhaps because they are so closely linked.</p> <p>When she first arrived at The Banyan, Ms. R was diagnosed with psychosis and a mild intellectual disability. While her psychiatric symptoms remain at a constant, her disability scores have decreased from 4 to 3, on WHO-DAS</p>
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Section 3: Processes and Micro-Processes – Critical Tenets

Transitions into the community:

Pre-engagement - An introduction to the Home Again approach

Pre-engagement refers to the period when the Home Again approach is introduced to the client. It is extremely critical that this process is participatory and facilitated with utmost care, since many clients may have undergone traumatic experiences and debilitating stigma whilst living in the community. In addition, their years, or decades within the institution may have caused them to internalise some of the attitudes, values and practices that many large institutions embrace in order to be able to function effectively. This could mean compromised, or damaged feelings of safety and security, or a sense of passive conformity. One needs to be aware of, and sensitive to these factors, and ensure that the individual is not overwhelmed as a result of this transition. Emphasise that they have the right to choose when, and where to move, and that the final decision will be theirs. It is necessary to highlight the progress the individual has made since they first entered the institution and thus the possibility of moving forward. Share the excitement and pleasures that can be derived from pursuing one's own goals and aspirations. The pre-engagement period typically begins from the time the concept is introduced, until the time the individual has moved in and settled into their home. So, you may notice an overlap between this protocol and those that follow, since they all lead up to the transition from an institutionalised care setting, into homes in the community.



### Day One: What is Home Again?

To effectively introduce the idea of living outside institutional care settings in an independent home within the community, you could conduct a group session with the clients who may opt to shift, and the extended care team. These introductions could be made in an individual manner, with one person at a time or shared with a group of friends or acquaintances at the same time, based on whatever you feel will work best. Some work better with private chats over multiple days, while others buy into the idea instantly and share it with their friends, creating a ripple effect. If the participants are keen and looking forward to change, this process is bound to be easy enough. In some cases, especially when people have found friends in the staff in the institution, or if they have gotten used to a certain structured way of life, then the resistance to engaging with a move such as this can be high. However, appealing to how beneficial it may be in the long run may help. Since there are multiple ways to get the person to at least engage with the process, such as offering them an opportunity to visit and then opting not to move, chances are that they will see the benefit of the arrangement as time goes by. More often than not, the lure of an independent home, friends who accompany the individual, and the hustle and bustle of a new place and all that accompanies it, tend to influence the person's decision positively. The idea is to get every individual to try it at least once. However, remember to keep the options open for them to return to their original place of stay - the mental health centre, if things don't go well. The back-and-forth movement could also be tried multiple times, based on individual responses.

### Session 1: Introducing the concept

This session should be carefully coordinated to ensure that the concept is communicated in a uniform and non-threatening manner across all groups/ individuals.

### Present Home Again

- The Home Again approach will be presented in a two-fold manner that showcases both individual and organisational needs and priorities. On an individual level, the natural progression towards personal recovery will be highlighted, and diverse living options aside from institutionalised care presented. On the organisational front, the magnitude of the problem, fixed number of bed spaces, and the critical need to reach out to more individuals in distress must be highlighted.
- Testimonials, and one-on-one interactions with clients who have been part of this initiative or are now
- living independently will be useful in instilling confidence and infusing additional energy into the conversation.
- 

- Having health coaches / personal assistants already working in such settings address the clients on the advantages of the concept, as well as transformations that they have already observed amongst residents who live in such housing/ care options, may also help motivate the client in considering this change. Do not exaggerate gains or positive experiences. What you say should be real, honest, and meet people's expectations.

### Concepts to touch upon:

- Long term goals, and the notions of 'personal' recovery - here the meaning of 'personal' refers to truly personal and not conventional, conservative or standardised.
- Importance of autonomy, independence, choice and participation – illustrate with examples - pick examples like visiting a hotel, place of worship, voluntary boarding, owning a house and getting richer socially with newer experiences etc.
- Pursuing individual aspirations, and engaging in social and political life as a member of the community - stimulate recall from premorbid (before onset of mental illness) phase of life - mention those years, even if you feel comprehension is poor or inadequate. Communicate with the same earnestness, regardless of your notion of their ability to understand conversations or events.

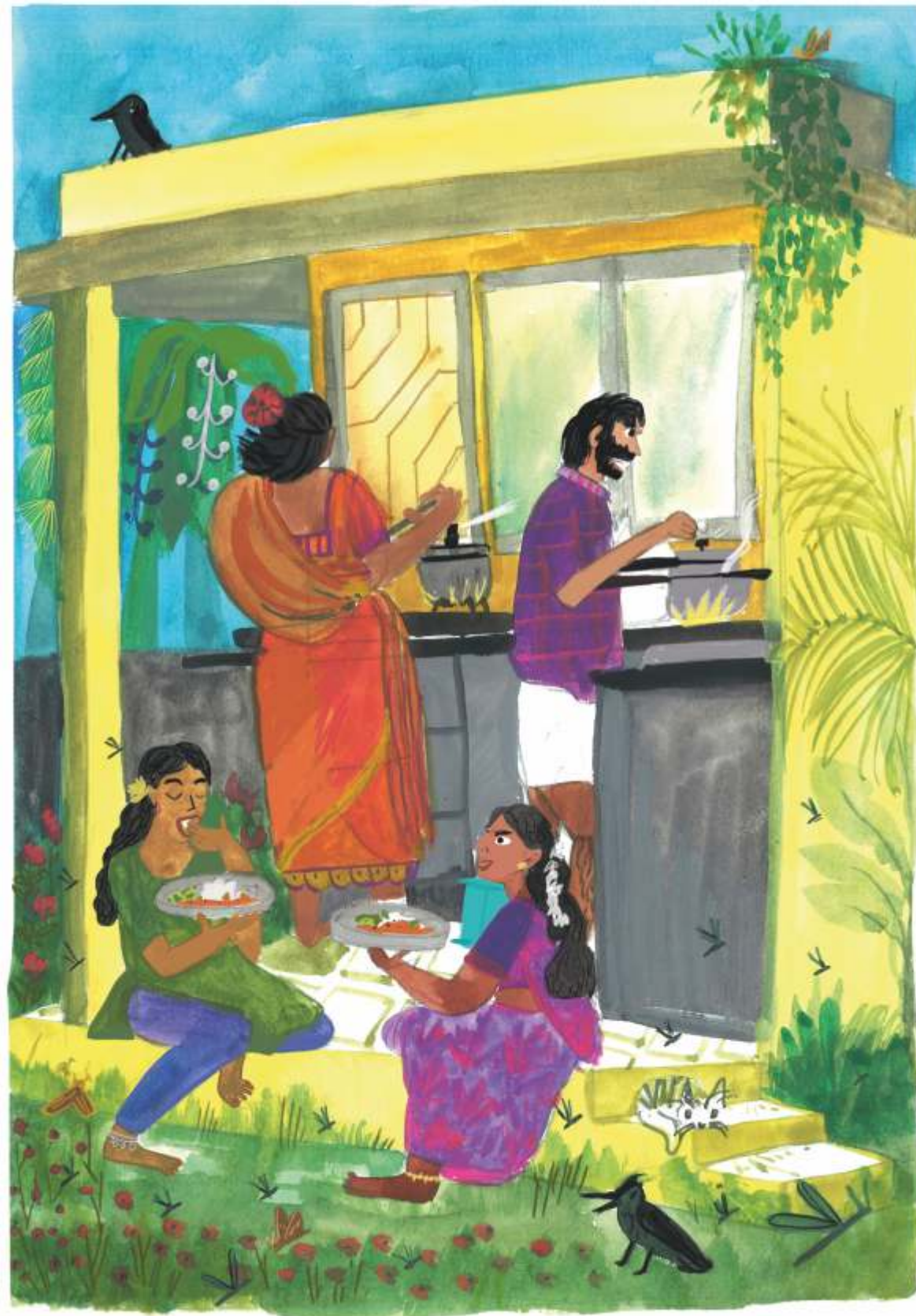
In essence, you must convey that this offers an opportunity to live like anybody else does, in a home, with others who eventually could / may become family or friends. This will entail managing and leading one's own life and daily routine, being employed, earning money, learning to save, travel, transact, form relationships, socialise and feel pain, sorrow, joy, enthusiasm.

### Day 2: Experiencing life in the community

For some of these individuals moving from a space that was their 'home' for perhaps several years, can be traumatic, daunting and almost unimaginable. The best way for them to get a feel of what this experience may hold, is for them to step out, live that life like others do, even if only for a day.

A group of individuals who are interested in exploring this, will spend the day at one of the other homes that is already set up as a part of the Home Again programme, and be hosted by members of that family and the PA. This will also offer a much closer mode of interaction with others who currently live there. The day will be structured in such a manner that it allows for them to have a well-rounded experience.





**Mealtimes:** Preparing and having breakfast, lunch and dinner together. Revisiting old recipes, cooking together, undertaking trips to the bustling market in the neighbourhood to pick up fresh vegetables and groceries, having a kitchen and choosing produce to cook, private spaces to occupy as their very own, cooking dishes they knew from their past and framing memories of comfort and identity. The whole process promotes bonding and draws occupants in the home towards oneness.

**Worklife:** Enlist efforts to ensure that people could retain social, economic and cultural participation. Specific activities to build skills and strategies for supported self-management in both home and community contexts are to be initiated. Offer tailor-made work pursuits (set pace based on preferences and integral choices) inside and outside the home, geared towards personal choices and aspirations. This can mean performing chores in one's own home, assuming a role in a factory close by, working in farm lands, starting a business and cultivating a new skill.

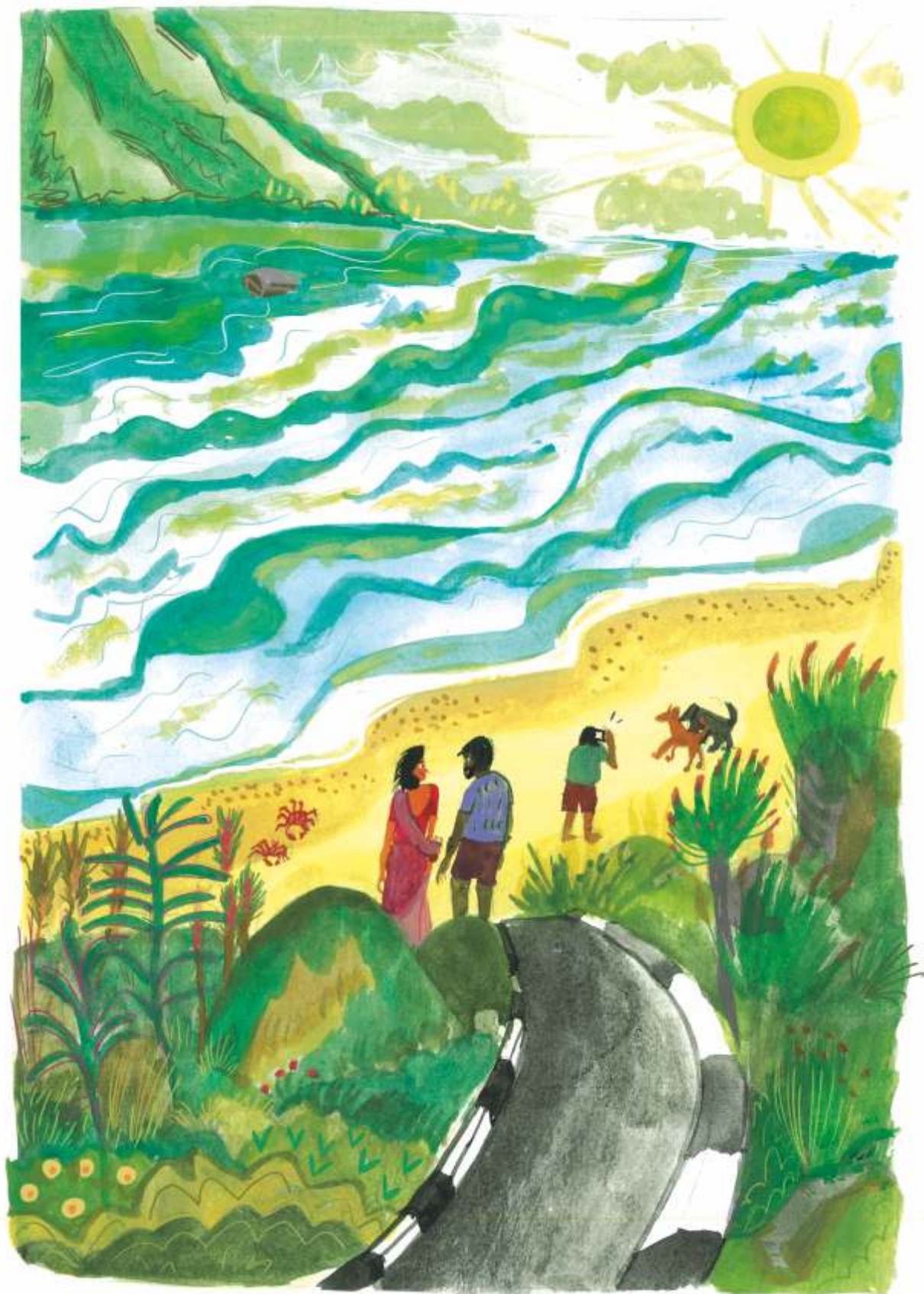
**Socialising:** Organise access to community spaces such as parks, beaches, libraries, places of worship and homes of neighbours in the vicinity. Create spaces to encourage social networks including peers, friends, children or community members, who foster support and assume spaces of investment in care plans to be involved. An example could be a verandah with an open setting people can curl up with the resident dog and cup of piping hot tea or holler out at a passing by neighbour for a fun chat.

**Spending the night:** Staying at the house overnight and carrying out their morning routines before heading back to the care facility.

In cases where leaving the institution before the discharge date is not possible or in cases such as the Covid-19 pandemic of 2020-21, alternative methods could be used to give the potential participants a feel of the Home Again model using videos, talks from a service user and video calls.

**Days 3-10: Clarifying concepts, one-on-one structured and unstructured sessions, free thinking and space**  
No major life decision can be rushed, especially one as impactful in terms of socialising, functioning, freedom and independence. It is important to ensure that there is enough room for clarification of doubts, and time and space to reflect on one's own thoughts.





Once the visit has been completed, you (the project heads, care coordinators, and personal assistants) must ensure that you are available over the next week to answer questions, clarify concepts, address concerns, and help ease any discomfort that the individual may have. These sessions must be flexible and cater to the needs of each individual.

- Make sure you facilitate an individual session with the care coordinator, to clarify doubts, discuss any feelings of nostalgia that could arise from going back to a place similar to where they grew up /lived prior to her institutionalisation, and feelings of discomfort that may have arisen due to the same.
- This time can also be used to bring up any likes / dislikes about the approach, and any feedback that a client may have on it.
- This could also serve as good time to go back and forth on the idea, and also a great opportunity for peer-to-peer talks.

#### Days 4-9: Free Thinking Spaces

- You can conduct group sessions if you find that several clients have similar questions about the move. But wait for this to be initiated. Do it only upon request.
- Give the individual time to think and reflect on the approach. Do not have any structured case sessions. However, you can have informal chats about it. Make sure to ask the individual if there are any specific concerns that they may have, and try to support them through it. In case some individuals do not explicitly state preferences, communicate all details in as much depth as you possibly can. Do not worry if the client remains passive and disengaged, and opinionless one way or the other. Take them through all the steps, regardless.
- Do not ask a closed-ended question regarding the shift, or pressurise the client to make a decision. Always indicate that you are available if she needs to discuss her decision. Make sure you cultivate a relaxed air around yourself and the move.
- You will also need to focus on, and address components mentioned by clients that they perhaps did not like about the new living arrangements, and be honest as to whether these issues can or cannot be resolved, so clients can make an informed decision.

#### Day 10: Decision to move

- After a week of letting this thought simmer, it will be a good time to have a structured discussion on the individual's choice to move to the home.
- Ensure that you convey that their decision will not be considered final, and they can always change their mind later, one way or another.
- Also convey that whatever decision they take will be respected by the organisation, and neither decision will affect their standing / relationship with the organisation or the care team.





*Mariamamma was typically seen stretched against a wall plastered with posters, in a half restive position, under the shade of the town bus-stand. Infamous for remaining obstinately silent despite efforts to engage, her routine through the day included tenaciously undertaking long walks crossing several kilometres across the local milieu unhinged and adrift while seeking alms. Folk from the village of Kovindakurichi recalled her as a familiar face whom they invariably came across while passing through but largely ignored. Given this demeanour, it came as a total surprise to the entire community when one fine day, on the day of the housewarming ceremony of the first Home Again home in Kovandakurichi, Mariamma walked unannounced into the house, plunged into participating in the ceremony with others like her and left only when the late evening twilight set in. There was something unspoken in the air - a mutual sense of solidarity and ease. Since then, Mariamma took to dropping in to visit every other day on her terms. She started recreating a sense of home for herself with friends and in the process reclaimed her sense of self. Revisiting personal stories from childhood, unearthing heirloom recipes to the tune of the radio, tending to mangoes growing in wild birches to pickle, sharing thoughts on upcoming movies, local festivities & pop-culture, laughing raucously aloud together to something funny, elaborating life challenges they had to confront on a regular basis, Mariamma joined in this and more. Although she prefers to not stay back and leaves when each day rolls on.*

#### Days 12 - 20: Initiating the transition

Clients who have chosen to move into new houses will get started on the next steps with their care coordinators and personal assistants. This will involve choosing their house-mates, procuring their personal belongings, furnishing/decorating their house, and settling into a new routine.

As exciting as it is, it may also seem a little tiring and daunting for some individuals. Ensure that you take things at a pace each individual is comfortable with, and do not rush or compare pace with others who are also transitioning at the same time. Support the shift of elderly clients who will follow a whole different routine and level of support (for eg. having beds and mattresses instead of mats, flexible and reduced work hours, increased pension amounts, increased support for activities of daily living etc.).



Choosing housemates and breaking the ice	<ul style="list-style-type: none"><li>● Have individual sessions with your client to understand who she would like to live with. See if there is anybody she particularly does NOT want to live with as well. Many in all likelihood would have already made plans with their friends.</li><li>● Try to facilitate group meetings once the members of the house have been chosen. Enthuse excitement about this transition. Go on small outings, try to initiate bonding activities in culturally appropriate ways including, cooking as an activity, invoking blessings from the Gods to get started, and pandering to their ritualistic and superstitious needs if recommended.</li><li>● It is also okay for the individual not to display any preferences. Don't force it. A period of prolonged institutionalisation can sometimes result in the inability to comprehend choice, and a perceived lack of control in decision making.</li><li>● In the event an individual does not express a preference for housemates, the care team may allocate a home based on other factors such a common language, interests, etc.</li></ul>
Engagement with new care coordinator and personal assistant	<ul style="list-style-type: none"><li>● Ensure that informal sessions with the new care team begin ahead of the shift, such that the transition is not abrupt. So, a visit to the old site on the part of the new care coordinator and personal assistant is a good idea, such that everybody seems part of the same team and family.</li><li>● Assure the individual of the new care team's credibility and strengths but also mention that the former care team will always be available to her. Plan visits for the former care team to the site as often as required - this again will vary from person to person and house to house. Use the telephone to chat or video call appropriately as well. Every house has a phone and thus access to all friends from earlier.</li></ul>

Securing housing

Identifying houses for the Home Again intervention should be with the help of key members of the community - not brokers or real estate agents. Make sure you also reach out to individuals who are sensitive to mental health issues, such as persons with mental health issues themselves or their caregivers. Some others you can approach include, the panchayat leader or other ward members, the local school teacher, priest at the church, temple or mosque, DMHP staff, local community leaders, mental health peer users, community-based rehabilitation worker (CBR) and / or ASHA worker, ANMs, Anganwadi workers, and any other members of the community who participate actively in social and cultural events. You will find that this yields much better results, and gives you a chance to get to know the community a little better. The process of securing housing for the Home Again programme is critical and needs to be operationalised carefully to ensure maximum engagement and participation from the individuals accessing care, the house owners, and the rest of the community. Also encourage the members of the house to be involved through the identification process, and make it a collaborative and fun activity when and where possible.

Community engagement and transformation of attitudes

We have learnt from the Home Again approach and other such innovations that myths and misconceptions surrounding mental illness are always shattered in a million ways every day. We just don't talk about this as much as we do about general, popular notions and perceptions. We believe that attitudinal changes in thinking and behaviour and not merely a result of social and public service messaging or didactic knowledge sharing, but more as a result of direct engagement, interactions and related experiences. The Home Again approach therefore, seeks to normalise mental illness to the extent possible by ensuring the creation of opportunities to interact, engage and form relationships in ways that any of us do, regardless of individual capacity.

None of these interactions are contrived or forced though. As, in any social situation, we wait for relationships to grow and develop organically, in their own time. What we do, however, is to gently introduce an appropriate event or stimuli to facilitate this and observe responses closely thereafter. Life always presents us with both negative and positive experiences. It is no different in this case. There will be good and bad days, ups and downs, judging and acceptance, love, empathy and discrimination.



For example, when the Health Centre, a mental health clinic was set up in the village of Kovalam, Tamil Nadu, by The Banyan, it was initially shunned by the community as a 'mental hospital' even though it offered a range of community services such as a general health clinic, a vocational training and tailoring unit. Over some months, the children in the community began to interact with the occupants of the centre and began to engage with them and soon began to play on the premises. This soon transformed into an after-school centre as some of the residents began to help the children with their homework. The attitude of the children slowly transformed that of the adults who also then began to seek out the health centre for its various programmes

What are some of the basics required?

Access to local critical support services	<p>Health: The houses must be located close (5- 25 kms) to a nodal health centre (primary health centre, private clinic or hospital) that offers emergency general health services.</p> <p>Transportation: The communities must be accessible through local transport systems, and have reasonable connectivity.</p> <p>Basic infrastructure and amenities: The houses should have access to all basic amenities (electricity, running water, sanitation), access to grocery stores, faith centres, parks or open spaces and at least a co-operative banking institution in the vicinity.</p>
Social and cultural appropriateness	<p>The identified communities must resonate with the individuals shifting out of institutionalised care settings and must be similar in socio-economic, cultural, and political contexts to those they resided in prior to entering the institutionalised care system to the extent possible.</p> <p>In short - they should feel comfortable in the ecosystem they are shifting into. A sense of openness and friendliness in the neighbourhood will always help</p>

Cost effectiveness	The identified communities must offer a good quality of life. However, keep in mind resource constraints, and ensure that the spaces chosen will be affordable in the medium and long term.
Scattered housing	<p>Do not look for more than three - four houses in the same community. Too many will give a feeling of overcrowding and will run the risk of mimicking an institution again.</p> <p>The Home Again approach is caste, class, and community affiliation neutral, and the location of the house will not be based on the religious /tribal /caste affiliation of the community.</p>

What are the non-negotiables to look for in a house?

- Ensure that the neighbourhood is friendly and welcoming. Ensure that there are houses around such that the opportunity to foster friendships is available.
- Pucca' or concrete houses that are bright, airy, and have good ventilation. If possible, have a small garden space.
- The house should have a minimum of one bedroom (preferably two, so it accommodates 4-5 persons), one living room, one kitchen, and one toilet. Toilets and running water are not always common in Indian rural contexts. Please ensure this is available and look for one inside the house as far as possible.
- Electrical (separate metre and junction box ideal), plumbing, sewage, and drainage systems intact with no damage. If possible, a two-phase set up.
- Good sanitation - toilets with all appropriate sanitary fixtures intact.
- A functional kitchen with kitchen counter, provision for wall shelving and/or cabinets, and a gas connection.
- Provision for a television and dish.
- Ensure that there are department stores, grocery stores and other small shops that are accessible close by.



- The local neighbourhood should also provide livelihood opportunities in case individuals wish to seek external employment.
- It is advisable to seek neighbourhoods with a good social mix. Avoid neighbourhoods that are specific to one caste or community as it is also the intention of the Home Again model to break these barriers and ensure social inclusion and mixing at all levels.

### So, I like a house, how do I get it?

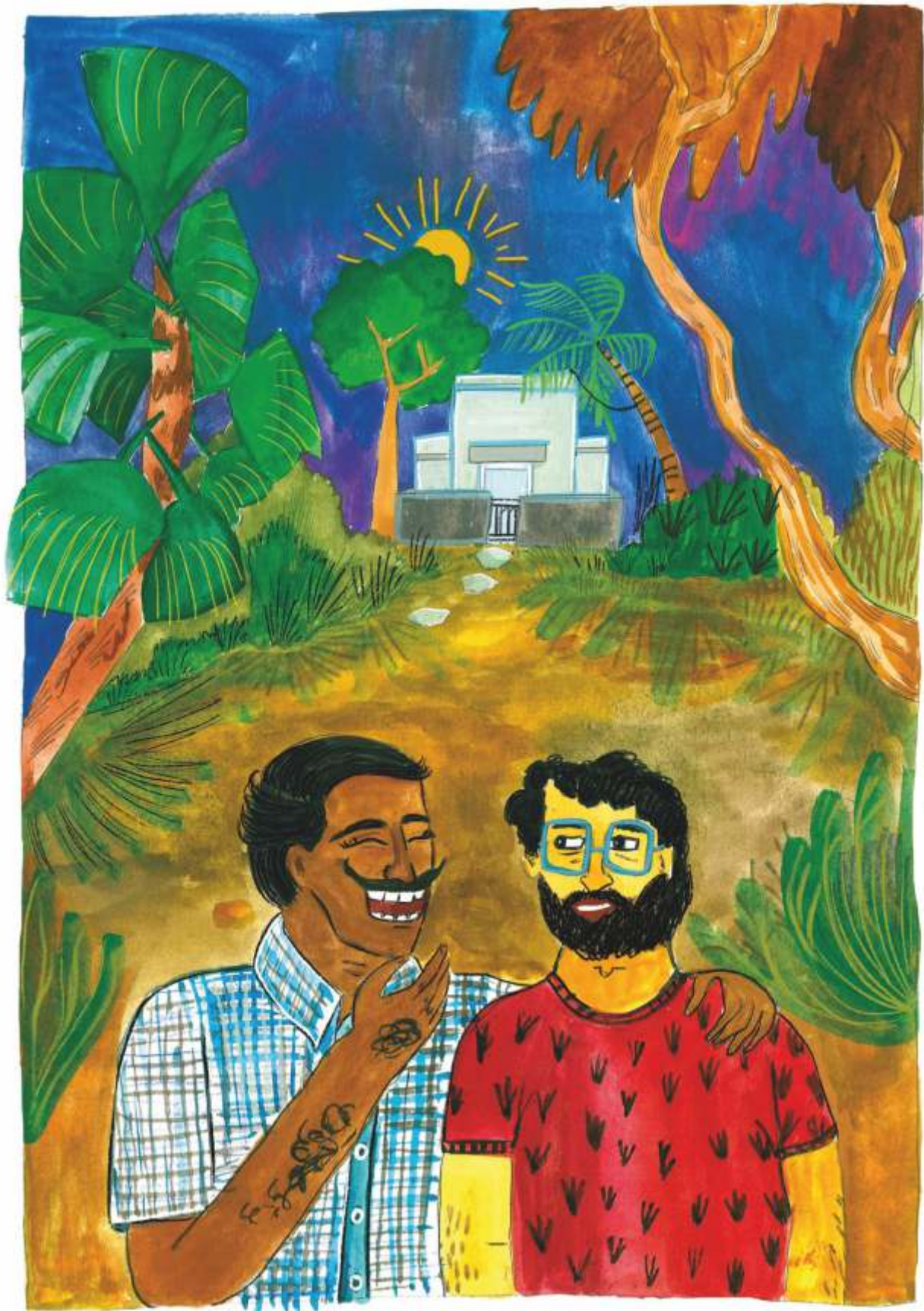
- Scout the area for someone familiar. References always help. Usually, the PA is a member of the community and is able to not just identify houses but also garner support and swing through a good deal. PAs typically could lead this negotiation.
- Set up a meeting with the house owner, and go with literature on your organisation, preferably with news clippings as well to ensure credibility.
- Explain the Home Again programme in detail.
- While explaining the programme, ensure that you focus on the need to normalise mental health issues, and how it will benefit the individual, and the whole community in the long term. As much as you would present the situation as is, do not be apologetic for anything, all members have the Constitutional Right\* to access basic amenities including health, education and housing in a community.
- Encourage empathetic and sensitive house owners. You want to build social capital, and increase the number of partners in this mission from the word go.
- Indicate that they will be key members involved in transforming the way mental health care is offered across the country.
- Give them time to think over their decision, and explain to them that you are and your team are available at any point in time for clarifications should they need it.

- Once you have finalised the homes, and while you are shifting into them, please make sure that you meet all key local functionaries and introduce yourself and the Home Again approach. This includes the postman, the local police inspector, and the panchayat leader. In addition, as time goes by, make sure you introduce yourself and build good relationships with key people at the electricity, water, and gas departments. This will make it easier to resolve any issues, should they arise. The programme is also contributing to building and strengthening the local economy by creating increased opportunity for economic transactions.

*Nathan's idea of home since 1998 was the Kozhikode Mental Health Centre in Kerala. Nathan recalls living in the north side of Kozhikode with his sister (also a service user, prior to subsequent institutionalization (which encompasses multiple shifts and readmissions) due to lack of care. When the team tried to pursue discharge options available for Nathan, it was learnt that post his father's sudden death, the family disintegrated. With poverty and day to day living becoming a struggle, Nathan's mother had later passed away as well. While his sister chose to continue living in a state funded home for women with psychosocial disabilities, Nathan asserted that he would like to return from the shared home he was living in to his familial home. Efforts were made to refurbish the house and help him secure a job in the community. With time, Nathan was able to save money that allowed him to place a down payment to purchase essentials as well. Transactions of this kind with the community have helped in doggedly reducing social distance correlates as well, implying greater inner agency in community participation.*







### *The paperwork - drafting rental agreements*

Once the house owner has agreed to lease the house, negotiate the advance and rentals to be paid, and ensure that the rental agreement is drafted clearly. Some of the key stipulations to include in the agreement are:

- *The advance amount required, and the conditions of return of the deposit.*
- *The mode of rent payment each month. Typically, cheques or bank transfers are the preferred mode.*
- *Protocols for responsibilities and payments regarding maintenance and repairs on the premises*
- *Period of stay, and renewal and / or termination protocols (minimum notice period of a month). Ensure that all leases are for a period of 11 months at the minimum.*
- *If the house owner is overseas or away, this must be followed up on the phone and confirmed before drafting*
- *Clearly communicate the chain of responsibility, and indicate how the house owner can reach programme/logistics leads if required.*
- *Ensure that the agreement is signed in the presence of two witnesses.*
- *The agreement must be signed by the programme lead until the transition is made to secure the rental agreements in the names of the individuals residing in each home.*

### *How do I tackle emergent situations that require sudden shifts from the house?*

There are some situations that will require residents to move out of their houses at short notice, due to unavoidable circumstances such as sudden eviction, experience of abuse or hostility, natural disasters, or even a breakdown in electrical, plumbing or sewage systems. In such situations, it is imperative that alternative arrangements are made. These contingency plans need to be laid out well before the programme rolls out.



Some of the avenues that can be pursued in this regard include:

Community centres	Panchayat / council owned buildings, or recreational halls, and spaces with access to appropriate toilet facilities can be explored. In addition, wedding halls are also a suitable venue that can be considered.
Paying guest accommodation	Programme leads can explore local paying guest options for clients residing at the Home Again programme. This can also serve as a strong way to facilitate social mixing and community integration
Halfway homes	Build linkages with Government run halfway homes across different geographies, such that clients can be accommodated if required in an emergency.
Short stay in acute care facilities	Ensure the possibility of a shift back to the acute care facility for a short stay during emergency situations.

What if we are asked to vacate suddenly?

In the unlikely event of an unplanned and sudden eviction, the programme manager must follow the steps outlined below with a sense of urgency.

- Reach out proactively to the house owner to understand the nature of the situation, and reasons for eviction.
- Attempt to problem solve proactively. This must be dealt with swiftly, particularly if it is an issue that affects the peace and calm of the family / individual member of the home. For e.g, some issues that may crop up include, damage to property or conflict with neighbours and the community, an experience of isolation because of distance from key locations, other houses, or just a feeling of not being in the epicentre of social activity in
- In case you feel that you are unable to resolve the situation, the rental agreement already has an inbuilt clause to continue to reside for a month before having to vacate the premises. Ensure it is enforced, and that you have terminated the agreement appropriately following this incident.

- Commence your search for another house immediately. Ideally ensure that you are aware of some of the available houses in the community such that you always have an option to fall back on in case of such a situation.
- Make the move a fun and relaxed activity, so residents of the house do not feel that they are being displaced or segregated against. Discuss the shift and ensure you have consensus before moving. In some cases, it is okay to discuss reasons for the shift, so members who wish to understand these experiences and discuss them have the option to. These could lead to critical insights and thinking at both the manager/ PA and house member levels.
- Make sure that you escalate all such events to the programme manager and to the internal services team such that all necessary statutory compliances can be adhered to.
- You must ensure that such issues are handled sensitively and firmly. Do not compromise on the needs of your client. Remember that you are advocating on behalf of your client, and that their wellbeing is your first priority at all times.
- Do not let them down in your need to pacify / ensure peace, however, do not be rude or unsympathetic to the issues that may be faced by the house owner or the rest of the community.

Mobilising resources and procuring utilities

How do we obtain utilities, and daily requirements?

One of the critical goals of the programme is to transition the resident from being supported by the personal assistant and / or care coordinator to acquire household materials and supplies, manage finances and household chores, to individual management and payment for utilities, maintenance, groceries, and other household expenses.

Just like we do when we move into a new house, the vendors offering all these supplies and services must be identified earlier on, with a clear understanding of payment schedules and modes of engagement. Given that many of the homes are likely to be situated in rural areas, you must also ensure that you are contributing towards building and strengthening local economies. As much as is possible, ensure that all vendors are local, and all items procured from them. While this may require some more logistical arrangements and planning, it will benefit the programme and community in the long-term as the entire neighbourhood will see gains, and begin to buy into the approach.



Utilities	<p>Household utilities such as water, gas, and electricity must be paid in accordance with the billing cycles indicated.</p> <p>Typically, this is:</p> <ul style="list-style-type: none"><li>● Electricity: Bi-monthly</li><li>● Water: Monthly</li><li>● Gas: Monthly</li></ul> <p>If the above utility providers do not accept cheques and must be paid in cash, all payments have to accounted for through cash bills.</p>
Maintenance	<p>Quarterly checks must be made to ensure functioning of the following:</p> <ul style="list-style-type: none"><li>● Plumbing systems</li><li>● Electricals (<i>circuits / fixtures / connections</i>)</li><li>● Gas pipelines</li></ul> <p>Septic tanks and overhead water tanks must be cleaned monthly if required.</p> <p>If not, routine quarterly checks must be initiated.</p> <p>Preventive checks must be initiated at regular intervals to ensure that there is no dampness or fungus on the walls. If there is, it must be cleaned at the earliest.</p>
Groceries, newspapers, and other ancillary items	<ul style="list-style-type: none"><li>● Shortlist vendors who will supply vegetables, milk, grains and other grocery items to the houses, based on quotations from three different suppliers.</li><li>● As much as we want to engage members of the house in the process of shopping,buying items in bulk seems to be the most resource efficient and cost friendly option. However, buying vegetables and cooking special dishes are activities that could take the resident to the market place.</li><li>● Negotiate prices, credit periods (<i>end of week / end of month payments</i>), and payment modalities (cheque / cash).</li><li>● Again,cheque is the preferred mode of payment, however, in exceptional cases where vendors do not accept cheque payments (<i>local vegetable vendors etc.</i>), ensure that all payments are within INR 5000 / transaction, and attach cash bills to the same, for accounting purposes. Always keep petty cash on hand for some of these payments.</li></ul>

Turning a house into a home

While the housing intervention is one of the central tenets of the programme, it is vital to remember that the intervention only succeeds when the 'house' truly becomes a 'home'. This transition only occurs when the individual feels a sense of safety, security, comfort, and ownership of the space inhabited. These are feelings that are often taken for granted, but those that cannot be forced. They develop in different ways and one must appreciate that diversity.

A critical element of the programme, therefore, is to ensure that the residents of each home begin to connect and identify with their residence, feel a sense of kinship towards their co-residents, and truly treat it as their own. This aspect has the potential to determine the success or failure of the intervention. To facilitate this, the PA and the care coordinator have to let go in as many ways as possible after initiating processes that enable cultivation of these feelings and participation. Be there and yet try to be invisible and around only as much as required. Below are some suggestions on how this transition from 'house' to 'home' can be achieved in a non-directive, non-contrived, and participatory manner.

*Farida remembers living a typical life with her small family consisting of a husband, daughter and son, till her illness beset her with difficulties. Her husband passed away with time, this worsened her state of mind. She subsequently became homeless and entered The Banyan without social capital of any kind. The next few years saw disengagement, interpersonal conflicts and generally poor outcomes of treatment being a mainstay. Resources are a matter of concern as well as an imbalance in the felt and the met needs from Farida's perspective was a constant reminder for her that she was alone, without family and excluded in the general sense of the world. However, when Farida shifted to Home Again, with time she has been able to realise a consistent increase in her quality of life and connected wellness. To the extent that she has been able to touch base with her family and confront their past. Her son visits her periodically and they have a relationship that they have mutually defined within a space which is interdependent but not intrusively dependent. Farida's desires to go back home have reduced, she sees the place she lives now as home, operates with a sense of ownership and thrives*





## Setting up a home

Our homes are often extensions and reflections of our personalities. One of the most exciting aspects of moving into a new house can be the process of expressing oneself by creating an aesthetic that we find pleasing and comforting, and surrounding ourselves with objects (photos, curio items and decorative pieces, gifts etc.) that are infused with personal meaning.

Some of the ways in which this can be facilitated are by ensuring that the entire process of moving is collaborative, participatory, and largely driven by the residents of the homes. This process begins before the physical shift is made, and continues well into the first year of the shift. You must remain cognizant of this at all times, and strive to create an environment that is conducive for free expression, interaction, and bonding. Also, bear in mind that no one's personality is static, and thus you are bound to see some dynamism in the home decor. Be open to change, but also keep in mind the resources available.

Some key elements to consider in order to ease the process include:

Appliances and furniture	<p>The non-negotiables that must be available in each home include:</p> <ul style="list-style-type: none"> <li>● Fans</li> <li>● Lights</li> <li>● Stoves (electric / gas)</li> <li>● Cots and mattresses or floor mats (based on resident preferences)</li> <li>● Cupboards / shelves to store personal belongings</li> <li>● Curtains / 'Thattis' (local bamboo blinds)</li> <li>● Mirrors</li> <li>● Clocks</li> <li>● Dresser</li> </ul>
Decor	<p>Residents must be encouraged to decorate their own spaces. This can be done by them:</p> <ul style="list-style-type: none"> <li>● Choosing home (<i>curtains and blinds, towels</i>) and bed linen in colours and patterns they like.</li> <li>● Displaying posters, photos or decorative items that they find appealing. Choosing the kind of lighting that is preferred by most in the group (warm yellow / white lights). LED lights will be sourced to ensure cost effectiveness, and commitment to green energy sources.</li> </ul>



	<ul style="list-style-type: none"><li>● Using agarbattis / sambrani / candles to infuse the air and create a pleasant ambience.</li><li>● Small daily tear-off calendars with photograph of a religious deity are very popular locally. These display the dates of all religious festivals, even those observed in other faiths (Christianity / Islam). In addition to it being critical to know the date, and have a good orientation to time and place, this also promotes inter-religious mingling and a sense of diversity. *</li></ul>
Religion and spirituality	<ul style="list-style-type: none"><li>● The homes are likely to be inhabited by individuals who practice different religions. In such cases, each individual should have the opportunity to express his or her own religious / spiritual beliefs.</li><li>● There must be appropriate spaces designated in each home to encourage all residents to set up small shrines dedicated to a deity of their choice.</li><li>● A house can also have multiple religious representations and corners.</li></ul>
The soul of the home: the kitchen	<ul style="list-style-type: none"><li>● Cooking is a particularly critical activity and must be focused on keenly. It involves planning (<i>individually or as a group</i>), procuring (<i>going to the market, transacting, interacting with the members of the community</i>), and execution of multiple components simultaneously (<i>measuring ingredients, monitoring cooking time, serving etc.</i>), thus it encourages socialisation, and also has a positive impact on functionality and participation.</li><li>● The kitchen must be organised collaboratively by all the residents of the home (or at least those interested in cooking).</li><li>● The pantry must be well-stocked with foods and snack items that are congruent with each individual's cultural orientation and palate. Residents of the home must be encouraged to cook foods that they enjoy, and evoke positive emotions that they associate with being '<i>home</i>'. It must be made clear that they can cook independently or together, and just for themselves or the entire group.</li></ul>

	<ul style="list-style-type: none"><li>● All utensils and plates must be purchased in consultation with the residents of the homes. They must be encouraged to choose the kind of plates / glasses / mugs / storage containers etc. that they would like to use.</li><li>● Local firewood “veragu” stoves can also be used by individuals (<i>under supervision if required, or independently</i>) residing at the Home Again programme if so desired.</li></ul>
Leisure and social engagements	<p>Each home should have:</p> <ul style="list-style-type: none"><li>● A television</li><li>● Radio / Transmitter</li><li>● Games based on local traditions (<i>pallankuzhi, teen patti, carrom, chess, kallanga</i>) (<i>Refer to the housing kit attached in the appendix</i>)</li></ul> <p>All individuals must be encouraged to engage to whatever extent they desire with the community and host or neighbours for impromptu chats, tea, and festival celebrations.</p>

Resident preferences must be taken into account with regard to all items listed above. Wherever possible they must accompany the programme staff for procurement of all items for the residence.

**Note to Personal Assistants (PAs)** - You do not need to curb your own self-expression. It will add a unique flavour to the home. Remember that you are key in driving personal recovery, and well-being of all individuals who are part of the programme. The depth and integrity of interactions that you have with each individual will determine the level of cohesion, and interdependence that is fostered. However, always remember to be aware of power dynamics at play and aim to remain as neutral as possible, thus ensuring everyone in the home has equal opportunity to represent themselves and their identities.





## Aesthetics and hygiene

According to the WHO, hygiene refers to, 'conditions and practices that help to maintain health and prevent the spread of diseases'. In day-to-day parlance, hygiene can be synonymous with cleanliness, however, it includes a much wider array of lifestyle choices, circumstances and practices, and commodities that engender a safe and healthy environment.

While there are global standards for hygiene, it remains a highly subjective notion, and what is considered hygienic can vary across cultures, genders, and socio-economic groups. Following a prolonged stay in mental health institutions, where care is largely prescriptive and spaces are maintained by staff of the facility, individuals moving out may find it particularly hard to practice good hygiene (both personal and environmental). This section will walk you through some of the non-negotiables with regard to hygiene so that individuals can be enthused towards improving their own hygiene practices.

Personal	
Grooming/ Self-care	<ul style="list-style-type: none"> <li>● Independence in self-care is important. It promotes a sense of self-reliance and increases self-esteem.</li> <li>● The PA must ensure that each member of the residence is aware and engaged in their self-care. Focus on oral hygiene, hair and body care, and grooming (refer to the housing kits attached in the appendix). Make these processes fun, for instance, play music / the radio while engaging in these activities.</li> <li>● Make sure that you are seeing transition and improvement across each domain. Try different approaches if one doesn't work. For instance, try using neem sticks, tooth powder instead of paste, hand instead of brush, Listerine etc., Do the activity with the individual or engage in show-and-tell if required.</li> <li>● Make the grooming products that are available items that are pleasing to smell, touch and feel. This invigorates the senses and can encourage appropriate usage, for example soaps, ayurvedic hair oils, deodorants etc.</li> </ul>



	<ul style="list-style-type: none"> <li>Support may be offered if the individual asks for it, but the PA and care coordinator must remember that privacy is important and it must always be encouraged amongst the clients even if they don't care or seem not to.</li> </ul>
Menstrual hygiene	<ul style="list-style-type: none"> <li>Menstrual hygiene is absolutely critical and the personal assistant must be in a position to support the individual to the extent required to ensure good health, and that the spread of infection / disease is avoided.</li> <li>Remember that there are cultural variations on how menstruation is handled. In some cultures, individuals (including personal assistants / care coordinators) may continue to use cloth instead of sanitary napkins. A brief yet detailed training programme on menstrual hygiene and associated practice must be held with the care team prior to operationalisation of the programme.</li> <li>Support can range from explaining the usage and disposal of sanitary napkins (<i>refer to the box with usage guidelines below</i>) and washing protocols, to actually physically supporting the individual with cleaning themselves and using the napkins until they are habituated to do the same.</li> <li>In case someone has stained her clothes, ensure that she is made aware, and that she cleans up and changes her clothing immediately. However, take care not to do this in a manner that makes her feel ashamed. Do this is private only.</li> </ul>
Aesthetics	<ul style="list-style-type: none"> <li>Try to enthuse the individual to be well dressed most of the time.</li> <li>Try to encourage the individual to express preferences in dressing and develop their own personal style. Try to jog memories from the past, or draw on aspects from her culture to see if they prefer styles from earlier that they were accustomed to. They may well have developed a new sensibility and style as well. Wearing a bindi or not, draping the sari or wearing a skirt or chudidhar (<i>women</i>), T-shirt or shirt or kurta (<i>men</i>), <i>wearing</i> a headscarf- there are many choices to be made and a whole range of simple options that can be offered.</li> </ul>

	<ul style="list-style-type: none"> <li>Try traditional re-training techniques but if those do not seem to succeed, try more engaging alternative techniques. For example, host a small fashion show or party in the house, and create an atmosphere of excitement around the act of getting dressed. Go through fashion magazines, visit a local shop and stimulate interest in colours and style, follow popular styles of actors on Television and chat about it.</li> </ul>
Environmental	
Living spaces	<ul style="list-style-type: none"> <li>Ensure that the home is cleaned well. Use a cleanliness checklist to ensure that the home looks good, and feels fresh.</li> <li>This should not be led by the personal assistant but by residents of the home. Support the residents in maintaining a clean and pretty or cluttered and clean, or clean and minimalistic home. This can be encouraged and inspired by ensuring that they visit homes of others of diverse backgrounds so that they gain exposure to what a well-kept house looks like and to that add their own personal style and aesthetic sensibility.</li> </ul>
Bathroom/ Toilets	<ul style="list-style-type: none"> <li>Ensure all areas are cleaned with strong anti-bacterial agents.</li> <li>Bathrooms and toilets must be cleaned every day. Areas behind the latrine, Under buckets, the buckets, mugs, and toothbrush stand all need to cleaned too. The practice of cleaning after each use must be inculcated. It may take a little while to instil, but continued engagement and show-and-tell exercises work wonders. Keep in mind water usage and wastage while you do so. Conservation of water is also important.</li> <li>There must be stands and holders for each resident's personal effects and items.</li> <li>Toothbrushes and soaps must not be shared. Each resident must have their own.</li> </ul>



	<ul style="list-style-type: none"><li>● Wash basins should have liquid handwash available, and residents must be trained on handwashing protocol.</li><li>● Small yet simple aspects of washing, such as ensuring the sink is clean after washing with no food or other particles remaining and ensuring that bathrooms are left dry for the next person are critical skills that should be inculcated.</li><li>● Remember some individuals residing at the homes may be used to open defecation as this is still practiced largely across the country. Do not be harsh if you encounter this. Rather gently discourage the habit, and explain the usage and convenience of the toilet. Use positive reinforcement techniques if required.</li></ul>
Towels/ clothes	<ul style="list-style-type: none"><li>● Every resident must have their own set of bath linen. Each resident should have a minimum of two towels. The towels should not be shared to avoid spread of skin infections.</li><li>● The towel should be washed after every use.</li><li>● Ensure that a good liquid / bar detergent is used to keep clothing fresh.</li><li>● Instil the practice of washing clothes while taking a bath so that the amount of clothing to be washed is less, and the process faster.</li><li>● Underwear should not be shared, and should be washed separately by the resident who owns it. It's okay for a few residents to not wear / use under garments occasionally as it may be a part of their culture not to. Or even a matter of convenience or a statement of feminism.</li><li>● Laundry can be a mundane task, however, ensuring that it is done well is a critical aspect in maintaining good hygiene and self-care. Try to make it as enjoyable as possible and perhaps do some parts as group activities, or incentivise it for a period of time if needed.</li></ul>

Kitchen	<ul style="list-style-type: none"><li>● Typically, there is only one person who handles the management or maintenance of a kitchen in every house. This is, however, not possible in a home that is a part of the Home Again approach, as there are several individuals inhabiting it who are likely to be interested in using the kitchen (<i>Refer to the section above on cooking as a group</i>).</li><li>● The Personal Assistant must facilitate an environment of sharing and ensure that a natural dynamic and process sets in soon.</li><li>● Ensure that you follow the hygiene checklist in the kitchen as well.</li></ul>
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Usage and disposal of the sanitary napkin

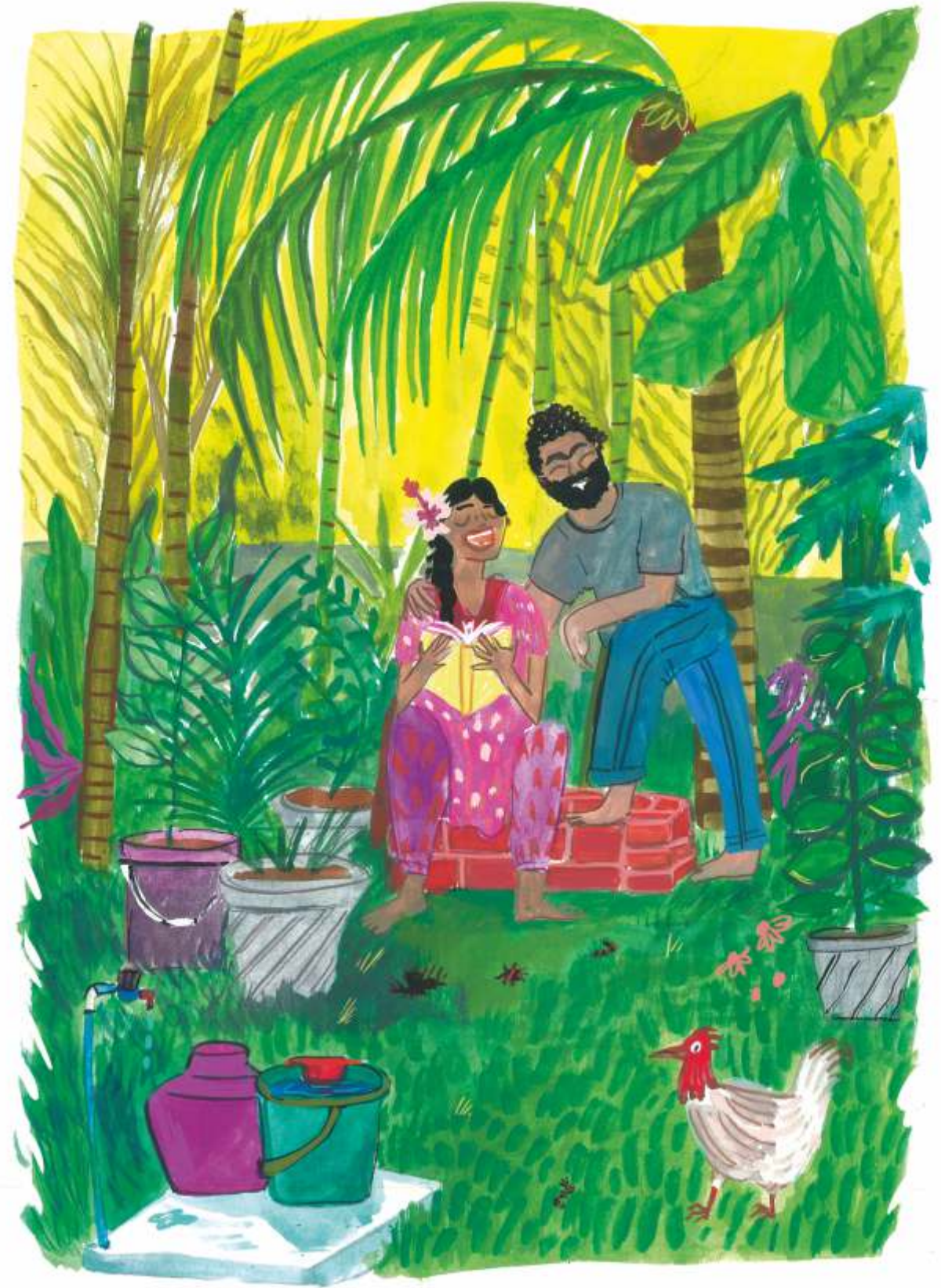
1. Take a napkin from the packaging, and head to the bathroom.
2. Once there, remove your in-skirt, and pull down your panties halfway down your legs (above your knees).
3. Peel the sticker on the back of the napkin off, and place it sticky side down, onto the centre of your panty.
4. Make sure it is well positioned, such that it is centred well, and you have enough coverage both in front and at the back. During the nights, you can use a pad that is extra-long so that there is no leakage.
5. Make sure that you are comfortable when you pull your panty back up and that it isn't stuck, or causing any friction in your legs. If it is, make sure you choose another brand / style of napkin.
6. Check your napkin every hour to see if it requires a change, or you can continue wearing the same. However, do not use the same napkin (even if not fully soaked) for more than 6 hours at a stretch, except at nights.



7. If you feel a sense of intense pressure, and think you may be experiencing excessive bleeding - go to the toilet, and relieve yourself. You will notice that you feel less pressure in your stomach, and you minimise the risk of staining your clothes.
8. If it needs to be changed, repeat the same process, but ensure that you have washed yourself each time, before you use a fresh napkin.
9. Ensure that you wash your hands every time you touch a sanitary napkin, or use the toilet.
10. At night, make sure you wear a fresh napkin just before you go to sleep, and ensure that you change it as soon as you wake up in the morning.
11. When you have your period, it is important to make sure that you have a bath every day (if possible, twice a day).
12. To dispose the napkin, roll it up with the soiled side facing inwards, and wrap it in newspaper, and throw it in the bin.
13. Make sure that you are not throwing it into the flush cistern / the latrine direct

### Safety

Ensuring safety in all homes is key, and it has been referred to across multiple sections of this manual (housing, hygiene, and functionality, to name a few). This section seeks to summarise some of the critical concerns and safety issues that you (the programme team) will need to be aware of and plan for at all times.





House	<ul style="list-style-type: none"><li>● Safety at home is critical in ensuring a secure living environment. This ranges from physical safety (<i>doors, locks, deadbolts etc.</i>) to electrical connections, gas lines, and plumbing faults.</li><li>● Make sure the doors are locked carefully at night, and that no valuables are kept close to windows that may be kept open.</li><li>● Check for wiring faults, particularly in bad weather conditions.</li><li>● Make sure the gas is turned off and unnecessary electricals are of as well.</li><li>● Ensure the home is maintained in a hygienic manner to prevent the spread of infection / disease.</li><li>● Make sure the home is located in a safe and populated neighbourhood, and help in case of an emergency is always accessible. This is done by ensuring they have access to a telephone (mobile or landline) close by.</li></ul>
Fire	<ul style="list-style-type: none"><li>● All residents and staff in each house must be trained in basic fire safety, and taught the exit protocol.</li><li>● The dangers of fire related accidents should be clearly communicated.</li><li>● Teach some of these safe practices through engaging audio visuals and make sure that you don't alarm the residents.</li><li>● Do not leave matchboxes lying around, and ensure that the puja oil lamp (if lit in the house), is extinguished at night. Also, make sure there are no <i>agarbattis</i> / candles left burning.</li><li>● High-risk issues such as electrical short circuits, gas leaks, must be escalated to the programme team immediately.</li></ul>

Sex	<ul style="list-style-type: none"><li>● The need for intimacy and physical connection is absolutely normal.</li><li>● This should not be shamed, and does not necessarily need to be discouraged.</li><li>● Discuss safe sex practices, and the usage of condoms, oral contraceptives or intrauterine devices, and ensure that individuals have access to these easily.</li><li>● Speak candidly and openly about sexual urges and do not allow for them to be repressed. Explore the option of using sex toys / vibrators (<i>however this is a decision each organisation must take independently.</i></li><li>● Ensure you discuss issues surrounding consent very clearly.</li><li>● Stress that the dangers of sexual assault are real, and speak about what needs to be done if a situation such as that should ever occur.</li><li>● If you encounter or are privy to a homosexual relationship do not be alarmed, try to navigate this tactfully, and see how you can give the individuals some privacy, even if they are members of the same house. This is but natural and follows a trajectory similar to heterosexual relationships. Make sure harsh judgement calls are not made on this account, either by the care team or by the neighbours.</li><li>● If there are queries that you are unable to answer, or feel awkward to tackle speak to your care coordinator / programme lead immediately.</li></ul>
Health	<ul style="list-style-type: none"><li>● Always ensure access to basic amenities (<i>food / clothing, water, sanitation</i>). This is fundamental to ensuring good health.</li><li>●</li></ul>



	<ul style="list-style-type: none"><li>● Remember to take into account both physical and mental health of individuals residing at the homes. They are equally important, and influence each other. Mental health differs from mental illness. Mental health refers to a state of wellbeing and thus involves a whole range of positive and enabling experiences which you must try to cultivate.</li><li>● Signs of ill health must be managed immediately before it reaches a situation that is critical.</li><li>● Make sure all distressing issues such as weight loss, withdrawal, agitation, loss of appetite, skin infections, hair sores or lice, frequent fevers, coughs, diarrhoea, chest pains, etc. are escalated to the care coordinator.</li><li>● Refer to the medical management section of this manual for more details.</li></ul>
Access to telephones, address and phone numbers - your own and others	<ul style="list-style-type: none"><li>● In the event that a resident is lost, missing or in any other emergent situation, it is important that he/she has access to telephones and knows how to reach the personal assistant, care coordinator, or his/her friends, neighbours and his/her own home. It is thus important that he/she has some money at all points.</li><li>● Each individual must have their own purse / wallet that they get used to keeping on their person at all times. The individual can keep a handkerchief, money, critical phone numbers in a small diary, and perhaps some face powder / lipstick inside.</li><li>● It is also critical that each resident knows these numbers, and his/her own home address and directions to get there from some of the key spaces in the community. Walks in the evening enable this. You could ask different members from the house to lead the walk every other evening.</li><li>● This will help him/her get back home, by asking for directions or informing someone to drop her off.</li></ul>

	<ul style="list-style-type: none"><li>● Also make sure that he/she has access to telephones to reach his/her family / friends in other locations as and when he/she chooses. This is important in ensuring a sense of safety, security and connectedness.</li></ul>
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Every panchayat will have a nodal health centre (Primary Health Centre (PHC) or sub-centre), that can be accessed in case of emergencies or treatment for general health issues. Make sure you are aware of where this is and maintain a good relationship with the care team there.

It is also important to inform the panchayat leader in case of untoward incidents. Issues such as sexual assault, robbery or accidents all have legal implications, and must be registered with appropriate authorities immediately.

Money management and banking services

It is critical that finances within the programme are managed efficiently and with a sense of integrity and transparency. In a context, such as ours, quality, cost effectiveness and maximum gains for as many people as possible go hand in hand. It can never be one at the cost of the other. In our eagerness to demonstrate cost effectiveness, quality of the programme should never be compromised.

So how do I manage my finances at the programme and individual member levels?

As indicated previously, the programme aims to instil a sense of autonomy and self-reliance amongst its residents, and in the long term, pursues individual financial management as a goal to the extent possible. In the short and mid-term, and in cases where that is not possible, the programme team will play an active role in managing cash flow and payments (*for supplies, rentals and everyday living*). The rentals and management of funds continue at the programme level (programme manager / personal assistant) for as long as it is required for the individual to settle in, and begin taking charge. In some cases, some individuals may never manage their own finances, but others in their homes may begin to, thus offering peer support and creating an informal buddy system wherein one supports the other.

Some of the processes that simplify financial management and accounting are listed below:

Money requisition	<ul style="list-style-type: none"><li>● You (<i>the personal assistant</i>), must send in a requisition to the programme manager for the upcoming fortnight's expenses.</li><li>● You must allow for a processing time of 3-4 days for the moneys to be released. Keep this in mind and ensure that requisitions are sent in time.</li><li>● The request must be broken down into the major line items of expenditure, namely:<ul style="list-style-type: none"><li>■ Residents' welfare (<i>social care, outings, movies, playing games etc.</i>)</li><li>■ Hospital expenses</li><li>■ Administrative costs (<i>repairs, maintenance, stationery</i>)</li><li>■ Local travel and transportation</li><li>■ Utilities and maintenance</li><li>■ Pet care (<i>if the residents in the homes have pets</i>)</li></ul></li><li>● Your first requisition must include an emergency buffer fund of INR 10,000. You must not use this fund for regular expenses. It must be used only in the event of an unexpected requirement/emergency. As soon as it is spent, the exact amount must be replaced immediately. This fund should always remain constant at the house.</li><li>● You must maintain a weekly record of all items being purchased / received in the home and submit this record to the Project Manager (<i>PM</i>) on the day that accounts are reconciled (<i>refer to the section on reconciliation of accounts below</i>).<ul style="list-style-type: none"><li>■ When you switch shifts, ensure that you have updated your colleague on all expenses till date and the balance funds available.</li><li>■ Extra funds may be requested during festival periods where there are likely to be additional expenses.</li><li>■ All vouchers need to be signed off by the reporting authority - typically your programme manager / programme lead. The sanctioning privileges at The Banyan are - INR 10,000 at the programme manager level, INR 30,000 at the Senior Management Team (Programme Lead) level, and INR 1,00,000 at the Director level. You will have to refer to your own organisational guidelines in this regard.</li></ul></li></ul>
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Settling bills	<ul style="list-style-type: none"><li>● .All bills must be settled at the earliest, or as stipulated in the vendor agreement, and in the mode requested. Eg. Provisions once a fortnight, vegetables- daily (so residents also enjoy the trip to the market), rentals, monthly etc.</li><li>● Ensure that all payments are made only on receipt of a cash bill. In the event that there are no bills available, the payment must be made only against a signed cash / suspense voucher* signed by the project manager or whoever the authorised person is in your programme. These accounting protocols may vary depending on your organisation policies. However, the cash vouchers and larger accounting patterns and systems have to remain somewhat similar.</li></ul>
Reconciliation of accounts	<ul style="list-style-type: none"><li>● Programme accounts are reconciled fortnightly. Ensure that the daily log is submitted to the Programme Manager along with all bills.</li><li>● All bills must be approved by the Programme Manager. The centralised accounts department will only release the next funding request based on this approval.</li><li>● Any discrepancies in accounts, however small, must be reported to the programme manager and to the centralised accounts department immediately. They will conduct an investigation into the incident and determine the course of action to follow.</li></ul>
Tackling emergencies	<ul style="list-style-type: none"><li>● In the event of an emergency that will require additional money besides what is readily available (<i>including the emergency buffer fund</i>), inform the Programme Manager at once. She will ensure that she is on site to support you with additional funds / expedite the transfer of additional funds. Never compromise care because of lack of funding or operational hurdles.</li></ul>



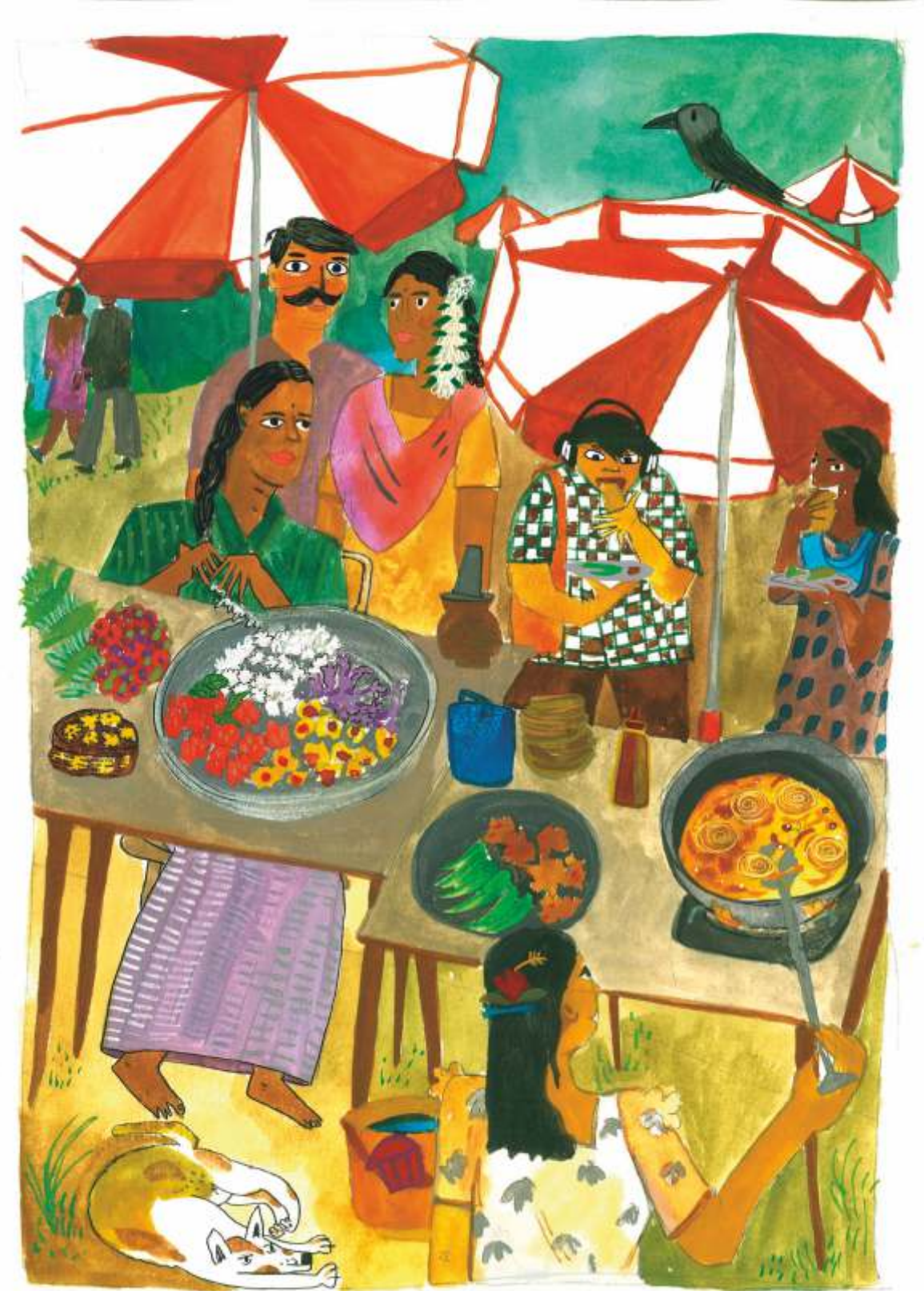
- Do not use your own personal money unless it is absolutely necessary. In case you have to, follow the same procedure as you would with programme funding, but submit the bills separately and at the earliest, so that you get reimbursed.
- Ensure that any over-expenditure is justified and that all other expenses are as per the budget and funding allocations.

The programme team is collectively responsible for the judicious management of funds and should ensure that resources are optimised without compromising on the quality of care. Try to be resourceful and rely on community support systems whenever possible including donations in kind such as food, articles etc. Don't go out seeking funds actively since the members of the house also live in the same community and may not like the idea of living on what they perceive as charity.

### Money management at an individual level

We believe that individuals, regardless of their ability, desire, or capability should have access to a basic income that allows them to be in control of their personal / familial expenses. In the case of the Home Again approach, this basic income refers to the funds that are allocated to the programme (initially managed by Personal Assistants) which could be handed over to individuals to manage/ transact wherever possible.

While this basic income is a non-negotiable component of care and an indicator of a better quality of life, we encourage work participation as actively as we can and in diverse ways. This ensures further access to additional top-up amounts received by engagement in a wide range of activities in various sectors such as the service and hospitality sectors, beauty industry, arts and crafts etc. Residents are guided through employment in homes, resorts, hotels, offered intrapreneurship and entrepreneurship options and assisted as they seek skills development platforms that facilitate home- based work). This additional amount will be based on individual capabilities, personal interest and the need and drive to pursue financial independence. This will ensure that every member of the house has spending and purchasing power, thus enhancing social mobility and participation in society.





Try as hard as you can to understand personal interest and recognise individual talent and provide opportunities for people to find ways in which those interests can be honed. Gradually introduce the opportunity to monetise one's abilities in ways in which the person can use gains that emerge to pursue happiness, newer experiences and individual choice.

In the long term, we (a confederation of stakeholders, particularly members of a self-advocacy movement represented by the Association of Persons with Mental Illness (APMI) - a soon to be nationwide collective of persons living with mental health issues) will advocate for access to this basic income from the Government by lobbying for smoother and non-bureaucratic implementation of existing schemes such as the disability allowance, housing subsidies, and access to the Government public distribution system. These are currently not entirely and easily accessible to persons with mental health issues.

The push for basic income

The Home Again approach is rooted in the philosophy that every individual should have a basic income irrespective of whether they have capability, ability or inclination to work. Everybody is encouraged to take up tasks / activities, however small. And it is our belief that everyone can and is talented and productive in their own unique ways. This is in an attempt to use work and productivity as a tool to promote self - reliance, participation, and a feeling of agency. However, if an individual is certain that they are not keen to work, they will not be coerced to do so.

Reclaiming the right to financial independence

Access to money / Choice / newer experiences	<ul style="list-style-type: none"><li>● Individuals may sometimes rely on programme funding to receive money for their basic needs. It is important to encourage them to understand that financial stability and economic self-reliance offers much more than purchasing power, and is also a means to feel good about being in control and exploring individual choices and paths. Being engaged in activities that contribute to life in one way or the other not just keeps you productively occupied, but also stimulates thought, helps you pick up newer skills and make new friends.</li></ul>
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Minimum Wages	<ul style="list-style-type: none"><li>● As the individual begins to realize the need for money and newer experiences, her motivation to work may also increase.</li><li>● The individual must be sensitised to understand the basic minimum wages that she should have access to, according to labour laws, in order to ensure that there is minimal scope for exploitation.</li><li>● Varied opportunities and options to access employment must be presented to the individual. This could be within the care system or outside. Encourage residents of the homes to pursue the latter as far as possible, as it will help individuals challenge themselves and push their own boundaries.</li></ul>
Government's schemes and entitlements	<ul style="list-style-type: none"><li>● Disability allowances, old age pensions, housing and food subsidies etc. are another source of income that persons with mental health issues should have access to. Some of these entitlements are currently not entirely accessible, but must necessarily be pursued especially keeping in mind long term sustainability of the programme (<i>refer to the section on sustainability further on in the manual</i>).</li></ul>
Understanding the value of money/ multiple training sessions in a real-world scenario	<ul style="list-style-type: none"><li>● Several individuals, owing to a lack of exposure for prolonged periods, may have lost the ability to comprehend the value of money, transactions, and the mode of management.</li><li>● You must engage with these individuals through both individual and group sessions, in order to re-train them on these aspects. However, it is important that these 'training sessions' are rooted in the local context and the real world, making them both interesting and meaningful in the immediate term.</li><li>● You may use a purse and small amounts of pocket money as tools to encourage and enthuse saving. Learning to keep the purse on their person at all times, and squirrelling away small amounts of savings every day is a very Indian tradition.</li></ul>



	<ul style="list-style-type: none"><li>● For instance, encourage the individual to purchase her shampoo and soap at the local shop and return with the balance amount. She will enjoy the hair wash and also learn how to transact in the process. <i>(Refer to the protocols on improving functionality)</i> One may need to do this multiple times and over a period of time. Do not tire in the process and take the easier path of doing it yourself. Remember, that life has grabbed away these opportunities from your wards owing to poverty, mental ill health, gender inequity and discrimination, not because they are less inclined or less intelligent.</li></ul>
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Banking services

At present persons with mental health issues find it challenging to access banking services. While these services can be practically impossible to access for individuals who are actively symptomatic and display profound disabilities, the process is fairly straightforward for those who experience mild to moderate levels of disability. This is largely due to the fact that they are not visibly symptomatic, and have perhaps not disclosed their mental health status openly.

However, this dichotomy is undesirable. Financial inclusion is key to encouraging participation in socio-economic networks, and building social and economic capital, both of which are critical to building supportive care systems that offer a buffer against sudden health shocks and economic downturns. The Reserve Bank of India, in an attempt to promote financial inclusion for all, and ease the process for persons with mental health issues, issued a notification stating that legal guardianship documents are only essential in the case of individuals with severe to profound disabilities. The long-term goal is to facilitate access to financial products for all.

Why financial inclusion?

<i>Moving towards stability</i>	<ul style="list-style-type: none"><li>● Access to financial services such as savings accounts, lockers, micro loans and credit, provides individuals with the opportunity to optimise their own personal resources, and make more informed decisions regarding their future. It offers them the ability to move beyond the 'here and now,' and plan for a future of opportunities that could be pursued.</li></ul>
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	<ul style="list-style-type: none"><li>● This experience of ontological security may be initially difficult to settle into for an individual who has long been subject to one crisis or trauma after another, and has never before felt a sense of stability.</li><li>● It will be your responsibility to engage with the individual through this period and explain the benefits of this kind of arrangement, as difficult as the processes may seem initially.</li></ul>
<i>Encourage saving</i>	<ul style="list-style-type: none"><li>● A key component of money management includes saving. This does not necessarily have to align itself with the traditional notion of saving. The means of saving can be negotiated, based on personal choice.</li><li>● Encourage the individual to utilise the internal informal banking system at the programme first, if she does not yet have a formal account.</li><li>● Make the process of banking and transacting exciting. Do this by ensuring that each month's salary goes straight to the bank so she needs to withdraw and utilise the money from the bank in order to meet her needs.</li><li>● Create a little ritual around payday, or each time interest is accrued. Make sure you are stimulating a sense of aspiration, and something to look forward to for the individual. This could be buying a piece of jewellery, planning an outing, going on a holiday, visiting family, or even just to the movies.</li></ul>
<i>Chits and investments</i>	<ul style="list-style-type: none"><li>● Individuals may wish to invest their moneys investment bonds and local chit funds, small pieces of land or houses, or in gold. Encourage this and take her dreams and desires as seriously as you would your own, and strive to enable them. However, keep in mind that there are financial scams and people have lost money. Ensure that you analyse the pros and cons of the investment and also how safe they are. Provide alternatives of known financial investment schemes</li></ul>





*Work engagements - creating meaning and encouraging self-reliance*

*Fixing a work routine for individual members of the house is a democratic and collaborative decision. Work, or the act of being engaged in an activity that helps derive a sense of meaning and purpose, has long since been hailed as the cornerstone of promoting and ensuring wellbeing. It has the ability to instil confidence, a sense of responsibility, promote self-reliance, and nurture hope. You must ensure that you are building interest, and creating a variety of employment opportunities. Remember you have to match the individual with a job based on their interest and innate ability and talent, as indicated earlier in this manual and reiterated several times in different sections.*

*(A) Avenues for employment*

*The table below highlights some livelihood options that in our experience, have been a good fit for persons with mental health issues. Do not hesitate to move beyond this, be creative and pursue other options as well, based on local contexts, job markets, trends and demands as well as recommendations from your clients.*

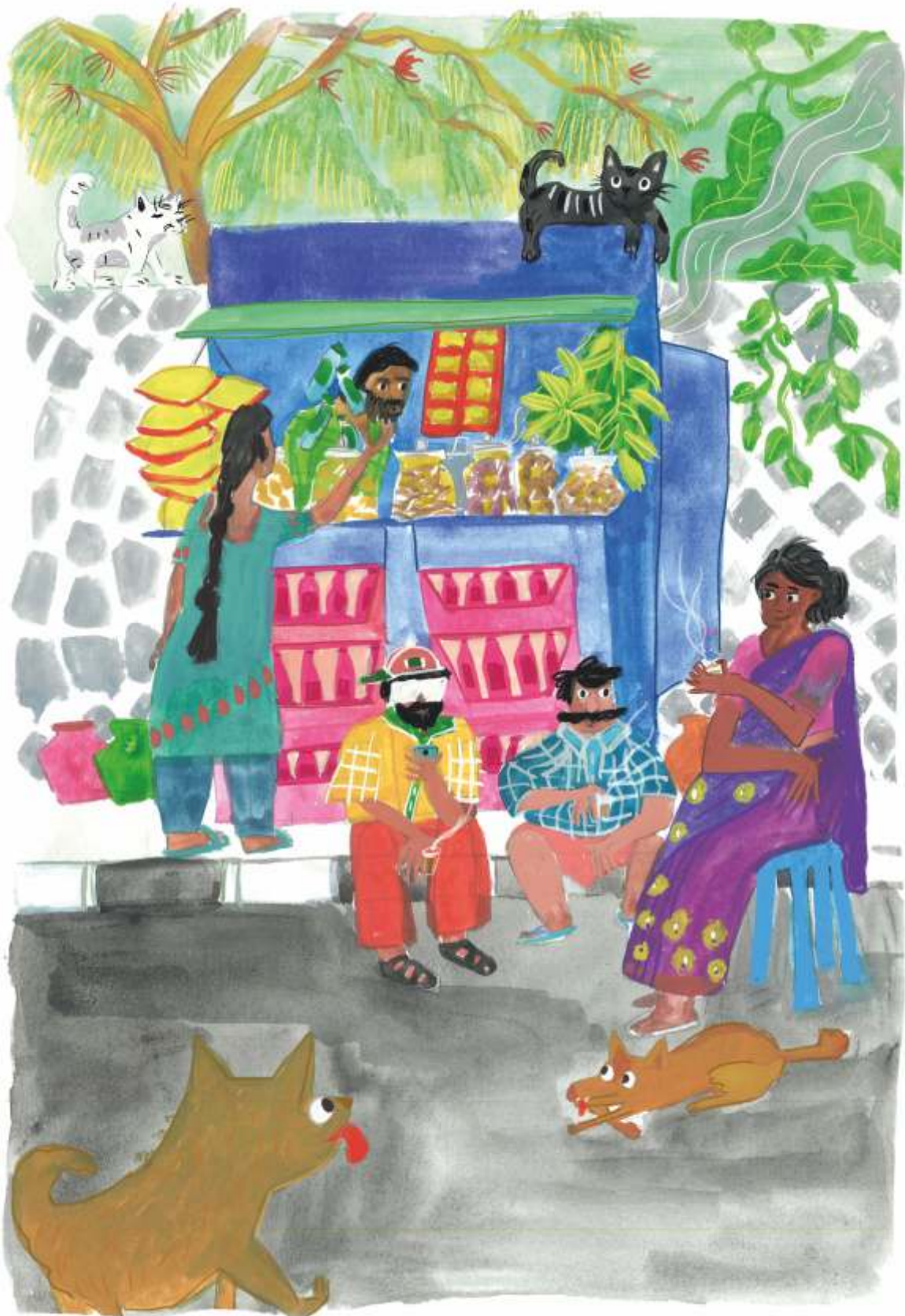
Hospitality	<ul style="list-style-type: none"> <li>● We have found that being engaged in the hospitality sector is a good option for persons with mental health issues who enjoy socialising, and interacting with a diverse range of people.</li> <li>● Some of the work profiles this covers include: <ul style="list-style-type: none"> <li>-Housekeeping / gardening jobs in hotels and resorts</li> <li>-Front office and receptionist posts</li> <li>-Kitchen and waitstaff in restaurants</li> <li>- Home management and servicing, e.g., cooking meals for members of the house, keeping the house pretty etc.</li> </ul> </li> </ul>
Arts and Crafts	<ul style="list-style-type: none"> <li>● For those who have a natural flair and inclination for the arts, enjoy working with their hands, prefer a slower and more flexible pace, and favour solitary activities, engaging in creating indigenous arts and crafts, is a favourable option.</li> <li>● In addition to being an enjoyable activity that can potentially be therapeutic, indigenous arts and crafts may come very naturally to some individuals who may have been exposed to the art from a very young age.</li> </ul>



	<ul style="list-style-type: none"> <li>Some activities include: <ul style="list-style-type: none"> <li>-Textiles and fabrics (block printing, tailoring, sewing, darning and hand weaving cotton - spinning looms).</li> <li>-Stationary (binding notebooks, marbling gift sheets, and creating pouches and folders)</li> <li>-Jewellery making</li> </ul> </li> <li>The programme staff will focus on packaging and marketing these products made, for sale in the mainstream market. This will not only raise visibility around mental health issues, but also aid in reviving traditional arts and crafts that are fast dying out in modern India.</li> </ul>
Retail	<ul style="list-style-type: none"> <li>The retail sector offers the best of both worlds: the opportunity to engage as part of a larger workforce, but also have a narrow, specific task to focus on.</li> <li>Some retail options that have worked in the past include: <ul style="list-style-type: none"> <li>-Stocking shelves at department stores</li> <li>-Folding clothes at clothing retail chains</li> <li>-Laundry services</li> <li>Garment export factories</li> </ul> </li> </ul>
Service Industries	<ul style="list-style-type: none"> <li>The service sector is an excellent fit for persons with mental health issues - particularly as care providers, peer counsellors, or health aids.</li> <li>We have seen several individuals accessing care at our programmes in the past, having completed training and diploma programmes in offering mental health care services and being employed both by The Banyan and other NGOs. Typically, these individuals report feeling an intense need and drive to help others in distress as a result of their own experiences. Their enhanced sense of empathy, and resulting understanding, sensitivity and kindness, will result in the highest quality of care that truly embodies the principle of treating others the way we would like to be treated (refer to the case vignette below).</li> </ul>

	<ul style="list-style-type: none"> <li>In addition to these traditional pathways to work, we have also seen success with requesting some of the elderly individuals residing at the programmes to share their wisdom and experience, and support in problem solving, as senior counsellors.</li> </ul>
MGNREGS*	<ul style="list-style-type: none"> <li>In the rural context, we have found that several individuals with mental health issues have enjoyed working at the Central Government funded labour employment programme (Mahatma Gandhi National Rural Employment Guarantee Scheme) worksites.</li> <li>It provides them the opportunity to socialise, and interact with different kinds of people from the community they live in.</li> <li>It offers the opportunity to engage in work that is somewhat repetitive in nature, an aspect of work that some persons with mental health issues typically could find therapeutic.</li> <li>There are flexible hours for work, and usually transportation services are available to pick up and drop individuals at the worksite (refer to the section below on The Banyan's time and motion study).</li> <li>MGNREGS worksites are mostly outdoors, and involve working in the fields / quarries towards public improvement works. This exposure to nature, the sun, local flora and fauna, is healthy and has been shown to improve a sense of wellbeing. Furthermore, the feeling of satisfaction after having contributed to an improvement in the local ecosystem also provides a sense of meaning and purpose.</li> <li>MGNREGS pays up to INR 140 / day for a regular workday of 8 hours. Persons with disabilities have access to special considerations that allow for a reduction of up to 4 hours per day, with the same salary.</li> </ul>

	<ul style="list-style-type: none"><li>● The salary is deposited into a bank account created specifically for this purpose, that the individual accesses with an Automatic Teller Machine (ATM) card.</li></ul>
Intrapreneurship and Entrepreneurship opportunities	<ul style="list-style-type: none"><li>● Intrapreneurship and entrepreneurship are great options for individuals who are naturally entrepreneurial and thrive under conditions where they have freedom to plan, manage and execute initiatives independently.</li><li>● Intrapreneurship offers a slightly more secure and stable footing to begin with, since the individual does not have to bear consequences of the risks at hand independently, but has the strength of the organisation backing the individual.</li><li>● At The Banyan we have several such initiatives that have been implemented with minimal assistance from the programme team. These include:<ul style="list-style-type: none"><li>-The NALAM Cafe: A small eatery offering South Indian cuisine, run independently by persons with mental health issues. This is run out of The Banyan's Emergency Care and Recovery Centre in Mogappair, and opens up the hospital to external engagement, and the creation of opportunities for different groups of people to mingle. It has created a vibrant, and inviting ecosystem - one that is far removed from the drab image associated with mental hospitals.</li><li>-The Bun Kadai: A baking unit specialising in cupcakes and cookies.</li><li>-Omelette stalls, dosa batter delivery businesses, and petty shops selling stationery, sweetmeats, and savoury (<i>vattals, pickles, pappads, etc.</i>) items.</li></ul>The Banyan Bistro, an eatery and canteen run at The Banyan Academy of Leadership in Mental Health (BALM) by a group of persons with mental health issues, caregivers and members of the extended community. By not creating a group of persons with mental illness alone, a sense of inclusion and social mixing is fostered.</li></ul>
Work from home	<ul style="list-style-type: none"><li>● Individuals who choose to remain outside the mainstream work sphere must be given the same kind of opportunities to explore and hone their interests and skills.</li></ul>





### Livelihoods and gender stereotypes

It is well known that men and women are likely to prefer, enjoy, and seek meaning and livelihoods from different activities. The experience of participation and engagement varies, and the care team must keep this in mind while facilitating work options.

In the case of women, culturally, preferred activities appear to be cooking, housekeeping, indigenous crafts creation, and caregiving. In contrast, men seem to prefer 'heavy work' - typically labour-intensive activities. Options include, but are not limited to, working as gardeners, daily wage labourers, drivers, and watchmen.

That being said there are exceptions to this rule, and we sure know of some women who are employed as watchmen and security guards, engaged in gardening jobs, and working in retail. In the same vein, we know of men who prefer indigenous crafts and / or housekeeping roles. So, keep in mind cultural orientations, but do not force individuals into subscribing to norms either. Remember the individual is the key decision maker, so be led by their choices.

### MGNREGS - The Mahatma Gandhi National Rural Employment Guarantee Scheme

A Central Government operated employment guarantee scheme that provides opportunities and ensures that all individuals can avail at least 100 days of work in a year. The scheme was introduced in 2005 to offer gainful employment opportunities during periods of drought / when other options of work were found to be inaccessible (<http://www.nrega.nic.in/netnrega/home.aspx>).

In 2012, The Banyan in collaboration with 3 other NGOs working with persons with disabilities, based in Tamil Nadu, conducted a time and motion study on the effectiveness of offering the MGNREGS programme for persons with disabilities. The study indicated that inclusion of persons with mental health issues into the scheme can prove to be extremely beneficial, offer a viable means to financial self-reliance, and in addition, increase participation, spur social mixing, and thus promote inclusion.

### How do you access the MGNREGS programme?

Adult members of a rural household, willing to do unskilled manual work, are required to register either orally or in writing with the Gram Panchayat. The Gram Panchayat after due verification will issue a Job Card. The Job Card will bear the photograph of all adult members of the household willing to work under the MGNREGS programme and is free of cost. The Job Card should be issued within 15 days of application. A Job Card holder may submit a written application for employment to the Gram Panchayat, stating the time and duration for which work is sought – a minimum of 14 days. The Gram Panchayat will issue a dated receipt of the written application for employment, against which the guarantee of providing employment within 15 days operates. Employment will be given within 15 days of application for work, if it is not then a daily unemployment allowance as per the Act, must be paid. Work should ordinarily be provided within 5 km radius of the village. In case work is provided beyond 5 km, extra wages of 10% are payable to meet additional transportation and living expenses.

### (B) *Incentivising patterns*

For individuals seeking employment within the care system, the programme has devised a method of creating varied incentivising patterns, from offering daily payments, to weekly and monthly payments, based on preference, and the individual's need at that time. This variation has been made keeping in mind the value of immediate positive reinforcement, in promoting a state of well-being, in some instances.

It has also been devised in keeping with the goal of creating an inclusive and flexible HR policy that is able to effectively reach out to all individuals involved.



Home making	<p>All activities involved in maintaining a clean home will be regarded as an activity that can be incentivised. This can include:</p> <ul style="list-style-type: none"> <li>-Sweeping, dusting and mopping the house</li> <li>-Cleaning the toilets / bathing areas</li> <li>-Ensuring cleanliness of the kitchen</li> <li>-Maintaining the 'puja' (<i>shrine</i>) area</li> <li>-Decorating the house and drawing the 'kolam' (<i>rangoli pattern outside the house</i>).</li> </ul> <p><i>Remember, that while these activities have been incentivised in order to provide a sense of financial security, you must take care not to focus too much on the money alone. Remember this is a home - everyone must contribute to the maintenance and upkeep of the home, much as we all do on our own. There is a unique value in doing so, and taking away from it may diminish the essence of the 'home' - ensure that this does not happen.</i></p>
Arts and Crafts	<p>It is not necessary for the individual to have completed an entire product all by herself. Even completing one portion, for e.g. sewing a button, or stamping one block print on paper will be monetised, and a salary paid. Every individual is an artist in her own right, and can create, and contribute to the supply chain in varied ways - none diminishing the other. The scope of work to be incentivised can include:</p> <ul style="list-style-type: none"> <li>-Threading beads / flowers</li> <li>-Stripping dried leaves and making broomsticks</li> </ul> <p>Maintaining common spaces utilised for the arts and craft activity</p>
Basic Allowance	<p>Even for those who have chosen not to engage in any work or activities, the programme will offer a 'stay well' incentive (of say INR 100 per month). Considering the trauma of rape, abuse, abandonment, and sheer distress and loss that these individuals have been victims of, we believe they are owed the right to experience a sense of agency, autonomy, and choice, all of which a basic income will provide access to.</p>

Elderly individuals	<p>Typically, any individual above the age of 60 retires from an active work life and enjoys a life of relaxation, and pursues alternative interests, that they perhaps did not have the time for through their hectic work life. In the same fashion, we consider elderly individuals at the Home Again programme as those enjoying the pleasures of a retired life. They do not engage in work unless they choose to.</p> <p>Irrespective of whether they work or not, we facilitate access to the Government Old Age pension, so that there is a guaranteed source of personal income.</p>
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How do you approach an external employer?

The philosophy of the Home Again programme is to encourage participation in socio-cultural, economic, and political activities. An active work-life is a critical aspect of this, and so, employment outside the care system is actively encouraged amongst all individuals keen to seek gainful employment.

This also encourages the individual to move out of his/ her comfort zone, engage more actively with the rest of the community and build his/ her social networks and resource pool. These are simple steps that will help you approach a prospective employer.

- Spend time with residents of each home, and learn about their interest and aptitude. See if they express any preferences regarding employment.
- Identify potential employers in and around the community they live in, and across various industries (retail, hospitality, service, food and beverage etc.). The Panchayat head, women from self-help groups and other Gram Sabha members as well as local NGOs could help you access these individuals or companies.
- Once you have an idea of what the individual would like to pursue, reach out to a potential employer. The manner of doing this will vary from person to person, based on their level of disability / functionality and aptitude/ talent.
- If the individual enjoys a high level of functionality, and is quite independent, encourage him/her to approach the potential employer on her own, and suggest that she takes a written resume along. You can draft the resume together if the individual asks for support. The process following this is fairly straightforward.

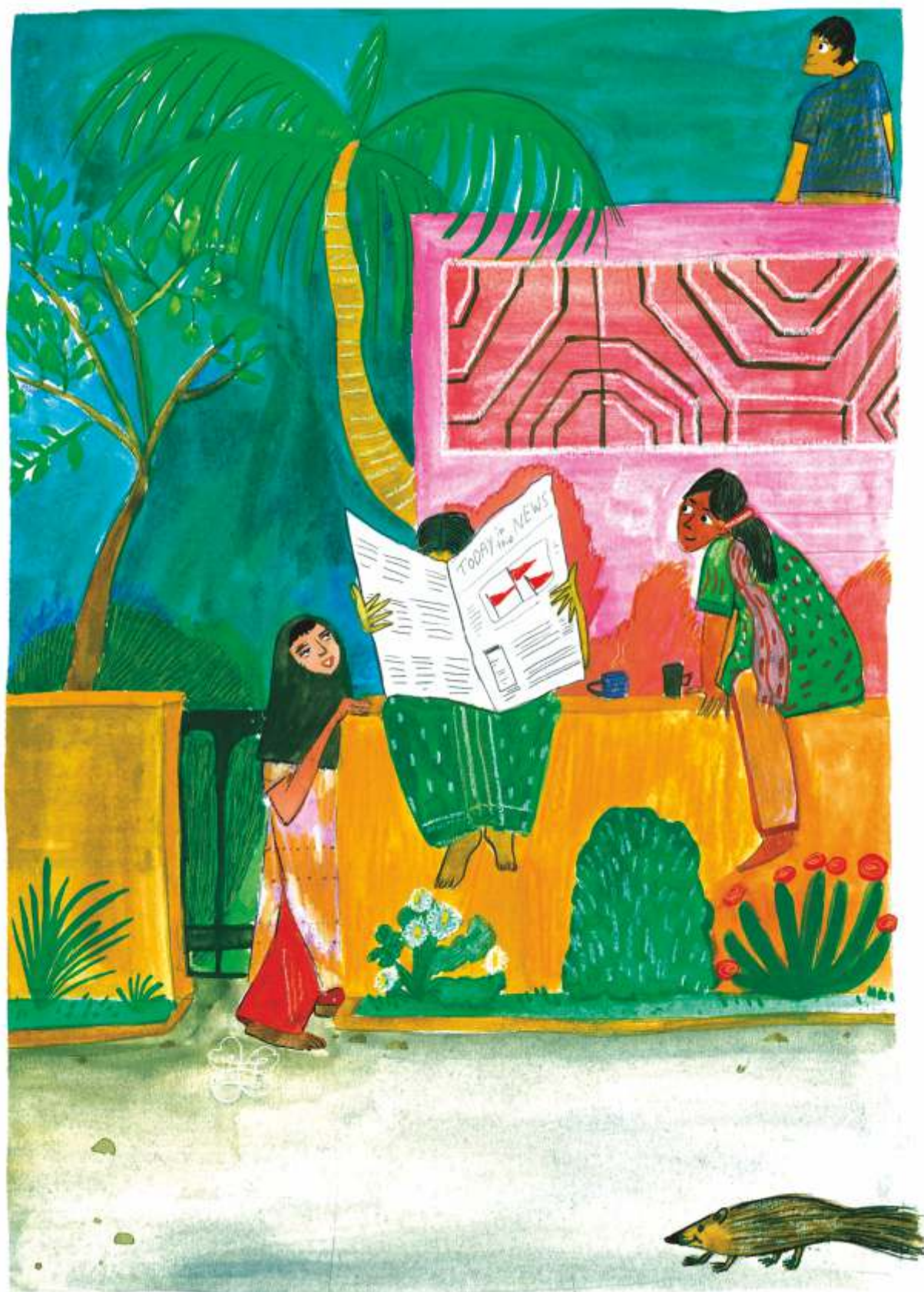


- If the individual requires some support and handholding on the job, ensure that this is made available. Meet the employer along with the social worker, and brief them about the individual's status, and needs, based strictly on however much the client wants to disclose. In such cases, follow up visits are also usually accepted and even welcomed such that issues that arise at the workplace can be promptly resolved.
- Disclosure: Sharing details on one's mental health and other personal details is at the total discretion of the client. You must support this decision either way, regardless of one's stance and hence be prepared to tackle consequences of the same. For e.g. if an individual chooses not to disclose their mental health issue, and their employer becomes aware much later, it may cause friction between all parties concerned and thus result in loss of trust. In this case, you must support the individual, and help them manage their own stress, in addition to rebuilding trust and rapport, and attempting to resolve the conflict and explain the situation to their employer, if at all that is possible.
- If the employer is open to hiring and offering required support, the individual may have to appear for an interview, in which case the Personal Assistant must orient the individual and offer support in whichever manner necessary. Mock interviews may also be conducted. Do not over input at this stage. Simply share information and prepare the individual. You don't want anybody thinking that they have to change themselves and seem or behave differently to seek a job or be accepted in the world.
- Employers usually make decisions based on hiring policies and in smaller businesses and homes based on personal need and a skill match on the one hand and intuition, gut feel, and the ability to get along with people on the other. Try and address barriers that will help the individual in ways that will support her over a period of time. For e.g., with hygiene - every small aspect right from one's appearance, to using the toilet, to using tissues when required, to etiquette when eating will help the individual in significant ways (refer to section on hygiene). However, it is advisable to have a trial period during which the individual can be oriented to the job and get comfortable with role, and the environment.
- Particularly during the trial period, it is imperative that the social worker and personal assistant remain in close contact with the client. This can be through informal chats at the end of each day for a period of a month, and following that, occasionally during the week, at their discretion, and when sought out by their client. Do not impose yourself on the client and if things are going well, let the PA just casually check, without too much of a fuss or too detailed a conversation. The care coordinator can step in occasionally and only if and when needed. Remember, we don't want to build too much dependence in the process of caring.

- Conduct a debriefing session after the trial period, and check whether both parties are interested in continuing the engagement. Continue to support the client with handling stresses related to work or interpersonal dynamics at play on the job site.
- It is critical to ensure continued engagement, as success on the job in the first few months is most crucial. Low performance or incessant issues during the first few months can demotivate the individual, and result in low morale. Sometimes the work may not be a good match/ fit. In such instances dropping off and looking for a new job should not be considered a failure. Offering both parties support and input over the first six-month period is a good way to resolve any issues that may arise swiftly, and ensure job retention.
- However, do not make this engagement intrusive. Keep it casual and have discussions about work while cooking dinner in the kitchen, or while walking to the corner shop. Do not make it a formal session, as that may make the individual feel ill equipped to handle a job.
- Recognise the employer as a company that has an inclusive human resource policy, and be sure to reflect this on social media. Remember, we need more people to feel inspired to change practices and embrace diversity. These small acts will build goodwill with the employer and also enthuse others to follow suit.
- As in all other aspects of life, you must remember, that you advocate on behalf of your client. You must ensure that they are not exploited, and you must articulate their opinions as you would your own. Exploitation on account of one's gender or disability should both be addressed







#### Section 4: A day in the life of the Home Again Community

No two days are ever the same in anybody's life, but we have all come to get used to patterns that set the cadence to our lives. In the same vein, the Home Again intervention seeks to enable every individual to initiate and set a pace that they are comfortable with.

##### Waking up - Breakfast

- People wake up at different times. They could either be woken up by the eldest in the house who is used to waking up early traditionally, or by the individual getting ready to head out for work, or by the personal assistant.
- Soon after some of them are awake, they take turns using the toilet and to brush their teeth, which some may need support with.
- One or two head to make tea or coffee for themselves, (and sometimes perhaps the group), in the way that each individual prefers it - with sugar / without sugar, with milk / without milk.
- While a group sits with their tea outside, breathing in fresh air and feasting on the clear dark blue skies, especially in the homes in rural Tamil Nadu, some of the others begin their bathing rituals, either independently or assisted.
- A few may sleep in late, either because they choose to, out of habit or because they are unwell, or because they are on stronger medication or simply tired.
- The local language newspaper arrives, and is read by some who enjoy it. The others who cannot read discuss the news that they find particularly exciting, and in a few months, most people in the house get to know the kind of news that each other enjoys.

*For instance, two women at The Banyan's Emergency Care and Recovery Centre, Ms. R and Ms. L spend each morning in deep conversation about the state of politics in Tamil Nadu - particularly the plight of 'Amma' the beloved Chief Minister of the State who was unwell during that time. Ms. R and Ms. L are the first recipients of news - and have much more insight into the developments surrounding her health, visitors at her bedside, and policies and decisions taken by her during this period).*



- Those who have showered, light a lamp in prayer, (or might choose pray to their favourite Gods sans rituals, lamp lighting)- a morning spiritual ritual that is very common in Indian households regardless of religious affiliation.
- While some engage actively in the process others may be passive observers and choose not to engage.
- There is no single time that everybody wakes / drinks tea / showers / bathes / or prays. The timing is scattered just like it would be in any of our homes - where different family members have different daily routines and manners of engagement with the rest of the household.
- There may be some amount of cooking for breakfast or in some cases the food may come from the nodal centre with just a special dish if so desired being prepared by members of the house.

### Mid-morning - Lunch

- Those who have found work opportunities in the neighbourhood or outside of their village/ town (as cooks, maids, gardeners, multipurpose workers) prepare to leave in a hurry, while the ones who have opted to live a slower life have just begun their day.
- The only role that the PA has through this time is to ensure that that all individuals residing in the home have completed their oral hygiene routines, had a bath and groomed themselves based on personal sensibilities, eaten their food and taken their medicines (if they are on any), ideally before 10.
- As much as there are odd days which break structure, and as much as individual choice is respected, we feel that the function of some mental health conditions including depression, schizoaffective disorders and even psychosis could result in an acute sense of withdrawal. In these cases, attempts are made to stimulate engagement in a manner that is pleasing to the individual. The idea is to encourage socialisation and interaction in different ways, and small steps like grooming, engaging in social processes such as cooking, praying and perhaps even work help in the pursuit and achievement of individual capabilities.
- Some of the members opt to work from home and earn small moneys and engage in craft making which includes jewellery making. This is an activity that is well loved, as jewellery occupies an important place in the local socio-cultural contexts, and women love adornments. The transformation of a single bead into a full product that has a strong aesthetic value flatters the craftsperson, and aids in promoting a strong feeling of self-reliance and achievement.

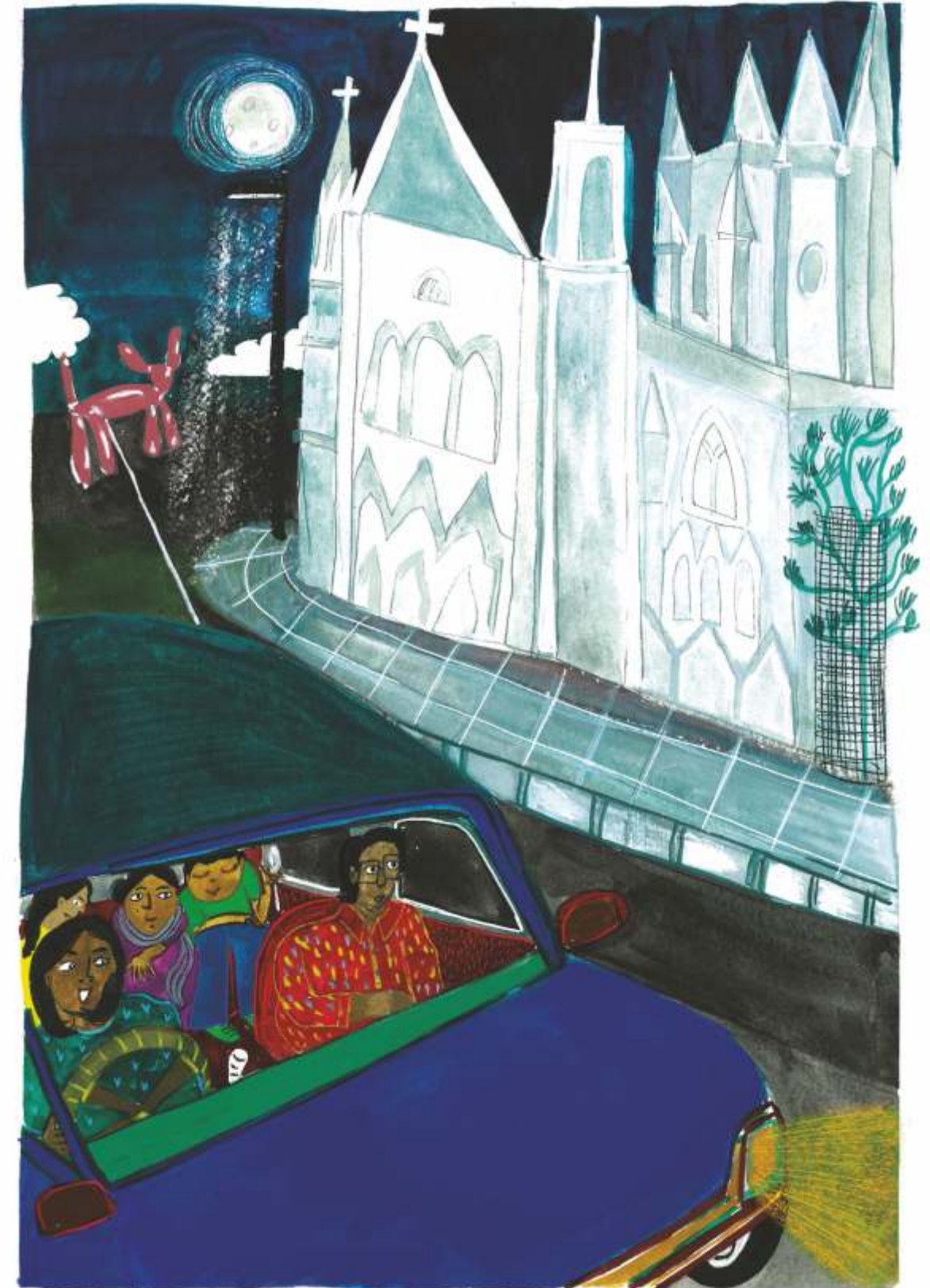
- Attempt to initiate engagement in work that best suits their interest, talent, and socio-cultural context. Ensure marketability of products (and thus the need for quality checks), such that products are sold for their worth, utility and attractiveness and not out of a sense of charity. Everybody in the group has some form of personal income this way. The workload is shared as are economic gains.
- While some people are working, others are perhaps watching television, going out on a walk, going to the market to buy vegetables, chatting, eating their breakfast, reading the papers, playing with a child from the neighbourhood, or are in the shower etc. A few of them may perhaps engage for a little while, get bored, and then go back to bed. All this is just fine. Do not always force uniformity or continued engagement.
- There could be a group or an individual who may want to make a special dish for lunch. A few may have something to talk about that excites them. A few others may opt to go the neighbour's house and watch television there, or walk down to the local teashop.
- Post lunch, many opt for an afternoon siesta. Napping may not be quite something others enjoy. They could turn on the TV, read a magazine or just chill in the veranda, doing nothing in particular, feeling content and calm.
- We must, however, highlight that it is not always a light and happy scene. There are still several individuals who will perhaps continue to stare blankly at a wall, continue to experience delusions and hallucinations, or remain withdrawn and disengaged. In some cases, they may be nostalgic and recall memories from the past and experience a deep sense of loss over failed or successful relationships that no longer exist, their childhood and a life that they knew that was far safer and much more comforting. As much as we enjoy other experiences, equally we have to brace ourselves to finding ways that address these recurring thoughts and feelings of abandonment, suffering and loss.

*“Moving into this house reminds me of all the positive times I had with my mother and father as I was growing up. We had a house that was our own, with four rooms. We all had lunch together, then I would go play outside, as my father went to work, and my mother was inside making a healthy meal. I can practically smell her sambhar and oh, the jasmine flowers on her hair - this feels just like that - like I'm home” - Ms. P*

- While it mimics feelings of a home and family for a few, in the case of a few others, memories of one's parents that they are not able to trace, or the daughter or son they long to be with, or the memory of a husband or lover lingers on. Do not force those memories away, maybe that's all that they have. You have done your best, so don't hold yourself responsible for their longing or yearning. These are two independent emotions.
- As much as the afternoons are devoted to snoozing, watching television, or sometimes just doing nothing, this time could be used to share and discuss such feelings and get to know each other better. The PA could consciously, yet casually initiate this occasionally without it seeming contrived. Best if it is fluid and non-structured. Members realise that over a period of time, that feelings of greater trust and openness have been fostered, without their even realising it. They have to undoubtedly be born out of a genuine desire to connect and make a difference. And better peoples' lives. Such honest intent can always be recognised by anybody, however disabled they may be/ seem.

### *Evenings and nights*

- Evenings are fun, the lights come on, the kids are out, and the community is agog with the hustle and bustle of everybody returning home from work, and socialising with their families and friends. There are constant visits to the beach, temples, dargahs (Fridays), and church (Sundays). Some individuals go to buy provisions and groceries for the next day. Plans for the approaching week are made as they head out to the local corner store to buy shampoo, soap and combs, and those who get back from work discuss their days and how it panned out; office relationships, upward climbs, raises are all discussed.
- There is an emphasis placed on special functions, occasions like birthdays, and festivals. This is to ensure that there are opportunities and experiences to look forward to. People visit each other's houses during birthdays, visit care coordinators, and other stakeholders from The Banyan, just like several stakeholders visit them in an impromptu manner to share a cup of tea, or a meal. These planned social engagements happen at least once or twice a month. There could be other friends, as well that some of the members have made, some we may not know of. Ensure that they have that personal space and time.
- Some of these planned social visits also double up as observation / monitoring visits. This is to ensure that the programme is monitored and small changes are observed in a non-obtrusive manner, and is sensitive to maintaining each individual's privacy





In the house, discussions around banking, work, and life in general including trauma from their past, are brought up multiple times (by the member(s)) and over multiple weeks. The Personal Assistant (PA) being the most consistent in her presence at the home, should be able to deal with these strong emotions, expressions and ambiguities and guide and facilitate a free flow of thought and not impose her own views. As much as you want to sound optimistic and encourage catharsis, you equally want to validate distress and pain, even as you stay hopeful of their future.

The housing intervention enables a shift in attitude- of moving away from a feeling of scarcity to one of abundance, not just at a material or resource level, but at an emotional and kinship level. Years of constant distress, disappointments, and multidimensional losses have resulted in some of these individuals having lost the ability to dream. They are resigned to what they would term fate or ill luck. Attempts are constantly made to instil a sense of hope, and instigate creative and aspirational thinking.

*Social disadvantage can often mean reduced care and recovery prospects. Encountering spaces and services that embody the same social hierarchies can constrict access to the already meagre resources and social capital, denying opportunities for individuals. Homelessness and mental illness led Shanta and Jamuna towards a downward spiral of long-drawn and protracted social rejection, ridicule and loss.*

*Their ignorant fellow villagers refused to understand their struggles because of a basic dismissal of their illness and associated markers. Caste and class-based disruptions exacerbated these experiences. After almost ten years of being service users, they both decided to go back to living life in the village, they once knew as home. Despite multiple setbacks with Shanta losing her husband to an accident and having to raise her only daughter as a single parent, and Jamuna experiencing periods of symptoms resurgence with added responsibilities as the primary earner in the household, the sisters formed between themselves an unshakeable support system that kept them going from strength to strength.*

*The sisters continued to experience stress in their relationship, but found unprecedented support from their community, which was taken aback by Jamuna's transformation. Members of the community approached the clinic at which she was employed for their medical treatment and entrusted her with their families' health and wellbeing. Jamuna's dedication and calmness offset Shanta's warmth and vivaciousness.*

*As an extension to this, Shanta and Jamuna decided that they would build a user-led community where service users can coexist and reclaim their agency. They decided to bring with them the possibility of mental health service, by anchoring the “Home Again” (for users with long-term care needs) in Trichy. As anchors of this programme, they are lending an intimate and in-depth perspective shaped by their own lived experiences and dynamically contributing to enhancing the intervention across sites. Entirely peer-led, the site offers the opportunity for friendship, relearning of familiar and new routines, intimate roles and meaning. Relationships of these sorts extend beyond boundaries, the community rallying around based on need allowing users to define personal recovery as they know it.*

## Section 5: Clinical and Medical Management: Appropriate pharmaceutical and psychotherapeutic interventions

### Medical Management

This section seeks to highlight and address some of the common health concerns that persons living with a mental illness may face. It is important to keep in mind that these mental health issues identified below are not labels to define the person and these symptoms may be present in the majority of the persons residing at Home Again. These symptoms are to help you understand the impact on the individual's functionality and quality of life, with the objective to help you understand when things need to be escalated or medical advice needs to be sought.

This is not an exhaustive list, and must be implemented in consultation with a trained medical professional at all points. However, go through it carefully, as it will help you pick up early signs and symptoms of critical issues that are likely to develop into emergencies if left untreated. This will enable you to take swift action, thus reducing distress and preventing crises.

Mental Health issue	Early signs	Management
Depressive episode	<p>Depression could be described as a disease of losses, characterised by morbid sadness, psychomotor retardation, a deep sense of fatigue, withdrawal and disinterest in most things that one previously appreciated</p> <p><i>Early signs</i></p> <p>Loss of sleep, subjective sadness and decreased or increased appetite.</p> <p>This is followed by decreased interest in most formerly pleasurable activities, decreased energy, crying spells, lack of confidence, a sense of hopelessness and worthlessness and suicidal ideation. Some persons may experience delusions of guilt, persecution, reference and nihilism.</p> <p>Most depressed patients have insight into their illness. In fact, many are also known to be highly realistic about life and profoundly so. 'Depressive reality' more often than not is viewing life as is - and not with a sense of optimism or rose tinted glasses that sometimes helps us get by.</p>	<p>A person who is withdrawn, dull or depressed could be reacting to a specific situation or may be clinically depressed. If that is the case, do the following:</p> <p>Talk to them and try to understand the difficulties they perceive or are reacting to.</p> <p>Ensure that they eat well and drinks sufficient water. If they have a poor appetite, ensure that they eat smaller quantities of food frequently. In case they are constipated, encourage them to eat a high fibre diet.</p> <p>If they have persistent depressive symptoms which are pervasive and present for more than two weeks, consult a doctor because they will require medication.</p>

Mental Health issue	Early signs	Management
		<p>In case they are suicidal, talk to them about their distress or suicide plans, if any. Ensure that harmful objects such as knives, blades, screwdrivers, iron rods, ropes, medicines, cleaning d etergents, pesticides and plastic wires are kept away and in safe custody. Ensure that someone is with the individual at all times and yet not naggingly so. If required, e nsure that bolts and latches are removed from her doors.</p> <p>Administer medication regularly as prescribed by the doctor. Ensure that they adhere to the treatment plan.</p>
Manic/hypomanic episodes	<p>A manic episode is characterised by elation, overactivity and increased ideomotor pressure (<i>fast speech</i>).</p>	<p>People with hypomania or mania may need medical intervention as soon as initial symptoms are identified. Mood stabilizers such as Lithium, Carbamazepine, or S odium Valproate are typically used. These medications must be monitored closely since toxicity can develop if an increased dose is administered, though these drugs are considered safe normally.</p>



Mental Health issue	Early signs	Management
	<p><b>Early signs:</b> Decreased need for sleep, constant engagement in multiple activities without completing any, interfering in others' lives, exhibiting and displaying a sense of exaggerated self-esteem. Often the person is boastful and high on life. People who develop full-blown manic symptoms may experience increased psychomotor activity, pressure of speech, flight of ideas, circumstantial speech etc. They may additionally experience delusions of grandiose identity or grandiose ability. They may also lack 'insight' in the typical sense.</p>	<p>The care coordinator must be able to keep track of the therapeutic drug levels and work closely with the treating doctor for and continued management</p> <p>Ensure adequate sleep by titrating the medicines effectively until an adequate dosage is arrived at.</p> <p>Try not to confront or agitate persons with manic symptoms in the midst of an episode. Writing, painting, collage-making, organising things, household chores, creative arts, yoga, mindfulness practice etc. help.</p>
Mood switches	<p>Depressive patients treated with antidepressant medications like Imipramine, fluoxetine, Sertraline can develop a manic switch. In other words, they develop mania like symptoms as described above.</p> <p>If the person on treatment for mania develops sudden unexplained withdrawn, crying spells or sadness, consider depressive switch a possibility.</p>	<p>Consult a doctor immediately. Administration of an injection of 2cc of Ativan IM is helpful. Once the medication is changed, manic or hypomanic symptoms will reduce in a couple of weeks.</p> <p>Consult the doctor immediately as medication may need to be changed. Talk to the person to understand if she is reacting to any psychological, social or environmental factors.</p>

Mental Health issue	Early signs	Management
Schizophrenia	<p>Schizophrenia is a common mental disorder seen quite frequently in homeless populations. It is a somewhat disabling condition and pharmacotherapy amongst other options may reduce dysfunction and disability. It is important to note that identification of schizophrenia around the time of its onset can result in better recovery and prognosis.</p> <p><b>Early Signs</b> include withdrawal, disinterest, difficulties in scholastic performance, poor self-care, difficulties in communication, moodiness, poor social networks, sleep problems, and disturbances in appetite. Gradually this progresses to development of more pronounced psychotic symptoms like hallucinations and delusions. Patients may also suffer disorganization in thinking, and poor insight.</p>	<p>Schizophrenia is a treatable condition. Effective, economic and safe interventions are available today in the form of antipsychotics, neuroleptics and psychosocial therapies. The medication produces the desired effect by blocking dopamine transmission.</p> <p>As a result of the hypo dopaminergic state some side effects such as tremors, slow motor movement, and rigidity are common. Gradually, if not treated, this may lead to other side effects which are relatively rare such as akathisia, and tardive dyskinesia.</p> <p>Another serious side effect acute dystonia may occur as soon as APM is initiated, usually within the first 24-72 hours of starting treatment. It can affect a part or groups of muscles in the body. Such acute muscles spasm can be very effectively reversed by administration of inj. Phenergan 50mg IM; the muscle typically spasm will disappear in 30-40 minutes.</p>

Mental Health issue	Early signs	Management
	<p>Persons undergoing treatment for mental health problems can deliberately harm themselves by hurting any part of their body or through violent acts like slashing their wrists, jumping, consuming liquid detergents, self-immolation using inflammable substances like kerosene or petrol. They may even attempt to hang or drown themselves.</p>	<p>Any act of self-harm should be taken seriously and psychological and social help must be sought immediately.</p> <p>In case of consumption of substances like kerosene or petrol, do NOT make the patient drink water but rush her immediately to a hospital.</p> <p>In case they have consumed tablets, encourage them to drink water. Empty the stomach only if you are sure they have consumed tablets.</p> <p>If toilet cleaning substances such as acids have been consumed, rush the person to hospital immediately without making an attempt to give them water. In case, the person has inflicted a deep cut on her body, she may require suturing: Apply a pressure bandage and rush her to hospital. In case the injuries are superficial, clean the wound, talk to the person about their distress and consult the doctor subsequently.</p>

Mental Health issue	Early signs	Management
Substance Misuse	<p>Substances like alcohol, cannabis or prescription drugs like tranquilisers can be abused by people undergoing psychiatric treatment. The most common substance used is nicotine. The most common method of consumption is oral - either by smoking or chewing tobacco.</p>	<p>People using substances should be educated on the harmful effects of these substances (use posters).</p> <p>Emphasise that drug interactions between the substance and medication can reduce effective blood levels or increase the effect of one of the drugs, which can be dangerous.</p> <p>Persons who are addicted to substances should practise protective shield rituals like meditation or yoga and be encouraged to share their distress with others as well as participate in household activities and recreational and physical activities. Ensure that advising persons to get off substances such as tobacco are more for health reasons and not moral.</p>
Picking up signs of an acute episode	<p>A person on maintenance medication can relapse into a psychotic illness, depressive or manic episode. Features of early relapse includes loss of sleep, decreased appetite, unexplained withdrawal, decreased socialization, desire to stay alone, frequent emotional outbursts or changes in manifesting behaviour.</p>	<p>A relapse is an acute medical emergency: Consult the doctor immediately.</p>



Mental Health issue	Early signs	Management
		<p>Identify psychological, social, environmental or other stress factors affecting the individual that may precipitate and perpetuate a state of distress. Interpersonal conflicts, breakdowns in relationships or the presence of high Expressed Emotion [EE] in the environment should be identified.</p> <p>Necessary modifications / titration in medication or addition of new medication may be considered.</p> <p>Watch for suicidal or agitated behaviour, proneness and states. If the person is very excited or highly irritable, ensure safety of the person and others. An injection of 2cc Ativan IM may help.</p>
Dementia	Residents of shared housing could be people who suffer progressive memory loss. Often such persons forget what they ate, where they are, whom they are talking to, what they did a few minutes or hours earlier and demand food without realising that they have consumed food just a short while ago. People who show disturbances in immediate and recent memories usually have intact remote memory. It is possible that such persons may experience confusion and thus exhibit agitation whenever they are, unable	<p>Dementia is a progressive degenerative disorder of the brain. There are no available and effective drugs that may reverse this condition at this point. Reality oriented therapy is an important intervention that is possible either by a personal assistant, a relative or a key caregiver. Reality oriented therapy includes updating the individual about where they are,</p>

Mental Health issue	Early signs	Management
	to find answers to some of their behaviours and loss of memory. It is also common for them to fill false information about themselves with no intention to deceive (confabulation). Disorientation to place, person and time could result in their losing their way as well.	who they are talking to, what they are eating, etc. It is important not to ask them questions that they are unable to answer or to discuss things that they have no recollection of. Instead of asking them too many questions, update them on an everyday basis; this may comfort them a great deal. If they have problems in mobility, ensure that a walking stick is used
Challenging behaviours	Challenging behaviours such as belligerence, aggression, irritability, disruption, confrontation, active negativism and rebellion are often seen in people with severe mental disorders with comorbid personality difficulties, people with intellectual disabilities, people with mental illness with comorbid substance use or people with brain damage (due to intractable or uncontrolled seizures, etc.)	While challenging behaviours may seem very intimidating or difficult to handle at the outset, this is certainly not the case. Listen to the person, accept whatever she says, verbally reassure her that her distress will be addressed, calm her down and talk to her about the most pressing problem she is going through. Identify provoking or antecedent factors that contribute to her state of mind and attempt to minimise them. Understand the nature of the behaviour and its consequences using ABC analysis. Discuss with the therapist about further management.

Mental Health issue	Early signs	Management
	<p>Epileptic seizures are commonly seen in people diagnosed with intellectual disability, people with history of brain damage or in people taking antipsychotic drugs or antidepressants. Epileptic seizures could be of many types:</p> <ol style="list-style-type: none"><li>1. Generalized tonic clonic seizures</li><li>2. Focal seizures which may be clonic movements of one part of the body or brief lasting behaviour disturbances referred to as complex partial seizures.</li></ol>	<p>A person who has had a seizure should be made to lie on a cot or on the floor, turned to one side so that the froth can drain. The clothes of the person need to be loosened and sharp objects removed from the immediate vicinity. Since the seizure may last for 10-15 seconds, there is no need to do anything more than what is described above. If a person has more than 2 attacks of seizure in a day or has continuous seizures lasting for minutes, rush the person to an emergency room immediately.</p>
Physical health problems	<p>Acute infections: fever, body ache, vomiting, diarrhoea, loss of appetite or common symptoms of acute viral or bacterial infections. Suspect febrile illness if the person is not socializing, remains withdrawn for long periods of time, refuses to eat food or complains of tiredness, etc.</p> <p><b>Remember</b>, people with psychotic illness and depressive disorders may not talk about fever or discomfort spontaneously. Look for pyrexia or any infection proactively.</p>	<p>The patient's temperature, pulse, and respiratory rate must be recorded every four hours.</p> <p>Administer paracetamol tablets (500 mg) as and when necessary. Ensure that the patient does not receive a dosage of more than 2000 mg in 24 hours.</p> <p>Ensure that the patient is well hydrated. Consult a doctor as soon as possible.</p>

Mental Health issue	Early signs	Management
	<p>Falls and injuries are very common in locations where people are treated for mental health problems and this could be related to medication or poor safety features such as uneven or wet/ slippery floors, ill-lit rooms, etc.</p> <p>Falls and injuries are very common in locations where people are treated for mental health problems and this could be related to medication or poor safety features such as uneven or wet/ slippery floors, ill-lit rooms, etc.</p> <p>Bites: interpersonal violence in the form of human bites or aggression resulting in bites can be encountered in psychiatric patients rarely.</p> <p>Diarrhoea and vomiting: Diarrhoea and vomiting are common in cases of febrile illness or gastrointestinal infections.</p> <p>Skin: The most common skin infections encountered in patients with mental health problems are fungal infections, bacterial infections, allergic reactions or contact dermatitis.</p> <p>Folliculitis scalp (boils on the scalp) is very common in people with mental health problems due to poor personal hygiene.</p>	<p>The moment you come across a person with injury, examine the wound and clean it with safe water. Apply gauze and bandages to stop the bleeding. If the wound is contaminated with mud, Inj. Tetvac (tetanus toxoid) should be given. In case the person has a deep wound, refer her to the nearest emergency room.</p> <p>Clean the wound with soap and water. Dress it with antiseptics. If the wound is extensive with lacerations, urgent medical attention may be necessary. There is no need for Inj. TT or an anti-rabic vaccine.</p> <p>If the person is vomiting persistently, injection Perinorm 10 mg or tablet Emeset 4 mg is very useful as an IM injection. Ensure that the person drinks orally and in small sips, frequently. Similarly, if a person has loose stools associated with a painful abdomen or reports of bloody stools or mucus in the stools, it is best to consult the doctor immediately. Ensure that the person drinks enough water.</p>



Mental Health issue	Early signs	Management
	<p>Urinary tract infections: UTI is very common in women. It is often accompanied by fever, chills and rigors.</p> <p>Hypothyroidism: This is a very common condition amongst people with mental health concerns. Such patients are obese and may have a hoarse voice, coarse skin, menstrual rregularities, dullness and slow motor activity. Hypothyroidism is also known to affect moods and result in depressive behaviour patterns.</p> <p>Diabetes is a very common condition seen in people treated for mental health problems. Nearly 15-20% of residents may be diagnosed with diabetes. Patients with diabetes are treated with oral antidiabetic drugs or insulin.</p>	<p>Dry skin and itching is not a disease condition. These can only be avoided by good levels of personal hygiene. <i>(Refer to the hygiene protocol and follow in detail).</i></p> <p>Frequent anti-lice treatment is very critical to prevent folliculitis. In case the folliculitis is severe, an antibiotic is indicated. In case of increased severity when combing or if anti-lice treatment cannot be initiated, tonsuring may be considered if its causing the person distress, itching, infection and ill health etc. Ensure that the person also agrees with the course of treatment wholeheartedly. Always explain why a particular method of treatment is initiated. Information sharing is the most essential part of human rights promotion.</p> <p>The patient's temperature, must be recorded every four hours. Collect mid stream urine samples to check albumin, sugar, microscopy, culture and sensitivity. Ensure that the patient drinks 6-8 litres of water in a day (to flush out infections). Administer bactrim DS to patients who have a UTI after the sample has been sent to the lab for routine, culture and</p>

Mental Health issue	Early signs	Management
		<p>sensitivity tests. In case the patient develops an allergic reaction after ingestion of tablets, take her to the doctor immediately.</p> <p>Hypothyroid patients should be given thyroid supplements on an empty stomach. Ensure that they do not take anything orally for half hour after the thyroid supplements. Monitor the patient's weight and menstrual cycles regularly. Note: blood samples for T3, T4 and TSH should be drawn after 12 hours of fasting.</p> <p>Diet, exercise and medication are three important pillars in the management of diabetes. Please ensure that patients with diabetes avoid sweets, chocolates, ice creams etc. as much as possible. Do not add sugar in their coffee or tea. Educate them about the need to drink coffee or tea without sugar.</p> <p>Patients who develop hypoglycaemic episodes, characterised by sweating, tremors, weakness, shivering and a sinking feeling should immediately be fed some chocolate, or a teaspoon of sugar. The case should be reported to the doctor. Please ensure that the correct dose of insulin is administered. Errors in administering insulin can be dangerous.</p>

Psychosocial Therapeutics and Interventions

In addition to the aforementioned management strategies, psychosocial interventions such as psychological therapies, open dialogue, vocational training, occupational therapy, dance and movement therapy, or sometimes just being there for the person are critical, and can be quite effective in reducing distress. Also, take into account the role of culture and personal belief systems in influencing better outcomes

Social Work theories and therapeutics

Used by social workers during the identification/treatment phase.

Theory Group	Social Work Objectives	Contribution to practice
Psychodynamic		Emphasizes the importance of people's internal feelings and conflicts in generating behaviour and in resolving the problems that they face
Crisis and task centered	Problem-solving	Focuses on brief, highly structured models of intervention with clearly definable problems that will respond to active efforts to resolve them
Cognitive behavioural		Focuses on brief, highly structured models of intervention with clearly definable problems that will respond to active efforts to resolve them
Systems/ecological		Integrates interpersonal work with individuals with interventions with families, communities and social agencies
Macro practice/social developmental/social pedagogy	Problem Solving/Empowerment	Gives priority to the social and educational factors, engaging people with shared interests and concerns to work jointly to overcome them

Strengths/solution/narrative		Recasts clients' and families' apparent problems , seeking strengths that enable them to build positively for the future
	Empowerment	
Humanistic/existential/spiritual		Emphasizes personal development through shared experience as a source of individual and group empowerment
Empowerment/advocacy	Empowerment/Social Change	Creates experiences and alliances that empower people to achieve a greater understanding of their lives and changes in them
Critical		Offers critiques to the present social order that analyse and deal with social factors that underlie problems or social barriers
	Social Change	
Feminist		Explains and respond to the oppressed position of women in most societies through collaborative dialogue and group work to achieve consciousness of issues affecting women's social relations



Assessments and Psychometry					Psychotherapy	
Type of Disorder	Screening	Periodic Assessments	Disorder Specific Tools	Option 1		Option 1
Dementia	Initial Screening forms Physical assessment Mental status examination Diagnostic evaluation Mini Mental Status Examination	Clinical Dementia Rating Scale	Clinical Dementia Rating Scale NIMHANS N europsychological Battery Addenbrooke's Cognitive Examination	Didactic Information on illness and management		
Substance Use Disorders	Initial Screening forms Physical assessment Mental status examination Diagnostic evaluation CAGE Questionnaire Alcohol Use Disorders Inventory Test (AUDIT)	Brief Psychiatric Rating Scale (BPRS) Clinical Global Index (CGI) Extrapyramidal Symptom Rating Scale (EPSRS) Modified Global Assessment of functioning (m-GAF) WHO Quality of Life (QOL) Presumptive Life Event Scale(PSLES) (OP)	CAGE AUDIT	Individual/Group Therapy Motivational Interviewing Transtheoretical Model of Change Cue Exposure Therapy Aversion Therapy Relapse Prevention Strategies Contingency Management Family Therapy Didactic Information on illness and management		Self Help Approach - Alcoholic Anonymous (AA Groups) Religious Approach to deal with moral reduction / strengthening Therapeutic Community Re-emphasising option 1 is necessary

Assessments and Psychometry					Psychotherapy	
Type of Disorder	Screening	Periodic Assessments	Disorder Specific Tools	Option 1		Option 1
Psychosis	Initial Screening forms Physical assessment Mental status examination Diagnostic evaluation	Brief Psychiatric Rating Scale (BPRS) Clinical Global Index(CGI) Extrapyramidal Symptom Rating Scale (EPSRS) Modified Global Assessment of functioning (m-GAF) WHO Quality of Life (QOL) Presumptive Life Event Scale(PSLES) The Indian Disability Evaluation and Assessment Scale (IDEAS)		Individual/Group Therapy Social Skills Training Cognitive Behavioural Therapy to deal with hallucinations and delusions Distress management techniques and positive symptoms diary Cognitive Retraining Didactic Information on illness and management		

Assessments and Psychometry					Psychotherapy	
Type of Disorder	Screening	Periodic Assessments	Disorder Specific Tools	Option 1		Option 1
Bipolar Affective Disorder	Initial Screening forms Physical assessment Mental status examination Mood Chart Diagnostic evaluation	Brief Psychiatric Rating Scale (BPRS) Clinical Global Index (CGI) Extrapyramidal Symptom Rating Scale (EPSRS) Modified Global Assessment of functioning (m-GAF) WHO Quality of Life (QoL) Presumptive Life Event Scale(PSLES) (OP) The Indian Disability Evaluation and Assessment Scale (IDEAS)	Montgomery-Åsberg Depression Rating Scale (MADRS) Young Mania Rating Scale (YMRS) Hamilton Rating Scale for Anxiety (HAM-A)	Individual/Group Therapy Didactic Information on illness and management Interpersonal and social rhythm therapy (IPSRT) Family Therapy Stress Management		
Depression	Initial Screening forms Physical assessment Mental status examination Mood Chart Diagnostic evaluation	The Beck Depression Inventory	The Beck Depression Inventory Zung Self-Rating Depression Scale	Individual/Group Therapy Didactic Information on illness and management Guided Self Help strategies Interpersonal Therapy Behaviour therapy Mindfulness-based cognitive therapy (MBCT)		

Assessments and Psychometry					Psychotherapy	
Type of Disorder	Screening	Periodic Assessments	Disorder Specific Tools	Option 1		Option 1
Anxiety Disorders	Initial Screening forms Physical assessment Mental status examination Diagnostic evaluation	Hamilton Anxiety Rating Scale State-Trait Anxiety Inventory (STAI) Liebowitz social anxiety scale Yale brown obsessive compulsive scale (Y-BOCS)	Hamilton Anxiety Rating Scale State-Trait Anxiety Inventory (STAI) Liebowitz social anxiety scale Yale brown obsessive compulsive scale (Y-BOCS)	Individual/Group Therapy		
Intellectual Disability	Initial Screening forms Physical assessment Mental status examination Diagnostic evaluation	No periodic Assessment	Binet Kamat Test of Intelligence Seguin Form Board Vineland Social Maturity Scale Bhatia's Battery of Performance Test of Intelligence	Didactic Information on illness and management		



Below is a list of psychological and social work therapies that play a role in addressing specific problems such as interpersonal issues, anxiety, depression, substance use, existential crises and many others that you may come across in the residents of Home Again. Your organisation may have a dedicated psychology or social work department to which a referral can be made, or you can identify external practitioners and organisation who can support your programme and complement the intervention delivered by you.

1. Clinical Interviews (case work up, diagnostic formulation and clarification, therapeutic formulation): Mental ill health is a complex problem that often manifests in a variety of ways. In order for the mental health practitioner to understand the primary problem, they often use a technique known as clinical interviewing. This is a semi- structured process that helps in acquiring information which contributes to developing a diagnosis and then toward therapeutic formulation- What is the primary problem? What does the person need? How can it be offered? What is an appropriate psychological intervention that can be offered in order to achieve these needs? - these questions are often answered through clinical interviewing. Clinical interviews usually are completed in one session; in the event a follow-up session is required, it may be offered on a need basis.
2. Individual Care Plan: Developing Individual care plans collaboratively with the Dept of Social Work, Nursing and Psychiatry In offering good mental health care to each individual, it becomes important to provide a care plan that is need based, holistic and personalized. In order to achieve this, 'individual care plan' are developed using a biopsychosocial framework, for each person accessing services at The Banyan. This will be developed with the individual seeking the service after a clinical interview is completed.
3. Behaviour Therapy: Developed by the school of behaviourism, this form of therapy holds that undesirable behaviour is learned and has a purpose to the individual. The therapy therefore focuses on interventions that are offered are carefully monitored to the detail and reinforced positively or negatively, depending on the therapeutic formulation.
4. Marital and Family Therapy: Offered in contexts of couples and families respectively, this form of intervention is used to strengthen or improve upon existing interpersonal relationships that may be strained due to a variety of underlying problems such as sexual health, bereavement, financial problems and so on.
5. Cognitive-Behavioural Therapy (CBT): We all engage in patterns of thinking and behaviour in our day-to-day living. CBT explores the dynamic relationships and patterns between our beliefs, thoughts, and emotions in relation to our behaviours and actions.

6. Cognitive remediation program: The primary aim of cognitive remediation therapies is to reduce cognitive deficits. When considering the remediation tools that are currently in practice one could compare it to brain training. However, in contrast to cognitive remediation, brain training is aimed at healthy subjects wishing to prevent aging-related cognitive deficits before they occur. Brain training programs (in addition to possible medical indications) employ evidence-based techniques to prevent cognitive aging. Cognitive deficits can manifest as disorders of attention, memory, and executive function (ability to organize one's actions and speech). Certain mental illnesses are sometimes characterized by specific cognitive deficits, such as social cognition disorders (which prevent the patients from understanding other people's intentions, desires and emotions). These types of cognitive disorders highly compromise the social and professional integration of people going through such problems. Rehabilitation treatment offering exercises with an aim at improving attention, memory, language and/or executive functions can be used to address these disorders.
7. Client Centred Therapy: This form of therapy holds the view that the client is most important, and they are capable of managing their lives given appropriate support and direction. It's non-directionist. Given that the individual is most important, unconditional positive regard - total acceptance and support of the person without judgement and evaluation - is the key principle in this form of therapy.
8. Dialectical Behaviour Therapy (DBT): Dialectical Behaviour Therapy is a Cognitive Behavioural approach that addresses psychosocial aspects of mental health. Some people's emotional arousal levels can increase far more quickly than others, achieve a higher level of emotional intensity, and involve a significant amount of time to return to normal arousal levels. As such, these individuals can experience extreme swings in their emotions. DBT focuses on teaching coping skills for managing intense emotions in our day-to-living.
9. Open Dialogue: The Open dialogue approach focuses on support networks, that results in co-production of knowledge and enhancement of social capital, critical in building perspectives and supporting expressed needs of individuals and groups. Studies have demonstrated the effectiveness of Open Dialogue in reducing hospitalizations, readmissions and improving employment rates for persons with severe mental health issues. For example, around 75% of those experiencing psychosis have returned to work or study within 2 years and only around 20% are still taking antipsychotic medication at follow-up.

10. Spiritual Therapy: People often turn to religion to seek help and counsel for many of the concerns that lead a person to seek therapy, and a person who is spiritual or religious may utilize both fields in the pursuit of healing or well-being. Therapy, a model of treatment for mind and body, is considered to be a more scientific or medical approach. Spirituality, which encompasses the spirit and other immeasurable aspects, is generally believed to have little place in the field of psychoanalysis, and with the exception of pastoral or religious counselling, therapy does not often include discussion of religion or spirituality, although a therapist may inquire about the beliefs of a person in therapy and encourage that individual to connect with others in the religious or spiritual community.
- 11 Gestalt Therapy: At the core of gestalt therapy is the holistic view that people are intricately linked to and influenced by their environments and that all people strive toward growth and balance. Gestalt therapy is similar to person-centred therapy in this way, as well as in its emphasis on the therapist's use of empathy, understanding, and unconditional acceptance of the client to enhance therapeutic outcomes. According to Gestalt therapy, context affects experience, and a person cannot be fully understood without understanding his or her context. With this in mind, Gestalt psychotherapy recognizes that no one can be purely objective—including therapists whose experiences and perspectives are also influenced by their own contexts—and practitioners accept the validity and truth of their clients' experiences. Gestalt therapy also recognizes that forcing a person to change paradoxically results in further distress and fragmentation. Rather, change results from acceptance of what is. Thus, therapy sessions focus on helping people learn to become more self-aware, and to accept and trust in their feelings and experiences to alleviate distress.
12. Supportive Counselling: Often times, individuals do not require intensive sessions. Supportive counselling integrates various forms of therapies aforementioned and offers individuals support for specific issues they may experience. Unlike in other forms of therapy, the therapeutic formulation, here, pertains to the extent of only the specific issue and focuses on the here and now. It does not consider influential patterns between behaviours, emotions and relationships. This form of intervention is often brief, lasting for between 2-4 sessions, although may last longer if used adjunct with other therapies.

Escalation of emergent issues - When, how and to whom?

Pre-emptive action is always better than having to deal with emergencies. While rigorous training, accompanied with commitment to protocols and checklists are absolutely critical, equally is intuition, deep engagement, responsiveness and swift action.

You, (The Personal Assistant (PA) must learn to pick up crucial signs of distress, low moods, worry etc. even if they aren't explicitly articulated. Don't get overly concerned with the enormity of this responsibility. While this seems difficult, being open and sharing a good rapport will soon enough enable you tune into your housemates' moods, like you would with your close friends. Like they say, sometimes we just know things. It will get to that, soon enough.

However, in the event of an emergency that requires you to think quickly, you must remain calm. Do not make snap judgements, panic or get frustrated. This is likely to make the situation worse.

The situations outlined below will provide you with an idea of some of the critical events you need to watch out for:

Isolation/Extreme withdrawal:	<ul style="list-style-type: none"><li>Individuals having experienced mental ill health often do ask for some more personal space and can have days when they require it more, than other days. However, sometimes, an exacerbation of symptoms or acute distress can precipitate an episode of extreme withdrawal where individuals disconnect from any interaction.</li><li>A warning sign is when this disengagement seems 'out-of-character' for that individual; or when the individual not only does not initiate contact or conversation but also refuses to engage when an attempt is made, even if it is in relation with an activity he/ she formerly enjoyed.</li><li>In such cases, you must contact the care coordinator in charge immediately who will then take necessary steps as per protocol (either handle it themselves, or make appropriate referrals to a psychologist, social worker or psychiatrist, as the need may be).</li></ul>
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<i>Discrimination</i>	<ul style="list-style-type: none"><li>Individuals can be discriminated against by members of their house or by others from the extended community including treating doctors or mental health professionals in hospitals, clinics and primary health centres.</li><li>This is very painful, and can cause extreme distress, particularly when it is a reminder of a difficult past.</li><li>Keep a close eye on the kinds of interactions that individuals have with each other, with you, and with the rest of the community. There is no need to be overly watchful in an obvious manner, but just train yourself to pick up small details. For e.g. slight avoidance by a member of the community, a client specifically refusing to engage with someone from the community or home or even with a particular PA or care coordinator etc.</li><li>In case this occurs, reach out to the client and have an informal chat. Scope out the situation, and see if you are able to handle it yourself, or if you need to request for support from the care coordinator.</li><li>Either way, make sure the care coordinator is informed of these situations. Remember discrimination is not always packaged the same way- it could vary from usage of harsh words to teasing, bullying, avoidance, malicious gossip and sometimes even just body language that oozes segregation.</li></ul>
<i>Suicidal thoughts and self-harm</i>	<p>Suicidal thoughts and self-harm are a clear sign of internal distress that has not been articulated well enough.</p>

	<ul style="list-style-type: none"><li>Could be either a skill deficit (the client lacks the ability to express herself adequately, e.g., speech impairment), communication issue or an attitudinal problem or perception issue (the client has the ability but is not able to express herself for fear of being judged, or if verbalising her distress is too overwhelming).</li><li>Could be either a skill deficit (the client lacks the ability to express herself adequately, e.g., speech impairment), communication issue or an attitudinal problem or perception issue (the client has the ability but Is not able to express herself for fear of being judged, or if verbalising her distress is too overwhelming).</li><li>Self-harm may appear in various forms that range from mild to severe. For eg. slapping oneself, repeated head banging, or even cutting those results in a significant amount of bleeding or even death.</li><li>It can even manifest itself in the form of prolonged periods of fasting, or the ingestion of harmful substances.</li><li>Keep an eye out for the tone of the conversations within the home, and outside. Watch for mentions of death / dying / wanting to die / feeling hopeless / wanting to end it all.</li><li>If any of the above occur, report it immediately, and then take a call collectively with the care coordinator on how you wish to handle the situation.</li><li>Do not dismiss it without raising it. This is critical.</li><li>Try to understand the cause for self-harm or suicidal ideations, and address it.</li></ul>
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<i>Acute exacerbations in physical or mental health</i>	<ul style="list-style-type: none"><li>Physical health problems are often noticeable and attention is much more quickly sought than for mental health problems.</li><li>However, sometimes it is easy to miss gradual weight loss, a low-grade fever, unnoticeable skin infections or rashes, or changes in moods that are more subtle.</li><li>Keep watch, and see if any individual seems more irritable, lethargic, or tired than usual.</li><li>Changes in one's persona, demeanour or interactions must be reported to the care coordinator who will then investigate and help the client navigate the issue.</li></ul>
<i>Death</i>	<ul style="list-style-type: none"><li>This is an unfortunate, and distressing but unavoidable event.</li><li>Given that individuals within the home are bound to have formed deep and close bonds, this is a difficult situation to manage for everyone involved, including the personal assistant.</li><li>The PA must be trained in grief counselling, and be equipped with skills in managing her own emotions. Since they are usually young themselves, structured support may be provided to them by the care coordinator or the PM.</li><li>A 'death audit' should be conducted in order to ascertain the cause of death; details of the same should be maintained in institutional records. This is a method to reflect on the nature, appropriateness and quality of care and assess if there was any negligence.</li></ul>

	<ul style="list-style-type: none"><li>The family (<i>in case they are accessible</i>), must also be informed about the demise of the individual, as must all her friends in the community.</li><li>Once the medical and legal formalities are completed, the care team must make arrangements to perform the last rites based on the individual's religious affiliation, or their wishes if stated previously.</li><li>Ensure that other residents of the home are adequately supported, and able to express their grief at the loss of their friend. This is extremely critical in ensuring they cope well and manage their feelings of loss and separation in the long term.</li><li>The death of a friend, especially for those who are elderly can trigger a sense of impending doom, and remind them of their own mortality. This must be handled sensitively. You must take care to assure the individual that she is not alone, and will always have a support system to rely on.</li><li>It is important for everyone who was close to the individual who passed, to attend the funeral unless they choose not to. That will provide a sense of closure, and ease the natural grieving process.</li></ul>
<i>Persistent Interpersonal issues causing distress/discomfort in home:</i>	<ul style="list-style-type: none"><li>Very often fights and skirmishes break out amongst people who live in close proximity with one another. While more often than not these are small issues, that resolve themselves, sometimes they can simmer for extended periods of time, and create an environment of hostility, and discomfort.</li><li>In such cases you must be careful not to take sides, as much as you may be tempted to based on proximity to either of them, or you own comfort with one of the opinions vs the other. Do not pit one individual or a set of individuals against the other.</li></ul>



	<ul style="list-style-type: none"><li>• You must try to resolve it tactfully by trying to understand all perspectives.</li><li>• See if it can be mediated by one of the members of the home without your intervention. Step in only if this option doesn't work. It may however be a good idea to suggest a brief separation, in any case, and let both parties get some space.</li><li>• If the PA is unable to do this, it is OK to reach out to the care coordinator and see if she is able to help resolve the situation.</li></ul>
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*Malar's unexpected passing away after being with The Banyan for close to ten years, brought about a morbid period consumed by grief and desolation. When a string of four people in Home Again died in quick succession (all due to various medical complications coupled with old age), people including personal assistants started “seeing” apparitions of Malar and all those who had passed during that period. Nights became tough to manage, sleep suffered and fear crept in. When all rational and scientific ways of breaking, this pattern failed, one had to seek support from the Priests across religions, based on suggestions from residents of those homes and their carers.*

*They were certain that their trauma would end only if the spirits of the dead were satiated. They wished to invoke guidance, support and blessings of the Gods such that any bad spirit or ill luck wouldn't interfere with their lives and daily routine. As we progressed with these fairly expensive rituals, each unique, based on religion specific customs and traditions, the ghosts or spirits first became hazy, and then gradually transitioned into shadows or silhouettes, until they finally disappeared coinciding with culmination of the offerings and ceremonies. When one refers to social and cultural appropriateness in care approaches, mere integration of psychosocial interventions will not suffice. Faith and culture sensitive practices that are explicitly sought by persons also have to be integrated to reduce distress and should not be condemned, shunned or ridiculed based on scientific approaches to care. By doing so, you would be questioning another's belief systems and cultural identity. Science and subjective well being, each have their place.*

Section 6: Values and Philosophical Underpinnings

Complex dilemmas

*For generations people with severe mental illnesses who are unable to care for themselves entirely and need between substantial to very substantial support, have been living either in their own homes, assisted by their families, or in hospitals or rehab homes if they are very ill or if an actively engaged and caring family is absent. Can they live in the community like everyone else with minimal support?*

All individuals regardless of their ill health, disability, cognitive and social communication deficits and impairments are thinking, feeling individuals. We must remember this, regardless of their extent of participation in society. Their aspirations and needs are just like anybody else's even if not explicitly articulated. A home, family, fun, friends, independence, relationships, etc. are not luxuries. They are basic needs that all of us should be able to access. Imagine having to live in a large institution, following a common schedule with no real opportunity to just do your own thing, whatever that may be. Or imagine feeling intimidated by fellow residents who are much more vocal than you are. Perhaps being quiet and introverted leads you to being side-lined or ignored. Imagine waking up day after day for the rest of your life and watching uniformed nurses or health workers lead you into/through your routine in a large impersonal space. These are not always pleasant experiences. Not because institutions are bad places, but because they serve a purpose and function which is different from that of a home, where people “live” their lives. People cannot make an institution their home unless they choose to, which more often than not, they don't.

Unfortunately, for years, we believed that it was in the best interest of such persons to continue to live in mental health centres, rehab homes, or other institutions, so they could be cared for. The truth is that similar care can be provided in a home-like environment which is co-created by individuals with mental health issues and their partners – be it their caregivers, organisations such as The Banyan, the state, mental health professionals, or engaged and concerned volunteers and members of society. What we essentially need to do is trust the consciousness of each individual to feel, think and be, regardless of a medical, psychiatric or social diagnosis. Based on the nature of the problem and responses, the support systems in the house, organization and community needs to gear up to enable this transition, firmly invoking their belief in the need to understand and accept differences amongst people in particular and the essentiality of diversity in life, ability and behaviour in general. If this radical acceptance is upheld, then no one will ever doubt the need for every individual, regardless of the extent of disability, to live in a home that they can and wish to call their own and thus gain the opportunity to pursue newer experiences and be exposed to newer stimuli, often resulting in newer responses. The last 18 months have been testimony to the fact that this is indeed possible. Mostly, the changes that we observe in quality, frequency and nature of interactions and the extent of enthusiasm and engagement, both on the part of the members of the homes and their neighbours or other members of that

community, are positive and remarkable. There will indeed be ups and downs, some days that go terribly wrong: angry members in homes after a showdown, maybe even angry community members following an unpleasant experience, but don't all of us in some way or the other let others down, anger others, do things that people don't like, behave in ways that others find unacceptable? Why then should just a few, who have reason to be behaviourally different, be segregated? Remember, that that person could have been you or your loved one, and still can. Pathways into distress can be sudden and dramatic and non-discriminatory. The only way we can reconcile with this sort of conflict, inequity and injustice around us, is by celebrating diversity and differences, knowing that there is a sameness that binds us, as much as we build an air of separateness. There is of course a need to appreciate individualism and uniqueness; this though is distinctly different from judging ability and people on the basis of self-imposed standards that are conformist and somewhat conservative and thus limiting.

### While philosophically, one feels good about inclusion and lofty ideals, how do I deal with someone defecating outside my house or having a sudden dip in mood resulting in a violent outburst?

Both violent outbursts and open defecation cannot be exclusively associated with behaviour patterns of persons with mental health issues. 48.3 percent of the country defecates in the open, frequent skirmishes occur in homes and in communities. Forget squabbles, how do we account for murder in the name of honour killings, female foeticide, caste-based clashes. Which amongst these are more aberrant or abnormal behaviours? Maybe we need to sit back and reflect on recent trends in India and globally, and then critically analyse our assumptions and attributions. It's more about us and our openness to experiences and diversity and less about persons with mental health issues.

### There are kids in the community. How do I feel secure if persons with mental illness live with us in the same community?

Every community in any case has persons with mental health issues living in it. At least 5 per cent of the population - about 50 million people - are affected with mental health concerns, in India. Most of them live in communities such as yours/ours. Communities that are home to kids, elderly, men, women and transgenders. How often have we heard of distress caused to children, or violent acts perpetrated by persons with mental health issues in the community? Research indicates that there is a greater chance that those without a mental illness (those considered 'normal') commit crimes, when compared to those living with one; and that in fact, people living with a with mental illness are at greater risk of being victimised and hence are more vulnerable and prone to torture and crime.

Your kids are safe. Most people with mental health issues are kind, gentle and sensitive persons who seek affection and bonding. Their interaction with you and your kids will be gainful to both you and them. Your child could well find a friend, mother- or father-like figure, aunt or uncle, teacher or a role model/ mentor. However, if the Personal Assistant or Project Manager explicitly states that your kid may need supervision when s/he visits a house to interact with its residents, then pay heed to that advice. It could well be that a particular member doesn't take to kids or has issues or behaviours that may affect a child such as masturbating in public or frequent crying spells, etc. But these are more the exception, and less the norm.

### So, are you saying that all persons with mental health issues are nice people and always kind?

No, people with mental health issues are human, like all of us. They are, yes, largely nice and kind, but they could certainly also be mean and angry, manipulative and exploitative and at times unreasonable and discriminatory. They are like you and I. As a society and race, we embody shades of all emotions, in varied proportions. Just like we seek and befriend people whose qualities endear them to us and remain a little distant from those that we think will hurt us emotionally, similarly, it's fine to bond more with persons with mental health issues that you get along better with. They are not to be viewed or seen as a group, but as individuals. And each individual is differently configured whether emotionally, intellectually, spiritually or philosophically. Strangely, in our experience, the closer a person is to a state of severe disability, with experiences of acute sadness, manic energy, or even florid hallucinations, greater the chances that the person is more real and kind. We say this without much research support and evidence, but experientially, we have observed that the further a person is from the trappings of having to belong or fit in and climb the socio-economic and political ladder, the greater the chances of their being able to embrace their personal truth, with no place for pretence or falsehood.

### Are Institutions then not needed at all?

No, Mental Hospitals and other Institutions serve a specific purpose. They respond to acute distress and psychiatric, psychological and social crises. They offer critical time interventions and service a population that need urgent and sometimes intensive care. These are treatment/care centres that should perhaps reinvent themselves to better cater to the needs of people that they are meant to serve - a need that is undisputed. A combination of factors have contributed to their present day violent image and reputation- the complex and ( to date) somewhat unknown nature of mental illness and thus an equally diverse history of experimentation, treatment approaches or care paradigms, glaring human resource gaps, deficits in value-based practice, the sheer largeness of institutions providing care, their social architecture etc. In addition, the power dynamic and hierarchical patterns in Society and life, is also reflected in such institutions and thus in the process of care provision, and nature of stigma and discrimination etc. Instances of using such spaces to tuck people away for extended periods of time and exploit a mental ill health condition for economic



gains are not uncommon, particularly in the context of women and related separation, divorce and property disputes. What is needed is an overhaul of this system such that reforms may take into account the ideal size in which such institutions may function more effectively, the number of persons they should service at a particular point and the robustness with which psychosocial interventions should be initiated. They should also revisit their goals and the measures adopted to achieve them. Justice, besides personal recovery should function as both a goal and a value. These are nuanced conversations which need dedicated time. To put it succinctly, it's never a binary position that pits institutionalisation against care in the community. Both are required at different points in time and serve different purposes.

### How do I deal with burn out, especially if I see no progress?

What you have to look for in your client/member of a house, is how she views her life. There is a strong chance that events or her life course may not dramatically change or transform into something significantly better in the traditional way. But remember, small changes are usually the most profound. So, when a member of the house wakes up by herself in the morning and bathes and dresses for the day, after not having done so in months or years, it could well be a result of the individual attention that she has received from the personal assistant or the care team and thus be perceived as a positive behavioural change, or mental health gain. There could, though, be more to it. Maybe she now looks forward to life a lot more and thus feels more inclined or motivated or prepared to go through the day with less support and more self-motivation and self-directed and mustered enthusiasm. So, her interest in her body and appearance may not just be a function of greater care and input (which it certainly is and it of course, goes without saying), but of her expectations and shift in perspective as well, as a result. This may be a philosophical and intuitive way of viewing progress, which usually works to the benefit of all concerned – the PA, care team, community and the person herself.

Using this lens, her interest in sharing stories from her past, even if not always coherently, coordinating her outfits a little more deftly, paying greater attention to aesthetics and colour more passionately, threading beads expertly, peering out of the window or door more frequently – could all be considered as acts that signify initiative, engagement and the need to give life a go. So, watch with optimism and patiently, without pressing for changes that you think are large or noteworthy.

There will still be times when you could begin to question the predicament of a few – the noises that never go away, the silence that kills and the mundaneness in their lives that you resist and they passively accept. Embrace the diversity principle and understand that needs and approaches to life are different. As terrible as it seems to you, maybe it's not all that bad for them. And if it is, and you feel overwhelmed, take a break, discuss it at length

with your care team. Do not hold back or keep it to yourself. Also, take days off, enjoy life and life at work, watch movies, chat, gossip, shop, do things that entertain you and give you pleasure. Engage and disengage as and when needed and plan schedules to accommodate this.

### How do I know how much to engage? And when?

More often than not, you will be drawn in by the resident when they wish for you to engage, either when there is an interpersonal conflict or felt need. Basic needs such as good food, clothing, leisure time, etc. are usually the same for most people. Ensure that all have access to it, regardless of their demands, or conversely, their resigned acceptance of whatever comes their way. Further, try to individualise it. For instance, someone may be used to and prefer wearing saris, while others may opt for kurtas as that's their traditional attire. Some may want to drape a shawl around their heads or shoulders for added modesty as that's how women in their milieu dress. Try and work around the individual's cultural identity and respect personal choice. Similarly, some may prefer to brush their teeth with a toothbrush and paste, while others may just use tooth powder and their fingers, or chew on neem twigs. Some may enjoy the fragrance of a soap, while others may prefer a traditional mix of besan or gram flour to scrub their body. Do not impose your views and socio cultural beliefs on them. Try to tune into their needs and mind space instead. It will vary from person to person in the house. Let them rediscover their personality in whichever way that they choose to. Clothing, cleaning, owning a house and meeting people always helps. In case of confrontations, step in if certain behaviours and their consequences surpass reasonable norms of civility. Always attempt to encourage individual-level resolutions though. One should not be tempted to conduct therapeutic sessions and intervene unless clear needs and gains can be gauged – be it the PA, the clinical social work practitioner or the psychologist.

### How do I ensure safety of the person as I'm advised to limit engagement? What about relationships and sex?

As we promote independence, our greatest barriers are our own fears and preconceived notions. Remember, all of us make mistakes in life, but enjoy the privilege of having second chances. Shouldn't it be the same for all then? So, if one of the members of a home chooses to form a friendship with a man from the community and then falls in love with him, there are three probable endings that one can visualize. One, that the love is reciprocated, in which case, we have a happy ending. However, we should also be prepared for a one-way relationship and unrequited love, or worse, an abusive relationship and exploitation. All of us are vulnerable to these circumstances. But we don't give up, do we? Why then, should others? What we can do is ensure safety as much as possible by sharing details on safe sexual practices, use of condoms and the right to say NO to sex. Discuss these issues unabashedly, particularly with women who are young. Older women might usually know practical tips and their choices might be more thought through. But then again, not always. They can sometimes be equally vulnerable. Use your intuition and experience of interaction with members of your home to share information based on perceived need.

In all cases, ensure that there is trust and that no one feels judged harshly or treated differently based on the choices that they make. Create an environment that lends itself to sharing feelings and experiences openly. However, remember that all information has to be kept confidential. Ensure that the member shares her relationship with others only when she wishes to - you cannot be the first to break the news. However, a little bit of friendly teasing as we would with our friends (especially if she seeks it out, which is also a likely scenario), is OK. But to what extent, when and with whom is something that has to be negotiated and comes with experience and perhaps has to be guided by a senior SWP. There is a thin line between intrusion, privacy, bullying and teasing. Always remember that. And do unto others as you would to yourself at all points. In the meanwhile, also remember that many of these experiences contribute in their own way towards normalising mental illness.

Typically, it's usually those who work outside homes and in factories or resorts who are most likely to pursue relationships since they have the opportunity to meet and work with newer people. Less than 1% of our clients across our centres) actively seek new relationships of a non-platonic sort. As much as we would like most people to have special friends, remember that previous history with unsuccessful, stressful, harmful and violent relationships may also come in the way of developing a new relationship. As does the extent of disability. Do not push or encourage people to seek out relationships. On the other hand, if they do pursue it, (unless they are visibly or potentially dangerous) merely observe and share only with your care coordinator, so you can support them when required. If a person from the community questions you on the relationship, which they may, indicate that it is well within any adult's right to pursue relationships and sexual independence. Balance the discussion or argument keeping in mind political and cultural sensitive practices and individual rights. While doing so, be calm and aware of the socio- political and cultural context, in which you, members of the houses and others live. Typically, as much as we appreciate and advocate the need for individuality and free expression, equally, we understand and realize the comfort drawn from complying with social sanctions and cultural appropriateness. Again, it isn't our place to defy norms if the people that we serve and the community that we are located in, thinks otherwise. It should however be clear that organisationally, our stance is to respect individual need and desire, regardless of dominant trends. One battle at a time!

### How do I deal with an unwanted pregnancy?

The need for love, intimacy, and a sense of belongingness, are amongst the most primal instincts experienced by a human. It is only natural that we seek this out, and sometimes make the joint decision with our partner to have a child. In some cases, things, don't go as planned and one is left dealing with either an unwanted pregnancy or with a child out of wedlock. In the case of an unwanted pregnancy, immediate medical support needs to be sought from a gynaecologist. In the case of sexual abuse or rape, if the person so desires, that the perpetrator(s) face the

consequences of the crime, legal action needs to be initiated in consultation with the individual concerned. In the event that the individual chooses not to press charges, clearly communicate all implications and make her aware of her rights.

Your immediate effort should be towards supporting the individual through the psychological distress and trauma that she will face which may further compound or exacerbate her existing state of mental ill health. Following therapeutic support that you will extend and medical advice on termination, safety issues need to be discussed with your client in the presence of her care coordinator, counsellor and close circle of friend(s) (if she so desires). In the event that she goes ahead with the termination, offer all support through the process, and thereafter, for an extended period of time, since impact related to loss of a child is known to influence moods, not just in the short term. Be prepared collaboratively for any repercussions at the community, medical, and individual distress levels, and train the personal assistant and her group of confidantes in mental health first aid.

If she chooses to keep the baby, despite counselling, clear communication on the violative nature of the crime committed, and resulting pregnancy should be shared. The responsibilities of bringing up a child as a single parent should also be discussed, so the person weighs all pros and cons before arriving at a decision. Her psychiatric medication will have to be reviewed and perhaps titrated and even stopped in certain situations (please refer the medical management protocol). This is a sensitive issue where the rights of the individual, and her personal preferences may seem in conflict with what clearly seems like coherent medical and psychological advice. Until the end of the first trimester, keep offering her frequent inputs and support as you continue to discuss the consequences of her decision and future. She may well decide post the first trimester to abort the child and in those circumstances, one can refer to the supreme court order on medical termination of pregnancy for victims of rape (*Medical Termination of Pregnancy ACT 1971*).

Once she delivers the child, ensure she is nutritionally and psychologically, supported in every way. Ensure there is no loose talk or character maligning, at either the organisational level across cadres, or amongst other stakeholders including members of the community. As much as the child's nourishment and growth is critical to both the mother and child, equally parenting patterns in terms of breastfeeding, bonding etc., also have to be observed, especially since both rights of the child and the mother have to be balanced. We advocate that the mother and child not be separated under normal circumstances. In the event of, abuse or neglect, one may need to seek support from the Child Welfare Committee, and even resort from brief to long periods of separation and in some instances, options of adoption. If positive attachment and nurturing patterns are observed, then do all in your power to ensure a good life trajectory for the child, and perhaps transition from the present home into another house, where just the mother, child, and another close confidante / caregiver can cohabit, such that personal attention may be provided and conflicting inputs from multiple caregivers/ persons avoided.



It may also be likely that some of these women who do not have or have never had children also pine for them, and feel the intense need to be mothers. In this case, some of these women may express a desire to adopt a child. This is a complex issue and should not be brushed aside. It would be a good idea to have continuous sessions with the women, to ensure consistency of intent, and simultaneously reach out to the child welfare committee (CWC), and local child rights organisations should be consulted as well.

### What about suicide?

Suicides are committed in both institutions and homes, for varied reasons; a few reasons are now clear while others still open to debate. Health and mental health issues contribute significantly as do other critical events such as relationship issues and breakdown, one's socio-economic context, abject poverty, loneliness, experience of multiple losses and failure, a sense of hopelessness and alienation etc. One cannot lock up persons in distress fearing they that may kill themselves. The lives they live in locked spaces could be much worse than death. And chances are that one can feel distressed enough to attempt suicide even without a mental health issue. It is far more beneficial if one addresses concerns around core issues that may influence suicide attempts, for example, poverty, interpersonal conflict, ill health and helplessness associated with what is viewed as social failure. Isn't it strange that most of these factors require a systemic-level change in thinking, behaviour and policy for people to feel safer, unconditionally accepted and better resourced. It's really time to dive deeper into these society- and state-level failures to care equitably and compassionately for people's physical, social, economic and psychological health.

What about the thin line between safeguarding privacy and fostering bonds? How do I deal with nosy neighbours?

Again, let members of your home negotiate their way around their relationships. They may weigh the pros and cons of their engagement with a neighbour and indeed forsake typical notions of privacy and trade personal secrets willingly and sometimes a little too easily for affection. Without forcing your view or being too controlling, attempt to balance the need for socializing, affiliation and companionship with gentle forms of restraint around full disclosure. However, it is important to remember that total trust can also actually serve somebody well. We have unfortunately been conditioned to safeguard ourselves from others, a behaviour steeped in a culture of distrust. This quality of openness may serve persons with mental health issues favourably. Perhaps we should aspire to emulate these behaviours of being more open, spontaneous and less guarded.

As much as we may buy into the need for this paradigm shift, equally, we may also need to ensure that perceived vulnerabilities of those with whom we partner with and care for are not exploited, simply because we are led by our ideology of limited engagement. Even as we exercise self-control when tempted to over engage, equally, we must proactively engage when required, especially when it is clearly in the best interest of the client. Tuning in and using your intuition is the best way to decide when to intervene and to what extent.

### These are difficult choices. What part intuition, what part training or protocols should we apply?

Much of the battle is won if we choose the right team members, be it the mental health professional or in particular the PA. Usually, those who find meaning in this work and begin to enjoy it, thrive and even grow as a person in the process. Such persons remain committed to the programme and individuals in the homes over extended periods of time. Those who do not align themselves to the values that this approach promotes for whatever reason, typically choose to part ways within the first 6-8 months. It could also be that they found the work too distressing. Do not sit on a moral high horse and judge others on their ability to stay but be aware that finding the right people who will remain committed to this goal as fervently as you desire, is not as simple as it seems. Training helps, but much of the perspectives develop and/or are cultivated on the job. Thus, training in this context uses a lot of reflective practice and reflexive methods.

Encourage all your PAs and care team to sure, go by the book, but at the same time, top it up by listening to their inner voice with great honesty. Train them to respect and value their gut feel and inner consciousness when required. In a milieu where values play such a critical role, intuition always helps. As much as we recommend adherence to protocols, especially in the context of medical management, equally, we suggest that you tap into your intuitive abilities to pull out all your strengths to support the individual. Tune in to their needs, expressions and language, verbal or otherwise. This also trains you to be more observant and responsive.

Strategies that aid in building strong intuitive abilities vary from individual to individual. They include knowing oneself well and taking time to understand and think through events and behaviour, tuning into one's own emotions and deconstructing experiences, impulses and actions, being open to experiences, taking a keen interest in people, communication and deeper level emotions, seeking an environment of quiet and calm to introspect, writing, reading, spirituality, the practice of mindfulness etc.

Since the PA is pretty much a roommate to the members of the house, their interactions with other members, and with neighbours or members of the community at large are of great consequence. It must be reinforced at all points, that they are indeed part of the family and that no personal detail should be shared or disclosed in a manner that is undignified, gossipy or voyeuristic. This training is again value based and has to be encouraged by the care team collectively, largely by modelling. Not just verbal communication, but non-verbal cues, messages and the like should also be self-monitored and regulated. These are difficult practices for many of us who are culturally entrenched in a philosophy or ideology of “share all freely”, especially when it's someone else's life and quite not the ordinary. Self-control must be exercised in these contexts and sensitivity to the rationale behind doing so discussed and reinforced.

### What if one of the members of my house opts to work for free or half the market salary in a neighbour's house?

This is highly probable and will have to be tackled on a case to case basis. A few residents may opt to trade money for companionship, home-cooked food, a joint outing, male company, the idea of spending time in a neighbour's house that reminds them of their own family, etc. This is their choice. Unless, this is forced, it doesn't qualify as exploitation.

One can of course educate those who are employed or engaged in any work at home or in others' houses, resorts, garment factories, or other industries, on basic wages, labour laws, their rights at work places, etc.

### What about issues of privacy? Are fictive kinships really formed? Do all members of the house mimic the ideal of a family?

Privacy means different things to different people. In Indian contexts and amongst people that we service, privacy seems overrated. While a few need their “me/ I time” and don't want others in their face, many dislike isolation and quiet. In an almost unbidden manner they gravitate towards where people and noises can be found. Regardless of the extent and depth of interaction, the sheer presence of familiar faces and voices seems to have a positive influence on many. Nevertheless, it doesn't hurt to introduce people to personal spaces and personal time for them to use it the way that they choose to. Fictive kinships form in ways that are subtle. For example, when a member of the house falls ill and moves into a hospital, one will soon find other members seeking her out, enquiring about her absence or health; even those who rarely speak and seldom display mainstream sophistication in conversations. Or for that matter when a working member is returning home late from work, a sense of unrest prevails until the person is home.

Even in regular families, it is in these subtle, unspoken gestures that one finds and looks for love and a sense of belonging. Equally, conflict and friction play an important role in almost all relationships. Some altercations escalate into serious interpersonal issues, but most settle after a while and members resume being friends, or a sister or mother to others in the house. These of course could recur from time to time. However, if the damages after a disagreement are irreversible, then either the member seeks a shift herself or the PA suggests the situation be addressed and reviewed by a MHP. It doesn't help to be around people you don't really get along with, in any family or family-like structure.

### How do we view mental illness, and understand human rights?

We believe that mental illness exists. We have seen distress of the worst sort experienced by persons that we have cared for. Some of them hear voices that cause pain and agony. These range from the sound of buzzing bees to the holler, shrieks and visions of people burning themselves. Others hear condemning voices that urge them to commit suicide. At the same time, we have also witnessed the highs of friendly and reassuring voices that have

lent support to persons with mental health issues when all resources and support networks have either been scarce or lost. A few others report experiences of low mood and a persistent feeling of helplessness and hopelessness - all that they can see and feel is gloom. Not all these experiences are located exclusively in the brain. Critical events such as childhood trauma, conflict, scarcity and violence often precipitate and perpetuate these forms of distress.

Often though, these experiences are clustered on the basis of signs and symptoms that include a change in pattern or concern at mood, perception, and behaviour levels. This results in what are typically referred to as cognitive biases, cognitive distortions, emotional dysregulations and maladaptive behaviours.

While symptoms and arriving at a diagnosis on the basis of these thoughts, beliefs, feelings, and behaviours, and thus attitudes and approaches to life, can be classified into diagnostic categories on the basis of standardised systems including the ICD-10 and DSM-V, into severe and common mental disorders), our approach to understanding these syndromes, behaviours or diagnoses integrates psychopathology and biomedicine on the one hand, even as it takes into account the social ecology and social causation patterns of these disorders, on the other. Meanwhile, in the Indian context, which is home to 17.5% of the world's population, approximately 70% lives on less than USD 2/day, and 37% on less than USD 1/day. Less than 1% of the health budget is allocated towards mental health, nearly 65-70 million people are estimated to have mental disorders and the estimated treatment gap is close to 90%. Access to material networks is poor; at the same time a significant percentage of the population is resigned to accepting a continuing condition of poverty, inequity and injustice. Structural barriers that accentuate a sense of otherness include poor gender consciousness and parity, resulting in physical and sexual violence, poor workforce participation, and limited or no access to resources. Similarly, class and caste barriers persuade loss of hope, identity and social capital, negatively influencing diverse domains such as nutrition, education, work and relationships and thus social life trajectories.

These harsh conditions could precipitate a further slide into abject poverty and result in an experience of social drift. On a psychological level, this slide actuates a state of withdrawal from society, community and self. In these circumstances persons who are subjugated, repressed, under-resourced, abused, discriminated against, and robbed of the opportunity to express their thoughts and views freely, feel further excluded and isolated, and suffer devastating consequences at bodily, emotional and spiritual levels.

Besides lower life expectancy, concurrent physical health conditions (Prince et al., 2007), higher rates of unemployment, lower incomes (Levinson et al., 2010) and greater risk of homelessness, lives of persons with mental health issues are further compromised by widespread stigma and discrimination. Which brings us to the



world of human rights. The notion and articulation of rights in the landscape of choice and autonomy should ideally also include the critical access to health care and other basic amenities such as adequate food, income and housing. In the absence of doing so, structural barriers that induce the downward slide, persist and continually inhibit one's drive to achieve one's fullest potential.

There are arguments that no person should, under any circumstances, be involuntarily committed to any health care facility and/treatment. At The Banyan, we feel this is true under ideal circumstances. However, our residents do not have the privilege of ideal circumstance. Our residents are in a state of siege and crisis. Our goal is to facilitate our residents' journey from a state of crisis to stabilization so that they may be able to make choices for their own life. In this way, we believe that the right to care precedes the right to self-determination.

We prioritize the right to care over self-determination because we approach service and care of mental health issues from a systemic perspective. We embrace the concept that personal experience is the result of complex interactions between systems whether they are the natural environment, society, government, families, etc. In this way, we reject the notion that mental illness is solely the problem within, or of, an individual person. Mental illness is also a product of a larger interaction in society, and between the individual and the various systems they inhabit. Therefore, the burden of mental illness falls on the most marginalized and vulnerable members of society

The Banyan however follows international trends, legislations and best practices including the UNCRRPD (adapted to suit our context) that has rightly focused on persons with psychosocial disabilities as subjects with rights and not as objects unto whom charity is done. Much of our understanding and practice of human rights is led and driven by service user feedback and individual need and context. The principal tenets of the UNCRRPD such as participation, inclusion and a sense of agency are not just critical to PLMI but to all, and this we subscribe to. Basic human rights mandate that all individuals should enjoy equal access to food, housing, and shelter, besides being able to express oneself socially, culturally and politically. Unfortunately, some of these rights are often violated due to societal attitudes, power structures, growing inequity and the inherently flawed nature of human beings.

We necessarily have to recognize that some, perhaps many, persons with mental illness have experienced isolation, segregation, violation or a forcible expropriation of rights. History influences current legislative reforms and practices and while patterns of abuse do not continue exactly in the old Victorian asylum or poorhouse mode, they can be still be globally observed in their own oppressive ways across multiple socio-cultural contexts even today. One must remember, that as much as rights have to be preserved and promoted, equally does life and diversity have to be celebrated, and to do so, one necessarily has to draw upon the value of interdependence.

In this context, the Home Again approach refers to the biomedical and psychological models when required, and draws from approaches, treatment and care paradigms that make useful interventions. Based on the hypothesis of the social context contributing to a state of distress, significant emphasis is placed on input at this level- addressing distress that could have emanated from a sense of scarcity and segregation. Hence, the thrust on two critical components - housing and access to support networks. This approach works towards securing movement and progress toward goals in the hierarchy of needs, ranging from essential safety to the ability to form healthy bonds and relationships, deriving a sense of economic self-reliance, a sense of well- being and personal meaning.

An explicit articulation of values

Using case studies, we have tried to demonstrate some critical principles and standards that we attempt to inspire amongst our staff. You may also find them useful.

Celebrate sameness, diversity and uniqueness:

Imagine a community in a rural space. Small, pink and violet houses that share walls. Typically, individuals residing in these families with homogenous characteristics talk, think and behave somewhat alike. They know no other way. A house in the midst of these has members who are seated glued to the television set, watching the risky stunts that their favourite star performs in a new movie. Seated in the little drawing room, on the pai, is a young village girl who is in her first job as a PA, confident and very much at home, seemingly the head of the family, and yet the youngest. She is bossed around affectionately by a much older co-member, Ms. 'X', considered to be intellectually disabled, speaking Tamil with a heavy Hindi accent. The paati (grandmother) of the house is as engaged in the thrilling movie sequence. Considered the wise one, she thinks of the young PA as her granddaughter, and others in the house as either her children or sisters. She also happens to be diagnosed with Schizophrenia. The neighbour who sits watching TV with members of this family can't stop talking about this young star who has a huge fan following amongst girls her age. She mentions her hectic schedule in college and shares her aspirations to join a popular accounting firm. Meanwhile, a little boy from a few houses away plonks himself in the lap of the paati. Ms. 'X' pinches his cheeks, partly to playfully irritate him, and partly out of affection. Lazing around the house is also the neighbourhood dog, who goes into an ecstasy of wriggling, lying on his back.

Each member is distinctly different from the other and yet connected by their sameness. Each member expresses herself uniquely, not intimidated by the norms that many of us abide by, and sometimes forcefully impose on ourselves and others. These are homes, like the other violet and pink ones, different only in that they have opened themselves to different shades and experiences that the members chose to paint it with.

In the process, fictive kinships have developed; *paatis* and *akkas* (sisters) have bonded; friends have laughed, shared and fought; and a family has come together, forming a collective identity that it cherishes.

**Celebrating imperfection, invoking empathy and embracing radical acceptance:**

'T's childlike demeanour and speech allowed her to mix well with the kids in the neighbourhood. Every evening, she would run out to play with the kids in the quaint village, Vadanameli in Kanchipuram district. One unfortunate evening, she had a disagreement with a child of almost the same mental age as her, and they engaged in fisticuffs. The women watching this were astonished and horrified. 'T's adult size did not favour her and they accused her of being violent and asked the PA to send her to a 'mental' hospital. This incident also led to other mothers from the neighbourhood keeping their children away from 'T'. Her insistence on playing with the children and the mothers' resistance caused 'T' to express her unhappiness the only way she could -- crying, screaming, even disrobing -- shocking the people in the community even more. The best possible decision the care team could make at that time was to move 'T' away from this community that was rejecting her.

However, as days passed, the community began enquiring whether 'T' was well and wondered if she could return. Women in the community missed her antics and the kids often visited her home, hoping she would have returned. The radical acceptance and empathy displayed, showed that the community had realized that 'T's core was more than what she had displayed, more than her disrobing and agitation, and more than her mental age. They realised that she may never 'fit in' in the typical sense and behave in a consistent, socially acceptable manner. Regardless, they believed that her engagement meant something. She wasn't like them, she wasn't perfect ( nobody was/is really!) and yet she was someone they wished to know and build experiences with. Embracing imperfections in others and in life is a sign of maturity and tutors you to embrace the same in yourself. Kindness originates from this process.

While working with persons living with mental illness (PLMIs), especially in the context of homelessness and poverty, it is important to not just feel one with the person but realize that there is a sameness in all of us that needs to be fostered. Unconditional support will help people understand one another and form relationships based on trust and interdependence.

**Challenging social order**

'G' is a young 35-year-old woman, living with five other women in a one-bedroom house in a picturesque fishing village in Kanchipuram district. One morning, when a social worker visited their home, the PA reported that 'G' often tore her pants between her thighs. The social worker had a private, informal chat with 'G' and asked her if she was doing so to masturbate. She nodded shyly. The social worker normalized this act, knowing that it was a natural and healthy process, and explained that she could choose a safe place to gratify such urges, such as a bathroom. The next day, during follow-up, the PA reported that 'G' was no longer tearing her pants, although she didn't know why. She never ever tore her pants again

A woman was encouraged to be mindful of her bodily urges and enjoy and celebrate her sensuality, without experiencing a sense of shame or judgement, in an environment that otherwise may have been condemning of such acts, particularly in her socio-cultural context. Similarly, instances of same sex preferences or relationships, premarital relationships, or casual sex partners may occur and the individual must be supported through the phase of challenging societal values, with reason of course.

Inculcating a climate of trust, free expression and personal recovery -- Promoting Control, Choice and Agency:  
Developing a sense of agency in treatment is not the only route to self-healing. Choices for well-being are made everyday when individuals decide to visit the beach, work, meet a friend, visit a religious place, practice spirituality and/or make a decision to engage or withdraw. As a care team member, it is important that you value these choices, just as you would a professional's advice.



Devi was diagnosed with depression 10 years ago. She was treated for a while with antidepressants. Four years ago, Devi decided to stop her medication after she realized that her low moods were always related to psychosocial stressors and triggers. She had an honest chat with her care coordinator and psychiatrist, and indicated that irrespective of her medication, she always had a relapse when her social environment changed. This was a challenge that she felt she needed to overcome, she used her own version of what we refer to as mindfulness as a strategy to influence her thought processes and associated feelings. It has been four years since she stopped her medication. Like everybody else, distress has come her way, and she has found effective methods to manage it, each time. Either by herself, or by reaching out to her friends and family when she needed it. Understanding complex processes around sadness, emotional regulation, coping patterns, and everyday life, Devi took a conscious and informed decision to face her distress head on, somewhat gingerly and yet intuitively.

Life is tough! All of us know it. Whether or not we make sense of it, one way to get by is to live in the moment and look forward to small joys and celebrate every occasion that comes our way that is even remotely positive. This stimulates the senses, helps counter negative thoughts and barriers and gives us something to look forward to -- a future, a plan, some goals. Sometimes this can be facilitated in simple ways, like in the case of P's home. 'A' (the PA) found that all the members of the home were bored with their regular vocational training tasks, making baskets or identical pairs of earrings. She sat down one evening with some beads and string, and figured that she could make other types of jewellery. She excitedly gathered the rest of the members and showed them her innovation. They all grabbed the material and enthusiastically began trying it out. A few weeks later, a care coordinator visited the home. 'C' and 'L', two women diagnosed with intellectual disability, ran up to her and said, "Look at what we can make for you!" They made a necklace for the care coordinator and put it around her neck. They said that they planned to talk to the VT instructor and make this a regular task.

This move away from routine, and attempting the unattempted, brightened up their spirits and gave them an opportunity to explore their potential much more robustly.

Similarly, the applause at the conclusion of a finished product during vocational training, or the cheering after a successful hosting of a gathering, and even continuing to care for plants in a garden are important transactions that promote aspiration. Encouraging individuals to feel that sense of accomplishment through simple gestures, and to feel a sense of contentment at the end of a task are important and must be focused on. More often than not, when this is done, the joy is contagious! Small tasks, and yet large outcomes!

## Sustained engagement, responsiveness and accepting pain and distress

'M' is tall, well-built, funny, quick-witted and does well in diverse social situations. However, on her bad days, her distress can be so palpable that it moves the onlooker. She screams and argues with her hallucinations, often using unpleasant words. While initially the PA and the neighbours were taken aback by this shift in persona, they have now come to accept M the way that she is: they realise that she has lived through undesirable experiences, and that distress is a natural outcome of that. Thus, life goes on as usual -- kids continue to visit, neighbours continue to engage her in light banter, and her housemates manage the home until 'M' deals with her agony and bounces back to resume her regular life.

Though 'M's resilience is unfathomable, the PA and care coordinator attempt to foster this by normalizing her distress, while still ensuring she has a safe space to cycle through this phase and regain her stability. Owing to the nature of her illness, 'M' moves between good and bad days. The care team ensures that they support her by remaining engaged.

Similar forms of engagement and responsiveness are also seen in situations that are less pathological and more everyday concerns, such as poor financial resources to sustain the family through the week, or interpersonal conflict with a housemate.

## Building a culture of interdependence

'C' lives in a house with four other women and a PA, 'A'. One morning, C woke up and realized that 'A' had left to visit her family back home. 'C' enquired about 'A' with the PAs in some of the other homes in the area. A week later, when 'A' came back, 'C', annoyed and with much authority, questioned her, "Where have you been?" A smiled and said, "I went home, my parents missed me." 'C' was relentless. "Why didn't you let me know you were going? How can you just leave?" she asked. 'A', taken aback by 'C's affection, masked and expressed as anger and complaining, said she was terribly sorry and gave her a hug. She later reported at a team meeting that every time she went home, she talks so much about 'C' and the others, considering they have become so a part of her life. They have all been invited to visit her family in her village recently. 'A' said that she realizes how much she loves them, every time she takes time off work

This culture of interdependence, with each offering the other some form of emotional support, is emblematic of the bonds fostered in the 'Home Again' project. Contrary to the notion fostered in schools and textbooks that advocates for a professional distance between a mental health practitioner and the client, we see that organic bonds such as that between 'C' and 'A' bring about more lasting change in the mental, emotional and psychological well-being of an individual, while also reducing burnout and exhaustion rates for the practitioner.

Respect and Dignity

Last, and perhaps the most important, is levelling the playing field between a professional and a client, treating each individual with respect and due importance. Small acts can show respect, or emphasize the lack of it.

'D' was a PA supporting five residents. They shared their living and eating spaces, made trips together to the beach, to movies and to dinner outings. Yet, it was noticed that on occasion, when members at home had conflicts and arguments or didn't complete their chores, she made them knock their knuckles on the floor, much like we might see young children being rebuked. The care coordinator enquired about this and found that 'D' had no intention of harming the residents, but was simply encultured to act that way. She was asked to stop this practice, with the explanation that these were 40 to 45-year-old women whose behaviours were unintentional, secondary to intellectual disability and thus needed to be managed differently. She was also offered support during such incidents, if she needed them

Section 7: Monitoring and Evaluation

Supervision of programme

Monitoring of the Home Again programme is essential considering that it involves people with substantial long term care needs transitioning into communities. Focus on safety and promotion of well-being continue to be central to this process.

Below is a suggested schedule for supervisory visits by different staff from the care provision and administrative team

Type	Content	Frequency
Home Visits by Case Manager	Enquire general well-being and comfort of clients  Discuss significant issues or events that residents and PA would like to flag off  Review general hygiene, health status and availability of assets for all residents  Discuss and review dynamics and interpersonal relationships within house and with neighbourhood  Engage in conversations and collaborative activity Reports are filed weekly with Project team	Weekly
Home Visits by Program Manager	Focus group discussions with residents  Enquire into general well-being and comfort of clients  Discuss significant issues or events that residents and PA would like to flag off  Review general hygiene, health status and availability of assets for all residents  Discuss and review dynamics and interpersonal relationships within house and with neighbourhood  Gauge participation, cultural resonance and social mobility of residents with respect to various facets of life  Problem solve and co-plan interventions with care coordinator, residents and personal assistant	



Type	Content	Frequency
	Home owner and neighborhood relations  Reports are filed weekly with Project team	
Home Visits by Nurse	Enquire general well-being and comfort of clients  Review in detail hygiene and basic health parameters - record vitals as per schedule  Review medication stock, storage and consumption  Review health interventions for special cohorts - low weight, diabetes and so on  Offer health interventions at home - depot injection, redressing of wound and so on	Weekly
Psychiatrist Review	Clinical review of resident's symptoms, disability and side effects in an outpatient setting	Monthly
Ethnographic Observations	3-4 hours of largely non-participant observation, to cover all homes and various days and times  Reports are filed with Project team within a week of observation	Fortnightly
One on One Meeting with Personal Assistant	One on one session by Program Manager to reinforce knowledge and skills, appreciate work that has been carried out well and innovations, specific cases and instances are discussed, challenges and difficulties, personal areas of growth and change are reflected upon	Fortnightly

Type	Content	Frequency
Team Meeting	Review house by house and resident by resident, weekly update of what is going well and not going well  Review significant project processes and protocols - challenges  Group discussion to collaboratively problem solve, coplan individual and group level interventions and activities	Weekly
Project Lead Oversight	Clinical reviews by Project Lead with resident, care coordinator and personal assistant - offering inputs for individualised care and special interventions  Visit all homes, conduct focus group discussions with residents and review: 1.general well-being and comfort of clients 2.significant issues or events that residents and PA would like to flag off 3.general hygiene, health status and availability of assets for all residents 4.dynamics and interpersonal relationships within house and with neighbourhood  participation, cultural resonance and social mobility of residents with respect to various facets of life  Check all files and registers - core health and social care related - to gauge adherence to service minimums in terms of quality and quantity  Focus group discussions with personal assistants - address their personal distress, challenges on the job and growth needs	Monthly - Stepped down to Bimonthly after first 6 months and Every quarter thereafter

Type	Content	Frequency
Administrative Oversight	Member of Administrative team visits all homes and review significant repairs and maintenance work if any and access to minimum assets for residents	Monthly
Cross-site Meetings	Review progress at each site, successes, challenges and lessons - to promote cross site learning  Discuss future plans for the Program	Biannual
Human Rights Committee	Overall audit of services, review significant and critical events such as deaths, hospitalisation, offer residents or staff who want to register a violation anonymous and safe space to discuss, probe into incident and recommend corrective actions	Monthly
Peer Reviews	Peers from another site or living independently review the functioning of homes and offer their impressions, insights and feedback to improve the program	Biannual

Outcomes need to be understood at three levels:

- The individual level* where impact on disability, quality of life and community integration needs to be understood in depth, in order to understand mental health and social inclusion gains. Besides scales, observations, interactions with clients, home visits, outings, field notes and FGDs with PAs hugely aid to deeper understanding. Typically, gains reflected or observed could be seemingly small, but their impact in the larger scheme of things, usually profound. This understanding is crucial and thus qualitative methods of data gathering.
- The community level* where members in houses through their interactions and participation could influence discrimination pathways and other such barriers. This is an opportunity to deconstruct and better understand stigma in more granular ways. Some of the questions that we may find answers to include- what influences attitudes? When do we see changes? Are these changes initiated by the PA or the resident of the house? What sorts of behaviour promote inclusion? How exactly is stigma built or mitigated? What influence do these interactions have on behaviour and thus the process of inclusion,

acceptance and social mixing? Does this further impact help seeking behaviour?

- The systems level* where it is important to understand the efficacy and effectiveness of this intervention (in the real world) in order to be able to generalise results and take the approach to scale it across multiple sites. Favourable results at this stage could help advocate strongly for progressive reforms and policies in servicing this very vulnerable population.

Some of the measurements and inquiries at the individual level:

- Quality of life:* One of the aims of the home again project is to create a better living environment, and inspire gains that one would associate with it, such as participation, agency, well-being etc. The desire to belong to a community, and live within a home of one's own is in all of us. Does doing so improve our quality of life? Assessing whether it does and how using standardised scales pre-and post the housing intervention will help us quantify the extent.
- Development of identity, self-reliance, autonomy and interdependence:* These are attributes that signify a state of wellbeing - qualitative methods are used to understand changes at these levels. Typically, self-care and culture appropriate behaviour, personal choice based decision making abilities, acumen and instances, patterns in interpersonal relationships etc. are observed and studied.
- Disability and functionality:* Does the intervention influence a decrease in disability, increase in level of functionality, and positively impact community integration? If so, to what extent and how?

Inquiries at the community level include:

- Knowledge, attitudes and practice:* Does the experience of interaction with a member of the home positively influence one's attitude and behaviour in the community?
- Nature of stigma:* Is the nature of stigma dynamic and dependent on multiple variables and not on a single, linear pathway? Will stigma levels change, and practices improve?
- Influencing attitudinal / societal transformation:* Does this have implications at the public service messaging level? If yes, there is strong potential to address attitudinal barriers differently.



1. Efficacy and effectiveness - systems level transitions:
  1. *Cost effectiveness:* Sustainability and resource optimisation is fundamental to planning and execution of mental health interventions in low resource settings. It will lead to expansion of services, and thus the opportunity to impact more lives. Cost effectiveness needs to be measured across programmes and over a period of time. However, it is important to note that this does not refer to absolute costs / economic costs alone, but must include quality, outcomes, and value.
  2. *Scalability:* Generalising results from the trial stage to understand its impact and effectiveness in other scenarios is equally critical. Thus, the need to de-contextualise and re-contextualise.

Both qualitative and quantitative methods are used to gather information. While quantitative data is objective, the nuances are measured using qualitative methods. Data gathered serves not just research goals, but also helps consistently monitor programmes and understand challenges and successes on an ongoing basis. They serve as continuous feedback loops that ensure quality, robustness, and add layers to programme level capability. Furthermore, much of the personal assistant's or mental health professional's training and reflexive practice ability comes from field note taking followed by reflections and discussions both independently and as a team.

### How is data is collected?

Data is gathered using the following mechanisms:

1. Peer led reviews: Observations and feedback from a committee of three- four individuals/ experiential experts, having attained a state of personal recovery and currently operating as peer counsellors or mental health advocates.
2. Ethnographic observations: Participant and non-participant observation methods and field note taking by mental health professionals (*including personal assistants*).
3. *Notes from files/records:* Data regarding everyday transactions are recorded in files by any/all members of the care team and thus form a valuable data source.
4. Standardized rating scales: Use of paper-pencil tests that have been developed to conceptualize specific variables within a said context.

### How is data recorded and maintained?

Data is recorded using printed forms and is later transferred into electronic records by a data entry personnel. Anonymity and confidentiality is maintained during the process. Further to ensure reliability, validity and authenticity of data, independent teams of researchers, triangulate information collected through questionnaires, scales, and interviews with other sources including care coordinator logs and client files. Data entry errors are also accounted for through member checks, and random matching and comparison of entered data with original document.

The table below provides an overview of the methods used:

Domain	Variables		Frequency
Community functioning	Home, Social and Workplace integration (Independence in daily life, Social network, Meaningful activity etc.)  Spatial mobility and social-economic transactions	Community Integration Questionnaire (CIQ) (Willer et al., 1993)  Sociometry exercises	Half Yearly
Psychological health	Symptoms  Disability (Cognition, Mobility, Self-care, Getting along, Life activities, Participation) Wellbeing  (Engagement, Relationship, meaning in life, Mastery including self-efficacy, self-worth, Autonomy)	Modified Colorado Symptom Index (CSI) (Conrad et al., 2001)  WHO - Disability Assessment Schedule 2.0 (WHO-DAS 12)  Brief Inventory of Thriving (BIT) (Su et al., 2014)	Half Yearly

Domain	Variables		Frequency
Quality of life	Subjective and Objective Quality of life	Quality of Life Inventory (QoLI - 20) (Uttaro et al., 1990; Lehman et al., 1996)	Half Yearly
Stigma and Discrimination	User Anticipated and Experienced Stigma and Discrimination	Discrimination and stigma scale (DISC 12) (Thornicroft et al., 2009)	Half Yearly
	Intermediaries knowledge, attitudes and practice related to mental health	Attitudes towards mental illness (Rosenheck et al., 2014)	
Service Evaluation	Service use and cost effectiveness - housing, hospital, vocational, social care, emergency, care coordinator contact, levels of support  Housing satisfaction and Choice  User perceptions of recovery and perceived support from care coordinator	Service Assessment Framework (SAF), Composite indicators and checklists for tracking service level and use, Costs from accounts and administrative records  Housing satisfaction and choice inventory  INSPIRE* (Williams et al., 2012)	Half Yearly

Qualitative methods	Domains/description	Frequency of administration
	Peer led reviews	
Observations by individuals who have attained personal recovery	These Individuals spend a day and night in homes and observe interactions between members in a house, engagement levels, opportunities to participate, quality of life, general mood, social inclusion opportunities etc.	Once in three months

Qualitative methods	Domains/description	Frequency of administration
Ethnographic observations	<p>Participant and Non-Participant Observation and field note taking coupled with in depth interviews, focus groups discussions etc.</p> <p>All notes are transcribed, coded and clustered thematically both using CAQDAS (computer aided qualitative data analysis systems), and if preferred manually.</p> <p>Ideally A 100-120 hours of observation will be good.</p>	Once in three months
Field notes (PA and care coordinator)	Observations and journal entries are maintained by the PA and care coordinator periodically.	Every day

Additional data is maintained by staff on:

Housing stock	Weekly updates
Housing occupation status	Daily and weekly updates
Clinical and social care transactions	All reviews and follow up, hospitalisation, outpatient service use, special interventions, social care facilitation, home visits, reintegration attempts etc. are all domains that are updated once a month.
General health updates	Fortnightly updates (including special interventions for anaemia / diabetes etc.)



How do you review programme progress, and challenges?

Weekly review meetings are held with:

- 1. Residents of the programme: Meetings with a single representative from each house (chosen on a rotational basis) are held each week with the care coordinator to gain insight into every individuals' experience at the Home Again programme. This offers a more nuanced understanding of some of the micro-changes that an individual may undergo. Aspects such as quality of care, access to food, experiences of cooking, interactions in the community, outings and leisure, work, relationships with staff, etc. are all discussed in detail. This allows the programmes staff to understand the nature of progress (or lack thereof), highlights, and challenges experienced.
- 2. Personal assistants and care coordinators: These meetings are held either, at one of the homes, or outside at a more neutral location such as the Home Again local office space. The purpose of this meeting is to problem solve at the client level, ensure clinical supervision is adequate and effectively carried out, introduce and plan newer and more innovative interventions, and ensure aesthetics of the home are well managed, and in sync with the individuals residing in the respective homes.
- 3. Programme leads: Programme leads have weekly review meetings to resolve human resource issues, manage and revise budgets, reconcile accounts and monitor fund flow, create innovations at a programme level and drive strategy, and ensure adequate and effective documentation of the programme. These meetings ensure that midcourse corrections to the programme are made if required, such that it is fine-tuned, and each individual's experience of the Home Again programme is meaningful, and promotes wellbeing.

Besides these, some of the monitoring techniques include, case conferences, and peer group audits.

How do you review the programme at a systems level and ensure organisational accountability while still promoting service user freedom and autonomy?

We suggest that service users of Home Again are all formally discharged from the hospital or institution, irrespective of the levels of independence that they may demonstrate, to manage all aspects of life in a community. Unless they require acute care services, or need medical or psychiatric intensive care because of a relapse, they could access outpatient services as and when required. Supportive services (detailed in section two, and further in sections three and four) are offered by organisations to all service users in their homes to support them in various aspects of life, from medication, grooming of self, shopping, and social ties, to economic transactions, recreation and leisure in a manner that they desire, and deem necessary. Such supportive services

that are delivered by the personal assistants will require oversight and robust monitoring methods to ensure both quality of care and protection and promotion of rights.

The following mechanisms are proposed to promote accountability in organisations and ensure, that they are aligned with an ethos of promoting personal recovery, and wellbeing:

Local Committees that support Home Again – Community monitoring mechanisms

Each site at which Home Again housing units are introduced will nominate designated, local committees which are comprised of key community functionaries (*panchayat leader and self-help group leader*, a lawyer or human rights activist, 2 peer leaders (*mental health service users*), one local mental health professional from a civil society organisation or the local District Mental Health Programme (DMHP) and one member from the original Home Again team.

The committee will offer necessary oversight that offers guidance and when required intervenes to ensure that supportive services offered by mental health professionals and personal assistants, and the collaborating NGO show fidelity to the values and ethos of the Home Again intervention and are in no way detrimental to the well-being and rights of service users. In addition, they will also offer oversight to all human rights related matters. Thus, this may in no way be used to regulate lives of service users or impose norms that have no consequence in promoting their well-being. The specifics they must look into during mandatory monthly visits are: overview of the number of people, health related issues, death audits (*if any*), socio-cultural challenges (such as experiences of discrimination within the home, or the community, or infringement of basic rights) and missing persons reports.

Hotline for Complaints:

In addition to a grievance cell, and the local committee, each home (across all Home Again programme sites) will also have access to a central hotline to lodge complaints. The hotline will be co-ordinated by The Banyan for the initial two-year period, following which it will be de-centralised to be manned across individual programme sites. The hotline can be operationalised as outlined below:

- The hotline number must be publicised widely across the organisation, and all residents at the Home Again programme. Ensure this is done in as engaging a manner as possible. Use posters, brief conversations and focus groups and introduce the idea and purpose of the hotline
- Explain what this hotline aims to do, why it is required, and give examples of some of the issues that can be raised. For e.g., denial or lack of access to basic amenities (food, clothing, shelter), feelings of intimidation (physical, emotional or sexual), social pressure, or the inability to experience life as has been deemed possible, and promised by the Home Again programme.

- It is critical that you mention that all issues raised will remain confidential. Each issue will be handled tactfully and sensitively by the team manning the hotline. They will ensure that the identity of the service user is not divulged unless necessary to resolve the issue. In that case, a member from the Local Committee will be present at the resolution meeting.
- The centrally manned hotline will aim to address all issues raised within a turnaround period of 72 hours. In case the issue is more complicated and will take longer to resolve, the service user will be kept notified. The service user will be assigned a key contact point (member of the hotline team) during the first call, who will then coordinate with the care team and local committees.
- The service user will be informed of the status of all proceedings through daily telephonic updates, or at more frequent intervals if the situation demands.
- In cases of extreme distress, the hotline team may recommend that the service user leave their dwelling for a temporary period until the issue is solved.
- All call logs will be maintained by the hotline team. This will detail the issue raised, action taken, individual responsible, and the final resolution. These logs will be reviewed on a monthly basis by The Banyan's Senior Management Team, and on a quarterly basis by The Banyan's Board of Trustees' Quality Audit Team.

### Advance directives

An Advance Directive (AD) is a legal instrument – a written document that expresses an individual's wishes about the types of treatments, social care services, livelihoods, living arrangements, property, wealth, and other supportive mechanisms they desire in the event of a personal mental health crisis. A directive provides a clear statement of the medical and social care preferences and other wishes or instructions. It can also be used it to grant legal decision-making authority to another person to be the individual's advocate and agent until the crisis is over. It is based on the principles of:

- A presumption of capacity – Every adult has the right to make their own decisions, and must be assumed to have the capacity to do so unless proved otherwise. A person must also be offered all forms of support before being treated as being unable to make their own decisions.
- Least restriction – Anything done for or on behalf of an individual who may lack capacity must be least restrictive of all their rights and fundamental freedoms.

Humanness in decision making: Making what may be deemed as an 'unwise' or otherwise 'unacceptable' decision must not be equated with lacking the capacity to make that decision.

All individuals residing at the Home Again programme will have the ability to create advance directives, and through them ensure the retention of autonomy and decision making power with regard to their course of treatment (admissions – if and when needed, nature of treatment etc.), living arrangements, work, guardianship *(if required)*.

The care team will explain the concept of advance directives in detail with all service users in collaboration with the Local Committee and the Legal Aid cell at The Banyan. Some critical points that must be communicated include:

- Examples of what can be included in the advanced directive must be clearly stated:
  - o Types of treatment / medication desired
  - o Types of treatment / medication that you do not wish to receive
  - o Who you would like to be your caregivers
  - o Whether you would like to have your pets with you / who should take care of them
  - o The visitors you would like / not like to have around you
  - o The kind of clothes you would like to wear, food you would like to eat, or the kind of recreational activity you would like to engage in
  - o The representative whom you would like to nominate as the person who will make decisions on your behalf. This person should be someone you trust *(a close friend, family member, or care provider whom you know has your best interests at heart, and a deep and accurate understanding and knowledge of who you are as an individual)*
- It must be made extremely clear that the Advance Directive can be revised at any point in time that the individual chooses. It is not set in stone, and it allows for every individual to change their mind, and choose a different path to care as and when desired. For the sake of the programme and to ensure uniformity, all service users will be able to revise their Advance Directives on a bi-annual basis with their care coordinators and the legal aid cell should they choose to.



## Section 8 Knowledge and Ethos Transfer: Capacity Building

### Why is training important?

Training is an integral part of the initiation and orientation that is offered to all who join the programme at multiple levels. However, Personal Assistants are the backbone of the program, and play a vital role in community integration, fostering bonds, understanding psychosocial causation of problems, managing prognosis of pathology and offering support through distress. A robust training programme is critical towards ensuring that quality of care is of the highest standard, individualised care and sustained engagement ensured, and fidelity to values maintained. This training programme will provide you with guidelines on when, how and how much to intervene, and what kind of intervention you must offer.

You will at some point need to trust and accept the individual's ability to manage and regulate their distress. This is a key element of the value framework of this programme, and yet, is not easy to practice. It will mean that you have to let go of ideas that you may have held onto for long. It may also mean being disappointed on outcomes, lack of it or on the course of care. You will need to learn to regulate these feelings, deal with them, realise and accept that there is only so much that you can do, and rest in the knowledge that the individual is resilient, because they have coped this far and can usually adapt and manage a few distressing events.

These trainings, besides much else will help you understand this in greater detail, learn how to adapt, and move forward.

### What will I learn during the training?

Orientation to programmes and values: You will be inducted into understanding the vision, mission, history, range of programmes, strategy, and more importantly, the values of this programme and approach. A significant amount of time will be spent on this module since it is fundamental to any service you will offer. Besides explicit articulation of the values and related discussions, significant input will be offered to you on self-reflection and analysis. This is of particular relevance considering the nature of work that you will engage in.

ABCs of Mental Health: This module involves development of technical skills, and know-how. It involves exposing you to mental health conditions and ways in which they can be managed through medication and other psychosocial interventions. Identifying stressors that have potential to trigger an episode of ill health and managing their side effects are essential within this segment. Your role in the context of the multidisciplinary team is also etched out in the process. Details on the Shared Housing Approach, including the list of protocols to be followed and micro

processes that ensure effective implementation, are shared. Expected nature of outcomes are discussed at length.

Conflict resolution and lay counseling: Dealing with interpersonal conflict can be a challenge when you share common spaces. It requires tact, patience, compassion and maturity. These modules will help you learn how to better manage these conflicts by diffusing tension, addressing issues and engaging in conversations, instead of displacing anger.

These modules will not only help you learn technical aspects of care but also pave pathways to self-discovery and personal growth. Having said this, the complexities involved in care can only be understood while on the job and thus much of your training will use continued supervision and feedback systems, frequently using case discussions, debrief sessions, reflective practice, etc. Periodic formal reviews of your progress with the programme manager will also be introduced.

Concepts of distress, health and ill health: This module will deconstruct, explain and prepare you to address concerns around distress, withdrawal, alienation, exclusion, pathology, health, physical ill health, well-being etc. Besides being oriented to the basic concepts and conditions and related technical or hard skills, you will also learn to be analytical and reflexive, and be aware of how your interactions with the individual affect her, and her relationships and equations with the ecosystem.

Learning from lived experiences: This is by far the most powerful knowledge one can gain; this training will help you observe, listen, and understand the nature of ill health from who will always be your best teachers- those who have experienced this distress first hand. It will also help you create feedback loops into the system in such a manner in which the knowledge that you have gained can be taken back to the drawing board, helping you create responsive and appropriate mental health care systems. This engagement, and the interdependence that will likely be fostered will promote personal growth, and foster deep connections and bonds. If careful attention is paid at this level, your intuitive, abstract thinking and analytical abilities may also improve.

Crisis, conflict, ambiguity and negative outcomes: Understanding these, the reason they come about, the implications and its aftermath on the individual and their mental health is conceivably important. While living in a home with other members, one's distress can affect another, even you - the care provider. This empathetic transaction must be managed well and crisis must be mitigated as soon as possible. You will, in this training, learn how you can be most efficient, take care of the individual and yourself to ensure all are well and happy. You will learn to manage and regulate your own emotions that may overwhelm you during negative outcomes, or frustrate you when there is poor progress or intimidate you when there is a crisis.

Listed below are the key modules:

Understanding Self	<ul style="list-style-type: none"><li>• Who am I?</li><li>• Knowing my family, neighbours, friends, relatives and colleagues</li><li>• Sourcing my inner power</li><li>• Listening and background conversations</li><li>• Stewardship conversations</li><li>• Working in the mental health sector – Values that drive action</li><li>• Assignments to enhance the understanding of Self</li><li>• Social structures &amp; social problems</li><li>• Community dynamics and power structure</li><li>• Social mapping and profiling</li><li>• Vulnerable and high risk populations</li><li>• Community organization process and methods</li></ul>
Mental health care	<ul style="list-style-type: none"><li>• Introduction to mental health and mental illness</li><li>• Signs and symptoms of common and severe mental disorders</li><li>• How do you achieve a state of well- being - what helps?</li><li>• Social determinants of mental health</li><li>• Pathways to care – clinical and social</li></ul>
Social welfare measures	<ul style="list-style-type: none"><li>• Social legislations</li><li>• Welfare systems and structures</li><li>• Functions of social welfare agencies</li><li>• Central and state Government welfare schemes - application processes and access mechanisms</li><li>• Role of the PA and Civil Society Organizations (CSOs) in promoting in social welfare activities</li><li>• Public relations and community participation</li></ul>

Psycho-social interventions and skills	<ul style="list-style-type: none"><li>• Interpersonal relationship skills</li><li>• Community organization for social change</li><li>• Guidance and supporting skills (Egan's model)</li><li>• First aid – physical &amp; psychological</li><li>• Disaster management</li><li>• Social prescribing – preparation of individualised care plan, planning social interventions</li><li>• Psycho-education</li><li>• Working with special groups</li><li>• Time, resource and activity scheduling &amp; management</li><li>• Research and evaluation</li><li>• Recording and maintenance</li></ul>
Human rights	<ul style="list-style-type: none"><li>• History of mental hospitals and rights violations</li><li>• Essentials of UNCRPD</li><li>• Mental ill health and structural barriers</li><li>• Notions of stigma and discrimination</li><li>• Rights vs rights, balance between autonomy and rights, and right to health and capabilities</li><li>• The Ten Central Capabilities (Nussbaum, 2011)</li></ul>



Section 9: The Transdisciplinary Care Team – roles and responsibilities

At the essence of The Banyan's care approach is the need to encourage I - Thou (based on Buber's (1937) philosophy) conversations, which are more respectful, giving both parties engaged the opportunity to throw themselves into the relationship, moment and context. They are more mindful, safe, open and engaging. They are centred around practices of better dialoguing and transparent and deep communication that enables connections, fosters a climate of kindness and invokes empathy. In our experience, fostering inter-dependence, deep connections and bonds, and using reinforcements in constructive, tangible ways that translate into immediate gains as perceived by the client produce significant changes in their mental health outcomes

Much of this philosophy is translated into activities by a well-coordinated transdisciplinary team (care and administrative); as a result, individuals whom we service can receive comprehensive and value-based care. Any mental health programme or any programme for that matter has a core services team and a support team that provides administrative inputs into the programme. Home Again is no different. Outlined below are the functions of the Care and Administrative teams.

The clinical care team

This team includes, personal assistants, social work practitioners, psychologists, counsellors, occupational therapists, vocational trainers, peer leaders, nurses, general practitioners and psychiatrists.

Personal Assistant (PA)

The PA is a key service provider and, in a way, the backbone of the 'Home Again' programme. They are usually young girls or women who hail from low socio-economic contexts, who more often than not, have experienced distress first hand. When interviewed, many of them reported finding it easier to understand and relate to the nature of distress and experiences of scarcity that persons with mental illness go through, having experienced shades of it themselves. Critical to the confirmation of their recruitment, is their willingness and inclination to work in tough settings, and their alignment to the values of The Banyan (in your case, your umbrella organisation) and the Home Again approach. Formal educational qualifications are seldom criteria for recruitment, but PAs are required to have basic reading and writing skills, and should ideally have completed their 8th grade. They must be able to think on their feet, be calm in a crisis, and proactively engage with the resident. The PA typically guides the individual through all activities of daily living, helps her negotiate spaces, find work and live a full life.

Note to the PA

An essential aspect to remember is that most individuals you interact with and support maybe older than you. This could present a conflict - on one hand there is an unintended hierarchy where you play the role of the care provider, while on the other, you could be the 'daughter', 'sister' or 'granddaughter', that they have lost. Remember that people whom you serve are in most cases older than you. They have experienced much in their lives - loss, love, pain, heartbreak, joy, and significant trauma as well. Respect their experience and wisdom and be guided by it where possible. Do not equate their illness and disability with compromised intelligences. Ensure that you maintain cultural expectations of transacting with elders. Do this much like you would with members of your own family. We are certain that you will learn a lot from them, and experience a lot of personal growth yourself

Care coordinator

Care coordinators are individuals with training either in social work, psychology, occupational therapy or any allied discipline, with experience of working with persons with mental health issues. In the Home Again intervention, each care coordinator is assigned 30 clients who typically reside across 5 to 6 houses. They use the case management as a tool and hence are single point of contact coordinating most services, medical, social, psychological or otherwise. They co-plan most interventions, collaboratively with their clients and PAs both at the individual and home levels. In case the care coordinator is of the opposite sex, e.g., male care coordinator and female client; it is important there is also a female member present in therapy or one on one sessions, unless the client explicitly indicates that it is not required and that she is OK. In some cases, a client may have two therapists. This is to ensure that both the care coordinator and the individual are protected. Though rare, incidences such as disrobing, infatuations, obsessive behaviour in relation to a romantic fantasy etc. may lead to problems we don't want to have to face. Abuse on the part of male therapists again, though rare are occurrences that we have heard of.

Nurse

Nurses are recruited at a nurse to client ratio of 1:50, and carry out a key role in monitoring the client's' general health. As previously mentioned, clients involved in the intervention are a mixed group belonging to different age groups and with several co-morbid health conditions that require periodic monitoring. The nurse usually trains the PA to pick up key concerns early on and then jointly addresses them with the treating doctor.

The tables that follow in this section will highlight key responsibilities of the PA, care coordinator and nurse. In addition, the following section on case management approaches and promoting functionality, will also highlight the interactive work culture between the personal assistant, care coordinator and client.

Table 1 below, provides an overview of tasks to be completed by a care coordinator at the Home Again programme

Role	Frequency	Nature of observation	Type of record
Visit	Twice a week	Observe different areas of the house- toilets, kitchen, behind refrigerators, tiles, backyard, frontyard, garden, corridors, interaction between residents, or between resident and PA; clothing, ADL, nails, hair etc. Make the visit fun, try taking a small gift along ( <i>budgeted in your per unit cost</i> ), chat, watch TV etc. Don't make this an inspection, you are paying the members of the house a social visit.	Reports are sent to the programme team.
Individual sessions -in the form of therapeutic interventions or social conversations	Collaboratively with the client - need based, do not make it a routine procedure.	Grooming, eye contact, demeanour, interaction with others, social graces, conversational ability, foot, tooth and hair care, clothing style, nature/ content of conversations, need to share concerns etc.	Notes in case files.
Group sessions for special cohorts. E.g. persons with intellectual disability or negative symptoms	Fortnightly/ Monthly	Observe interactions with other members of the group and levels of engagement. While group members may not be fully aware that they're being observed for specific variables, these observations can later be presented at the end of the group session and reasons for disengagement or poor involvement can be discussed. Modifications to the group process can then be made accordingly. Typically, personal attention may work better than group sessions in such cases.	Notes / reports are maintained in case files.

Role	Frequency	Nature of observation	Type of record
Troubleshooting- e.g., crisis intervention	As and when necessary-- need based.	Involvement and responsiveness of other members of the household, PA, neighbourhood, and community in the event of a crisis. Observe whether the house operates as a home and members as a family.	Notes in case files Follow up action, medical and legal recourse when required.
Single point contact for the individual	Need based.	A friend, mentor, therapist, social worker- depending on the relationship and nature of roles/ dynamic.	Notes if required.
Overall health and well-being of individual-- e.g., facilitating work options or recreational activities-- planned collaboratively with individual or with groups of residents living in the same house	Daily - Plans are made along with the care team by facilitating appropriate referrals. Plans may also be made with the PA to facilitate transactions in the larger community- ongoing.	The care team discusses details in monthly review meetings or when required	Records are maintained in case files. If urgent clarifications are sought the care team can be accessed accordingly.
Monitoring participation in work, skills development activities, home and community	Daily -- focus is on facilitating self directed, goal driven activities that stimulate well being. Under stimulation is a challenge and must be managed.	Commitment to plans; granular level changes or lack thereof to be observed and discussed.	Records are maintained in case files and the care team may be informed if necessary.



Role	Frequency	Nature of observation	Type of record
Connecting with client's family, if available and facilitating interactions if individual is keen. Reunion options may be explored, only if sought by the client.	As and when necessary or collaboratively decided between care coordinator and client.	Individual's reaction to questions related to families may generate rich data that can be used to understand the history and nature of their relationships.	Records are maintained in case files and reports are sent to the care team.
Promoting individualism and inter-dependence and facilitating self discovery -- help individual and PA manage cleanliness and aesthetics, cooking, supplies, home decor, relationships and so on	Completed during visits or if a concern has been escalated by a member of the household or care team.	Not all residents may articulate their needs and desires. Observations for subtle changes and micro-expressions can be helpful in identifying preferences and facilitating a better quality of life and increased well-being amongst all.	Field notes and ethnographic observations can be used to keep track of this.

Table 2 below provides an overview of tasks to be completed by a nurse at the Home Again programme

Task	Domains/description	Frequency of administration
Visits- health checks of residents - ranges from basic monitoring to acute to chronic complaint / condition management. (e.g., fever, asthma, diabetes)	Weekly / as advised by doctor (this may not always be required, and must be decided based on the individual's health status at any given point in time)	Results are recorded in registers and shared with the care team.

Task	Domains/description	Frequency of administration
Monitoring Vitals (eg., Blood pressure, pulse, body weight)	Once a month	Registers are maintained by the nurse, reviewed and signed off by the program manager/care coordinator.
Completion of routine tests as advised by the medical practitioner and psychiatrist (eg. blood tests, thyroid levels, therapeutic drug levels).	When required	A register is maintained and follow up planned systematically. Once done, reports are filed and signed off by the prescribing medical practitioner or psychiatrist.
Appointments at hospitals/ rehabilitation facilities -- when needed.	When advised - by the GP or psychiatrist or medical practitioner.	Notes are maintained in files and the care coordinator signs off.
Accompanying resident to the hospital in case of an emergency	When advised - Will be determined by the care coordinator or program manager	Periodic updates over the telephone to the care coordinator/ project manager; case file is later updated and signed off by the care coordinator.
Monitoring diet regimens and nutrition (underweight, overweight, obesity, and for metabolic disorders such as diabetes).	Daily through the PA	Diet charts are maintained in the case file of each individual and a register is also maintained for official records.
Group sessions - for diet maintenance, activities of daily living (ADL) and hygiene	Weekly - along with the PA	Reports are filed in the case files and emailed to the care team as well for action

Case management - Navigating the illness-wellness trajectory, promoting functionality and individual capabilities

Many people with a history of mental illness have a complex array of needs that must be considered when developing an individual care plan. Case management is one of the most effective methods of ongoing management, and navigation of the illness in collaboration with the client. It refers to a participatory and inclusive process of assessment, planning, facilitation, care coordination, evaluation, and advocacy in such a manner that an individual's unique needs are met. One of the critical goals of case management is to work towards inspiring and enthusing the individual to pursue their innate capabilities, thus reducing disability, and improving functionality in the process.

This involves smart co-ordination, building strong linkages with community resources and strong knowledge and understanding of each of the clients that one cares for. The relationship between the care coordinator and the client is important and usually results in reduction or alleviation of distress, thus helping her pursue goals more ardently, transact more effectively and feel better understood and supported.

Promoting functionality

A fundamental goal of most care paradigms is to produce substantial, tangible, and lasting supportive changes in cognitions, moods, and behaviours; changes that promote a better experience of life, a fuller immersion into activities of daily living and greater participation in social processes. Useful strategies and tips to navigate the illness, manage daily lives, work on desired changes in mood, and related behaviour patterns as well as build emotional regulation skills are shared. This goal is in tandem with the other central tenet of care - to reduce a client's distress to the extent possible. By determining a client's level of functioning while taking into account all the biopsychosocial and cultural aspects, specific care packages, tailor-made to suit the individual can be formulated and designed. By its very nature, such an approach is client centred, and driven to tackle challenges and distress that the individual encounters in daily life.

Aligning itself with this philosophy, the Home Again approach demands that the care team utilises tools and strategies that are culturally appropriate and related to immediate gains for the client. This may require for some of your regular clinical approaches to be adapted to better suit your clients' needs. For instance - rolling dough for chappatis (instead of regular usage of clay as part of psychological interventions), and tossing them on the pan, or stringing beads or flowers to improve hand eye co-ordination and motor function; using socialisation and connections as key goals, and thus initiating name recall of friends, neighbours, care providers and family as a strategy to stimulate memory instead of regular memory stimulating methods.

Much of The Banyan's approach to care including practices surrounding rights, participation, dignity and inclusion, is oriented around the 10 central capabilities propounded by the philosopher Martha Nussbaum. Our nuanced approach to understanding agency and autonomy that balances rights with well-being also draws from this framework. Some of the central capabilities are critical goals that our case management approach works towards. Values that these goals inspire overlap with our programme level values. For instance, the programme advocates access to care across a spectrum of services such that access to life, bodily health and bodily integrity are upheld and protected; the creation of diverse experiences, focus on social mixing and mobility are to ensure that emotional, leisure, and affiliation and bonding needs are fulfilled, and imagination, practical reason and thought challenged; and finally, the core tenet of reclaiming agency and identity is aimed at ensuring control over ones environment, and thus the ability to make informed choices that enable the attainment of ones fullest potential.

Role/Area of functioning	Personal Assistant	Care Coordinator
Ability to brush, bathe, groom, wash clothes, keep house clean	One-on-one support and monitoring of hygiene. These functions are most easily disrupted but the fastest to be regained as well. Individual level persistent attention is most critical at this stage. Looking clean and good is a first step to feeling good and similar to others in the community. The ability to interact with others increases as well, since it is more likely that persons in the community seek out company of people who look similar. This is not an approval of social sanctions that we operate around. Ideally, who we are should matter more than how we look. However, we do not want our ideology to come in the way of practical gains for the clients.	Results are recorded in registers and shared with the care team.



Role/Area of functioning	Personal Assistant	Care Coordinator
Ability to eat, clean, cut vegetables and cook a meal.	Encourage cooking of meals and hosting guests. Promoting a choice-based system of running a home that reflects one's own identity. Break the task into smaller tasks such as washing vegetables, going to the market, using money to transact, cutting vegetables, grinding and mixing spices, washing vessels, serving etc. Or even tasting, so everyone has a chance to contribute and the opportunity to feel engaged.	Co-planning activities that facilitate re-learning or re-identification with one's culture and tradition. Choice provided encourages autonomy and agency in decision making and facilitates re-connectedness with one's own life and socio cultural context. Encourage reciprocity in hosting meals and have guests over, even as the members of your house get invited to other homes including the care coordinator's, PA's etc. besides friends' in the community.
Ability to communicate	Initiate conversation, respond to queries, show interest in making friends, share experiences, emotions and thoughts, take stances on important issues, argue, articulate distress and dissent, indicate enthusiasm and boredom, aspirations and hope.	Promote free expression and platforms for communication of one's own needs and desires. care coordinator should also understand reasons for poor or inhibited communication patterns. Training maybe offered in structured and informal ways to improve such skills. and challenge existing barriers, regardless of the extent of disability.
Ability to use public transport	Trips with individuals to places of their choice, be it the movies or a tourist spot, could be one of the ways in which they are enabled to use public or other hired transport themselves. During such times, the PA engages with the individual to explain dangers that may be applicable and its management such as falling off a moving bus, auto jacks etc. This is also a good way in which money management can be initiated. One has to pay for their own tickets.	Co-planning trips and enhancing motivation levels by linking this to bigger goals the individual may have e.g. visiting friends or family, finding a particular kind of job etc.

Role/Area of functioning	Personal Assistant	Care Coordinator
Money Management:	To facilitate transactions between local vendors and individuals. Whether through grocery shopping, paying rents, eating/ snacking out or making a trip using public transport, the opportunities to transact are many. This is also a way in which the community realises that members of these homes contribute to local economy.	Educate and train individuals in collaboration with the PA. Plan fun trips that involve financial transactions in the real world such as visits to markets and shops. Link them to other tasks such as procuring raw materials for cooking, trinkets for grooming and art pieces to decorate their homes.
Literacy	Help the individual read newspapers and books, and have conversations that involve simple and complex themes. Facilitate trips to libraries or reading clubs. Keep in touch with current events on films, governance, politics, economy etc. Buy your newspapers and tune into radio / TV news channels.	Expose individuals to various activities that involve reading, writing, discussions and critical thinking, so everyone's opinion is sought and known to matter.
Physical Mobility	Initiate movement and mobility to get around to places such that one's social network increases. Plan to hop onto a bus or auto so travel options are diverse, as are related experiences.	Collaboratively plan mobility scaling such that expansion of networks take into account satisfaction of personal needs and interests. Link spatial and social mobility to arrive at eco maps <a href="#">[1]</a> and plans to improve access to social/ support networks.
Social Skills	Help individuals mix with the larger community. Encourage them to initiate conversations, make friends, celebrate festivals and host get-togethers around birthdays, Diwali, Golu, Eid, Christmas etc. in their own homes. Encourage meaningless banter as much as watching television with friends, a walk to the beach, or a visit to the temple, church or mosque.	Plan both solitary and small and large group activities, based on personal choice. Link with the PA to ensure that social skills training is either in the real world and in interesting ways or if in a controlled setting then transferred into real world transactions.

Role/Area of functioning	Personal Assistant	Care Coordinator
Manage household	Encourage division of labour; every resident typically has a unique role and contribution and should attempt to complete her household chores independently or with little support. As she makes progress in basic tasks, other complex tasks may also be suggested and participation encouraged.	Co-plan and motivate commitment to these tasks. A sense of responsibility towards each other and the home further influences participation and commitment towards each other, inculcating feelings of belongingness and mimicking values of a family. While all may not be interested in household chores, it may be a good idea to encourage every member to manage at least a few chores. Re-training can be provided towards this goal.
Stay in employment	Find and facilitate employment opportunities ( <i>refer to the protocol on facilitating employment opportunities for more details</i> ).	Work with employer and individual to ensure sustenance of work. Make it interesting and ensure that the joys of work are celebrated, both from status leap, newer experiences and material gain point of views.
Manage medication	Monitor intake of medication	Manage intake of medication. Coordinate with psychiatrist to ensure dosage is managed effectively. Work with client to ensure compliance. Address queries or concerns including side effects.  Compliance or treatment commitment can be an informed process and need not signify passivity.
Safety ( <i>refer to the protocol on safety for more information</i> )	PA to work with individual in discussing risks - for eg. keeping their home safe, identifying stressors that trigger a downward spiral (focus on health), keeping one's valuables safe, understanding and making boundaries clear in relationships.	Care coordinator shares information with residents on a range of issues e.g. safe sex practices, culture appropriate lifestyles, stressors and triggers that may induce a low etc. use informal sessions and case studies for the same. Discussing incidents from news reports also help.

Role/Area of functioning	Personal Assistant	Care Coordinator
Participation in socio-political processes	Being a part of the decisions taken in the community including voting, accessing banking, obtaining identity cards to access entitlements and participating in Panchayat meetings	Care coordinator ensures that all individuals have access to information as the first step. This opens up the opportunity to participate in most civil and political matters. In some cases, one-one sessions may be necessary to reorient the individual on the importance of participation. That every person counts should be reinforced.

Mental Health Professionals

Mental health professionals who provide supervision to personal assistants and nurses, are social work practitioners / psychologists (who also play the role of care coordinators), and psychiatrists. This section provides a brief introduction into the roles and responsibilities of these professionals.

Social Worker

A social worker aims to set up a comfortable environment for the client within which therapeutic, safe and meaningful relationships may be fostered and thrive. In the Home Again context, the home and community are essential spaces that the SWP would pay attention to, in order to ensure a sense of comfort, socio cultural affiliation and alignment with personal style and sensibilities. A social work practitioner focuses on the individual's social context, related consequences, critical events and relationships, and resulting experiences that could potentially influence thoughts, feelings and behavior, and uses diverse practice models ranging from psychosocial and functional to behavioural. Task centred practice and problem solving or interpersonal therapy are frequently used by the social worker to improve the quality of relationships and reduce distress, such that an individual feels better equipped to move towards his/ her goals. Additionally, the social work practitioner focuses on advocating on behalf of the client, and mediates between clinical and critical social work practice, promoting his/ her rights, social mobility, normalising mental ill health, inspiring participation and creating enhanced access to support networks



Psychologist

Psychologists aim at understanding the nature of psychopathology including causal attributes, the individual's personality (coping skills, management of life, problem solving skills), the individual's cognition, and thus her behavior. The psychologist offers therapeutic interventions drawing from multiple schools of thought including, behaviourism, cognitive and psychodynamic approaches, and humanistic approaches to bring together eclectic practices to address common and severe mental disorders.

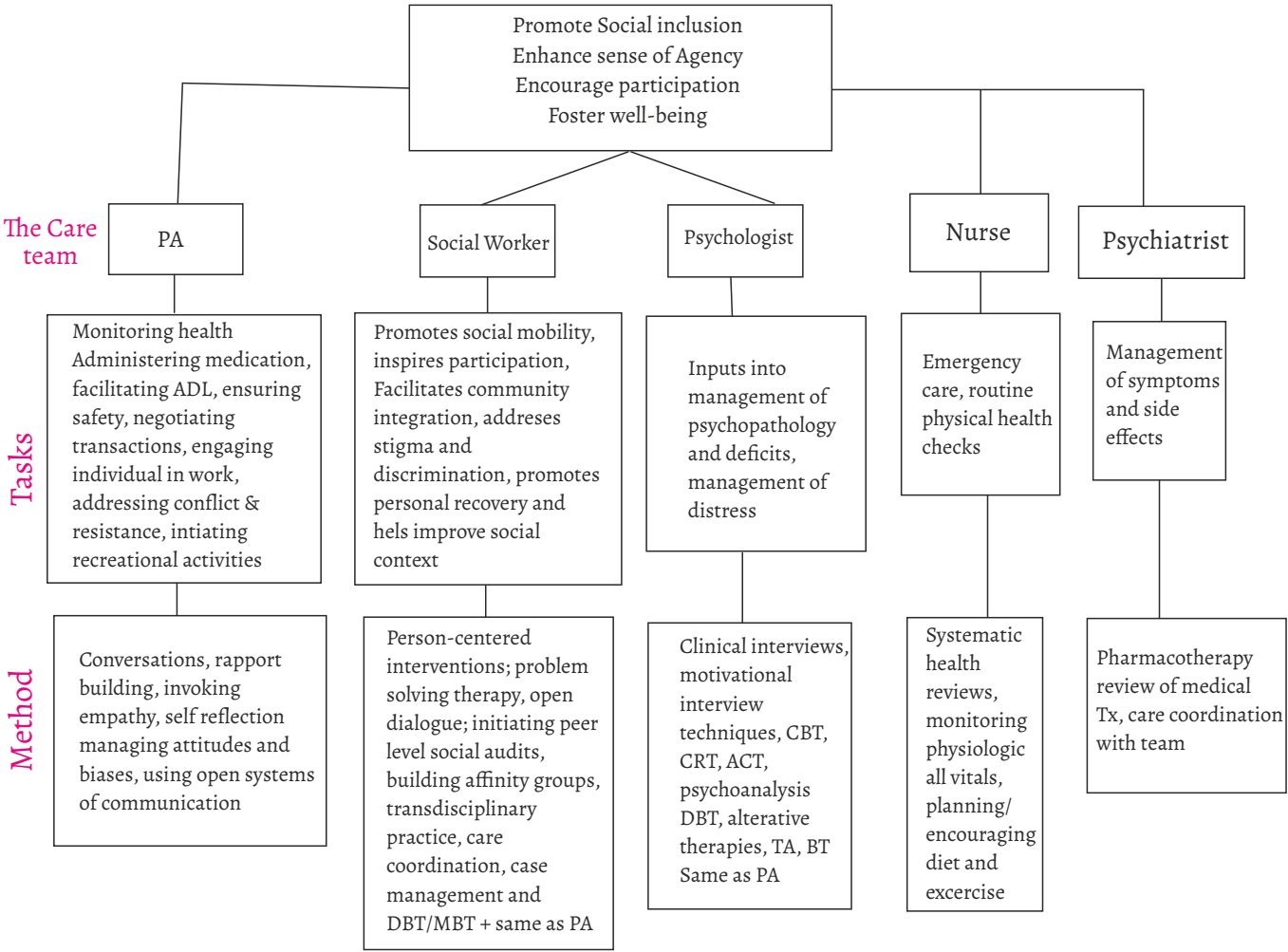
Both the social work practitioner and the psychologist attempt to work towards addressing the precipitating and perpetuating factors that often underlie mental health issues. Their roles extend into looking beyond the mere presentation of pathology and target implicit details that may impede recovery. In the process, newer therapeutic techniques such as open dialogue, mindfulness-based stress reduction, art therapy, dance and movement therapy, and targeted problem-solving approaches may also be used. Group interventions that disseminate coping strategies for better management of illness, loss and interpersonal relationships are also shared. Furthermore, counselling may also be offered to address everyday problems such as stress adjustment issues, interpersonal conflicts, emotional dysregulation etc.

Psychiatrist

A psychiatrist uses the biopsychosocial model to understand and treat psychopathology through pharmacotherapy. The main focus usually is at the physiological/biomedical level. However, at The Banyan psychiatrists are a part of a transdisciplinary team and thus a holistic treatment approach is adopted which duly considers the efficacy of psychosocial interventions. Psychiatrists at The Banyan realize the limitations of drug therapies used in isolation and integrate other approaches into the care regime. This is usually the case with most well informed, progressive practitioners - be it social workers or psychiatrists. Given that the principal aim is that of facilitating personal recovery for the client, these professionals integrate and draw from multiple approaches and best practices to arrive at one that is most suited for their client and the context.

*It must be noted that while each member of the team has specific roles and responsibilities, the entire team comes together to offer a comprehensive care package. There is a great sense of camaraderie and mutual respect amongst all members of the team, and they are encouraged to work collaboratively at all times.*

*The diagram below illustrates the collaborative approach adopted by the care team in helping the individual attain a state of well-being.*





*One or many members of the care team ranging from the personal assistant, to the social work practitioner, to perhaps even the psychiatrist could be an individual with a mental health issue themselves. A key facet of the programme is to ensure the creation of strong peer support systems, and self-advocacy platforms.*

### ***Administrative and management functions***

This section will provide you information on the structure and functions of the administrative and management teams.

#### ***Maintenance Assistant (MA)***

The home again intervention depends on rentals for its spaces, and each house comes with its own set of small repairs and maintenance work to be carried out. A maintenance assistant (MA) is usually a plumber/carpenter/electrician who is capable of attending to most basic repairs, and relies on a network to arrange other professionals if needed. The MA carries a complaint book in which he notes down all repairs for the houses that he received through phone or in person and makes weekly visits lasting approximately half an hour, to each house to ensure the infrastructure is in good condition. Either temporary or full time staff can be engaged for this post.

The MA is also involved during the phase of securing houses and checks the quality of infrastructure in each house including water availability, power supply etc. He/ she is involved in the final decision of picking a house.

#### ***Programme Manager (PM)***

Programme managers do just that - manage and run programmes across sites. This includes, supervising care plans, the staff and administrative details in coordination with the internal services department. The programme manager must be able to manage human resources, have strong communication skills, co-ordination and strategic planning skills, as well as the ability to assess risks and make well informed decisions.

Usually, a mental health professional (either a psychologist, social worker or professional from an allied discipline) is hired as a programme manager. This ensures deep understanding of the nuances involved in caring for persons with mental health issues.



The table below provides an overview of the roles and responsibilities of a programme manager

Roles	Particulars
Supervision	Supervision and support is offered by the PM to the care and admin team. The team is encouraged to approach the PM in case of emergencies or other challenges that need support. Within this, specific areas of supervision include, case management, nursing and health reviews, monitoring referral chains, briefing and debriefing the PA, problem solving in crises and advocacy. Typical problems could involve conflict in the house or neighbourhood, serious ill health, ethical dilemmas, burnout and staff apathy, erosion of values, other medical or programmatic (including financial) contingencies.
Monitoring psychiatric and medical reviews	The PM ensures that all individuals in the programme are periodically (collaboratively decided by the care team and the individual) reviewed by the psychiatrist, during which the client's medication schedule and care plan may be reviewed, vetted or/and modified. The PM also monitors the physical health reviews when applicable.
Documentation	Documentation is a vital part of the project, and is important to assess outcomes, address medico-legal concerns, and/or understand trends and challenges. The PM must supervise the process of documentation for quality, efficiency and consistency. Feedback is often shared swiftly such that mid course correction is possible.
Reviews	Project reviews are important to understand challenges, gaps and high points - these are typically focussed on individual level progress and goals; this also as a result, ensures programme level efficiency, quality adherence and effectiveness. Reviews also ensure well-being of staff to ensure that burnout, and other associated concerns are addressed. Finances and budget allocations are also looked into during this process. The PM may choose to conduct a review herself, collaboratively with the team or / and on a one-one basis with each member, depending on the agenda, time frames and need. Future planning is also an outcome of a review meeting.

Values - Applications in practice

As much as one imbues values of social inclusion, dignity for all, radical acceptance and participation in society, one needs to be equipped with methods and approaches that help deconstruct these abstract concepts into workable goals and apply them at the grassroots level. This section will highlight some strategies that are integrated into the case management approach, and have worked in The Banyan's experience.

**Roll with resistance:** More often than not, most people accustomed to the ways of an institution, by default, find any transition into other environments stressful, unsettling and difficult. Using motivational interviewing techniques, the Mental Health Professional can engage the resident and address these concerns and feelings of insecurity, self doubt and inadequacy. This technique enables conversations, helps stay with complex issues without feeling fatigued or overly distressed,for as long as required and mostly helps the therapist/ MHP roll with the resistance / reluctance;and in this case probably more with a sense of apprehension and even fear.

How do we do this?

We ensure engagement and association of a free and deep sort that bring to the fore all questions, concerns and even as much as a semblance of self -doubt. We do not persuade change in decisions or encourage quick turnarounds; neither do we persist overly so as to force change. We encourage full and complete expression and never curb dialogue. We stay the course, are around for clarifications, use simple methods to share approaches to better cope with situations – formal and informal, including talks over lunch, casual chats in the corridors or when seated on the beach, besides structured sessions.

In all probability, this resistance or reluctance and related issues that emerge will require continued engagement and a sense of fluidity and dynamism in responding with options. You should not feel disheartened by failed attempts or back and forth movement and flip flopping on direction or progress.

**Reflect:** Encourage reflection and stimulate discussion. Reflection on events in general – be it life, food, friendship, trauma, hope, future, work, meaning, spirituality, and all topics mundane and grand. Every individual regardless of his / her disability is a thinking, feeling person and reflection as a tool helps an individual take stock, consolidate emotions, feelings and perceptions in ways that are unique.

***Retrospect:*** Retrospection, usually in combination with reflection, determines what works for an individual, when, why and how. This could be a dynamic process and thus change with passage of time and events. Remember, retrospection sometimes could also result in accumulation of sadness and feelings of loss and guilt and thus should be used and encouraged by seasoned practitioners only when required, in order to stir feelings of familiarity, rekindle memories and on some occasions even to identify and address conflict that underlies distress.

***Resolve:*** Often retrospection and reflection result in some form of catharsis and help in offering resolutions to both latent and immediate issues including some crises from the past that have been source of ongoing distress

***Re-calibrate:*** Based on resolving conflicts or issues, and reflection – every individual is encouraged to re-calibrate his or her goals, expectations, plans and in many ways their approach to daily life. These processes of reflecting, retrospecting, resolving or even just accepting helps the individual derive new meaning and hope, almost symbolic of putting away things from the past in anticipation of a fresh start. While some may opt to retrospect and reflect, for many this may seem wasteful and pain-inducing. Thus, use discretion and let these paths / choices be self determined, keeping in mind multi- dimensional factors and non-linear interactions.

***Reacquaint:*** Very often, members gradually reacquaint themselves with a way of life that they were used to, almost spontaneously. After all, they were those people at some point, people who participated and engaged in society and life, in ways that they were used to culturally and inducted into early on in life. So even amongst those who may otherwise have withdrawn and/ or been isolated socially, one may gradually observe positive changes over a period of time. A member may greet and offer you a cup of coffee or tea, while another clears it up as you empty your cup. A third person may ask you if you'd like a hot paratha or dosa. If that takes a while, then they may begin by looking you in the eye and attempting to engage in a conversation. You could initiate a range of activities that enthuse these changes including inviting them to your house, organising social get togethers, chatting about life in general and drawing them into the conversation to get to know them better and learn more about their likes and dislikes.

***Renew:*** Persistent attempts have to continue to reintroduce the individual to a life that was lost intermittently or over a longer term owing to the experience of severe disability and loss of support networks. This signifies not just attempts to encourage independence and interdependence, but also those to renew hope and move away from a state of chronic despair. Interest in tasks and activities such as enjoying a nice bath, the fragrance of the soap or powder or cream, the morning ritual of prayer or puja, the threading of flowers or the opportunity to earn, spend and save money or the experience of a meal with a loved one, fun and affection with a pet, or a visit to the movies, have to be

regenerated. This renewal has to be celebrated for every milestone crossed, however small it may seem to you, realise that it is a huge effort for the resident.

**Restore:** As you experience renewed hope and rigour, dignity, agency and much else is restored in the process, as you begin taking control of your life. Restoration of dignity and choice are critical to the process of enhancing personal autonomy and self-reliance

***Revitalise:*** Vitality or the loss if it, needs attention and has to be addressed. Attempt to infuse energy into conversations and plans such that hope may be generated. Hope can drive change and influence one's ability to reengage in life. The difference between passivity and throwing oneself into an activity is that sense of vitality. So try to inspire it. Stay calm, upbeat and try to create positive memories. Break structured patterns of therapy and use eclectic approaches to engage with the person, that both of you find meaningful, fun and interesting. Don't do anything simply because it needs to be done and crossed off a checklist. Any such lacklustre half-hearted attempt can be seen through.

***Resurgence:*** The feeling of triumph when one bounces back is incomparable – giving life a second shot- a state of resilience is what we aim to achieve. Any sign of resurgence in any member should be celebrated and shared with all. So it seems less distant and more accessible to all.

***Respect for self and others:*** This is non-negotiable. That all members of the household respect each other and themselves. Practice of self love and respect helps those whom you are engaged with realise the importance of taking good care of themselves and feeling good about the things they do. Ensure that the PA and all those that they are in contact with, treat everyone with respect and expect reciprocity of this value. Both are equally important.

***Responsibility:*** A large part of group living, or life in a family, is shared responsibility. This is something that either grows organically or members learn to value, respect and practice. Typically a sense of responsibility also results in stirring a sense of purpose and usually enthuses engagement with life. Even if members of the house first resist all forms of responsibility to themselves or others, try cajoling them into it. The returns are usually significant, even if it seems difficult in the beginning, especially for those who may need significant support. It is always easier to do things for such persons than to work with them patiently and gradually lead them to more independent states.



**Rant:** Undoubtedly, interpersonal dynamics could result in pain and conflict. Even just irritation. Besides, trauma from earlier, reminders of unpleasant circumstances and loss could further build resentment and bitterness. Instead of burying this in one's deep crevices, we advice ranting, without lashing out against anyone person in particular, if possible. A rant is different from an attack. A rant is more cathartic and less accusatory and helps purge negative emotions without breaking too much peace. As much as emotional regulation and commitment to social norms are shared, equally is the need to unabashedly rant.

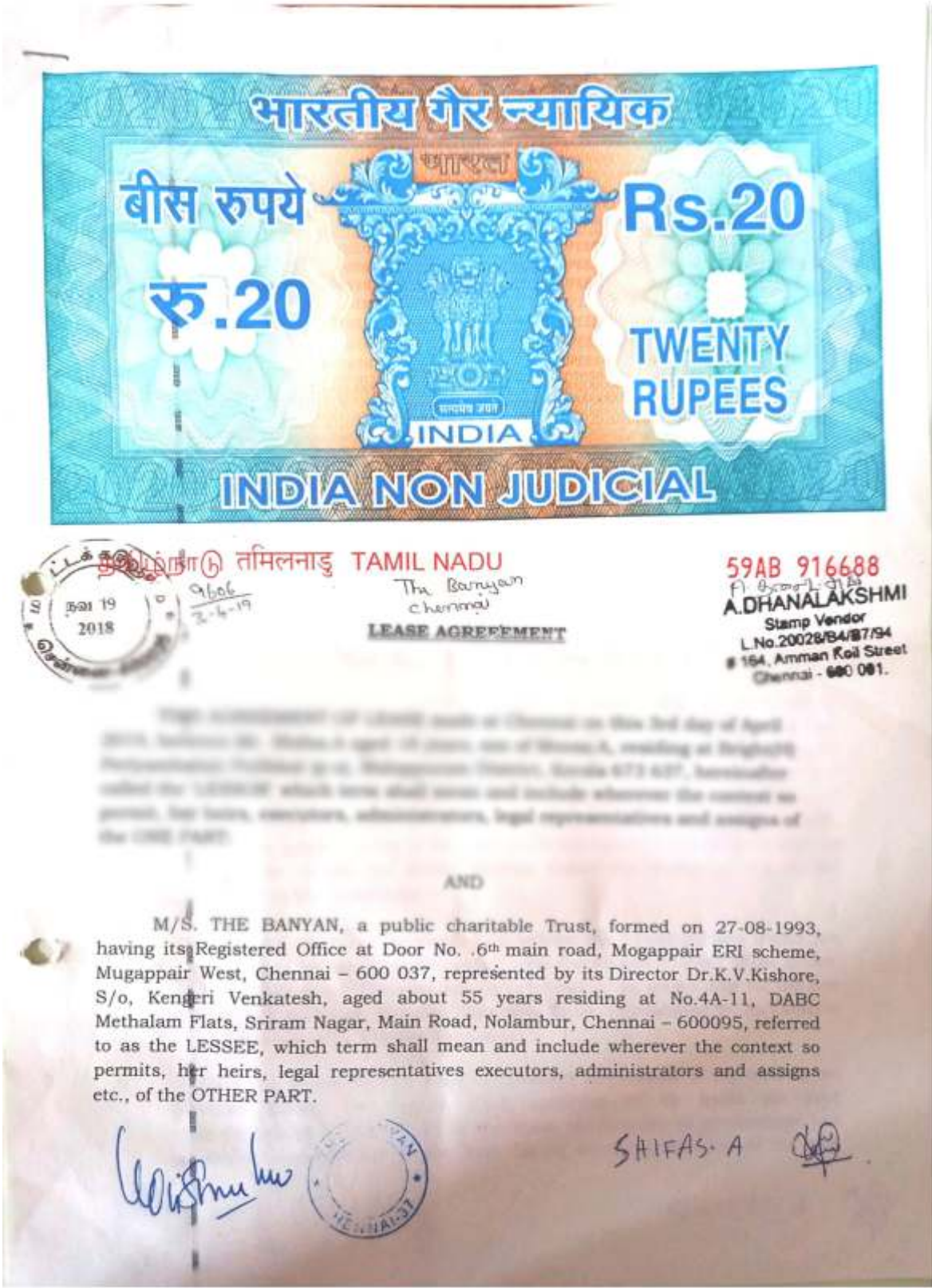
**Rally around:** Through such difficult periods, support networks beginning with the family, rally around naturally or learn to do so.

**Radical acceptance:** Regardless of behaviour, change or lack thereof, attitudes, rants and histories, all members of the HA programme are radically accepted, perceived deficits notwithstanding. If there is something we would like to see change in terms of a behaviour or communication patterns, then we will communicate it with the person in a safe environment and manner that will influence mental health gains. Regardless of the response or the extended nature of engagement in order to bring about those changes, we will remain connected and loving, unless our personal space and dignity is violated. The hope that this unconditional support offers, encourages every member to reclaim and own their life in their own ways over a period of time.

**Rights (Choice, Agency, Participation):** Rights signify choice, agency and participation, but also denote access to basic amenities such as adequate food, housing, clothing, healthcare etc. In order to pursue capabilities and a better life, these essentials have to be in place. We must strive towards this goal of social mobility and tap into all pathways that may lead to it . It is imperative that feelings of scarcity and abandonment are accepted and yet countered and those of belongingness, safety and security fostered.

**Rootedness:** All attempts are made to ensure every individual can be authentic and thus inspire honest interactions and expression. Hence, identifying one's core and attempting to reconnect with it is a goal that the PA, the care coordinator and other members of the house and Support networks work towards. Who you are is what you do and the two have to be aligned. This influences how you think and feel and again feeds back into who you are.

Appendix I – Rental Agreement



**THIS DEED NOW WITNESSETH AS FOLLOWS:**

1. The Lessor has agreed to let out the House No. CP8/139, Paravoor, Pulikkal Post, 673 637, Malappuram, Kerala.said house portion and the lessee has agreed to taken on Lease the afore said house portion, the said lease is to commence on this 3<sup>rd</sup> day of April 2019 till 26<sup>th</sup> day of February 2020 that is this lease agreements is for duration of ELEVEN months from this day onwards
2. That the Lessee has agreed to pay a sum of Rs.40,000/- (Rupees Forty Thousand only) as a security deposit and a sum of rent Rs.4000/- Rupees Four Thousand only).
3. The lessee undertakes that the said rent of Rs.8,000/- (Rupees Eight Thousand only) shall be paid on or before the 5<sup>th</sup> day of every month according to English calendar and it has been agreed by both parties that of Rs.40,000/- paid as security deposit shall bear no interest it shall be returned at the time of vacating and surrendering vacant possession by the Lessee, after deducting the rental arrears, if any or the repair charges for rectifying the electric connections, if any or which washing or plastering painting, the walls if as the case may be.
4. The Lessee hereby agree and declare that the Lessee keep the premises in good Conditions and shall deliver vacant possession thereof to the lessor on termination of the aforementioned period of the lease or in case given or delivers a notice of two months in advance to the Lessee to vacate the portion of under this occupation, the lease may redeliver the possession of the houses earlier than the date fixed for the terminations of this deed, provided he gives a notice of two months to the Lessor intimating hereby his intention to vacate the house portion before the expiry of the period mentioned in the agreement.
5. The LESSEE shall not be entitled to sub-let the house portion under his occupation to any other person expect with the written consent of the Lessor previously obtained. The said portion is let out to the lessee only for the use of M/S.THE BANYAN, a public charitable Trust, represented by its Director Dr.K.V.Kishore, S/o, Kengeri Venkatesh,
6. In Case the Lessee hold or does not delivery possession of the tenancy as provided above, the Lessee shall continue to be liable for rent proportionately for the period of the lease, so remains in possessions nor deprive or prevents the Lessor from taking vacant possession of the said

house portion at the rates of rent per month, so fixed by the lessor for the said period.

7. The LESSEE shall keep the premises white washed and effect repair or any, and shall keep on the fixtures and electricity fittings and water connection in good running conditions and shall pay all charges that may in law payable by him or imposed in respect of the said residential portion or which the lessor is not necessary bound to pay.
8. The LESSEE hereby undertakes that it shall pay the Electricity charges to the Lessor per the Meter meant for his portion.
9. The monthly rent of Rs.8,000/- shall be subjected to increase as per the Prevailing market rate.

IN WITNESSES WHERE LESSOR and the LESSEE have executed this deed on 3<sup>rd</sup> day of April 2019 with an undertaking that the terms and conditions of this lease deed shall be binding on them and their respective successors in interest.

WITNESS:

LESSOR

10/04/2019  
LESSEE



10/04/2019  
LESSEE



SUBAL A



## Appendix II Registers

## Attendance Register

[illegible]

## Skills Training Register

[illegible]

### Appendix III Bills and Cash vouchers

## Medicine Register

[illegible][illegible]





Appendix V Nurse’s Monitoring Sheet

Client Name:

File number:

Diagnosis:

MM/YY	Jan-2021		Feb-2021		Mar-2021	
Physical Examination						
Hair ( Lice/ Pediculosis/ Dandruff/ Wound/ Infection)						
Ears( excessive wax/ Discharge/ pain)						
Nose ( Cold/ infection/ Hair)						
Oral Hygiene (odour/ Caries/ Gingivitis/ Pain)						
Eyes ( Redness/ Discharge/ Eyebrow/ Eyelashes dandruff)						
Genital Hygiene ( Hair/ Infection/ Redness/ white discharge/ Dysuria)						
Skin ( Allergy/ wound/ Infection/ rashes)						
Menstrual Cycle ( Normal/ Menorrhagia/ Amenorrhea)						
Under Arm ( Odour/ Infection)						
Vitals Signs						
Temperature ( ' F)						
Pulse ( Beats/ min)						
SPO2						
Respiration ( Breaths/ minute)						
Blood pressure ( mmhg)						
Weight ( Kg) / Height ( Cm)						
BMI						
Periods Start Date						
Periods End Date						