FOREWARD

It has been a privilege for me personally and for the Paul Hamlyn Foundation to have been associated with The Banyan. In 2014, when the PHF funded Phase 1 of work with the Banyan, we foresaw the evolution of a long-term partnership. Almost 9 years later, I am happy that we have had a wonderful journey together.

Our partnership has exemplified the essential tenets of what a partnership should be made up of. Belief that the ideas and innovations we aim for will bear fruit, trust that ensures an openness and authenticity in conversations and a strong shared intent to do all it takes to ensure that people we work with become stronger, more resilient and in charge of their own lives.

We have lived through all these beautiful feelings as we have travelled together. As we progress on this path, we believe it is important to share the key glimpses of this journey. This document attempts to do that. While it will have its limitations, we hope that what you are about to read, will encourage you to explore further, want to know more and that you will reach out to The Banyan and go deeper into the dynamics of what implementing this initiative has meant. More than just the lives of the people it reached out to it has also impacted the lives of the people who have associated with it. And I would like to congratulate everyone at The Banyan for being part of this process.

We have made a major shift in the way institutionalisation in mental health is seen. We are now beginning to move in the much-needed space of community led care and have evidence to demonstrate that it works and works well. The ‘sense of family’, and ‘kinship bonds’ that establish as a result are what takes this idea forward. This led us to Nalam of which you will read in this book, which further developed the idea of deinstitutionalisation and community inclusion. An idea that is driven by a non-specialist workforce, most of whom are women, and in psychosocial distress themselves, it epitomises the roles local communities and social systems can play in delivering high quality and sensitive support to people in distress.

These are all beautiful ideas that have emerged from the Banyan’s experiences and now with evidence on their success and clarity on limitations, we are confident that they will spread widely. We hope this document will assist that process.
Home again started off as a brave and ambitious initiative and challenged every rule in the book and yet has emerged as a significant game changer in the way we see and understand inclusion and care in the mental health space. It brings upfront the importance of the social dimensions of health care and the fact that communities can and do take on responsibility and that the ‘inclusion’ is very much possible and doable. Home Again has been able to create an ‘engaged and interdependent therapeutic community that embraces differences and diversity and unites to care for its own’.

The Banyan has exemplified how an empathetic approach that brings together the technical and the social can create and innovate the future. I see this as the power of civil society; our ability to take on challenges and convert them into possibilities.

I feel honoured to have been associated with this initiative. And I would particularly like to recall the contribution of two phenomenal women in helping make Home Again what it is. Amali and Jacklin. They have been the mascots of this initiative and have shown the Banyan and everyone else the power or agency, and possibly the future of care in the mental health space.

Sachin Sachdeva
Director, India
Paul Hamlyn Foundation
The Banyan has been working on filling important gaps in mental health care systems for three decades now. And this is no simple or direct task because it involves understanding the complex nuances of mental health, illness and homelessness in a diverse country like ours. There has been consistent and proactive attention to detail at The Banyan over these years that has enabled us to reimagine what care, illness and mental health can look like. The Banyan is committed to an all-encompassing approach that embraces the central principle of ‘personhood’. Every decision taken by The Banyan has been towards social inclusion and collaboration that ensures dignity, participation and agency. There is a significant pervasiveness of exclusion that people with mental illness face on a regular basis. It comes with an added complexity and sensitivity when also dealt with homelessness. The Banyan aims to enable access to mental health care for people living in poverty and homelessness through a comprehensive, collaborative and innovative method that is embedded in dignity, quality of life and inclusion.

Our partnership with the Paul Hamlyn Foundation for the last 7 years has enabled us to make our vision a reality. Our shared dreams of social inclusion and openness to collaboration has been vital for this reality. This long term journey began with one of our first steps into deinstitutionalizing long term care with our Clustered Group Home program, now Home Again. This partnership enabled the expansion of Nalam, our community inclusion work in rural and other vulnerable urban locations. This partnership has also been vital to offer not just support but also recognition to caregivers who are crucial stakeholders in the vision of mental health care. This has also paved the way for our peer leadership movement, a service user lead leadership initiative that fosters action and collaborative learning on advocacy, social entitlements, employment, personal recovery, meaning, quality of care, need for and interest in employment, psychoeducation, financial stability, accessing entitlements and job opportunities, and advocacy with local governments. We have been able to build these initiatives including NALAM and other social cooperatives in Chennai and Chengalpet through this partnership with PHF. It is with pride to highlight that these initiatives have received public recognition. One of our social cooperatives, represented by Annamary, received the ‘Enterprise Award’ from the Honorable Chief Minister Thiru MK Stalin recently.

We at the Banyan are extremely grateful for this partnership and hope to build cross-sectoral partnerships with other initiatives in the country to collaborate on social entitlements, recognition and other disability movements, especially with larger state forums across the country. We are grateful towards Paul Hamlyn’s interest and collaboration in social inclusion and hope for many more years of equal partnership.

Dr. K.V. Kishore Kumar
Director, The Banyan
EXECUTIVE SUMMARY

150 million Indians are estimated to live with mental health issues, yet 83% remain without care. In this low resource scenario, socio-economic liabilities such as gender, caste and class, render people with psychosocial disabilities homeless. Their options are usually limited to either continuing to live on the street or be put into long-term institutionalisation.

The Banyan works to address this situation through a set of innovative approaches that include hospital-based care, supported housing in rural and urban neighbourhoods and community and clinic-based mental health solutions. It is currently active in the states of Tamil Nadu, Kerala, Karnataka, Andhra and Maharashtra.

Paul Hamlyn Foundation is a UK based independent grant-making foundation investing in innovations that contributes towards social change. It has been funding in India since 1992, prioritising capacity building for organisational impact with a focus on support for people with disabilities, shelter and other social development activities.

The Banyan-PHF partnership began with a home-like facility for clients with long term care needs that was based on the importance of choice-based care and reintegration. This intervention evolved into Home Again (HA) an initiative which offers people with mental illness, housing in rural and urban neighbourhoods with supportive services through an onsite personal assistant.

The next phase focused on an innovation called NALAM project. This is a community mental health approach that combines clinical interventions with social entitlements. It works through a network of locally recruited and trained mobilisers based in villages and urban wards, who engage with the community, identify those with psychosocial distress and where needed, escalate a referral to the closest outpatient clinic. Home visits are conducted to link people with necessary entitlements and offer supportive counselling.

**Highlights of the partnership:**

- Focus on deinstitutionalisation of care and community living
- Need based care rooted in collaboration with clients
- Democratic processes between clients and staff
- Fostering family-like structures in living arrangements
EXECUTIVE SUMMARY

- In-depth engagement with communities to understand the lived realities and needs
- Clinical-long term care along with the need for social care that can reduce re-hospitalisation and foster collaborative recovery
- Creation of knowledge, through empowerment and fostering the connection of self reliance
- Training and education of professionals and NALAM Mobilisers
- Policy changes through module development & research projects

- Building networks with potential stakeholders who can assist in care
- Outcomes of the partnership:
  - Demonstrated the feasibility of housing in the community
  - Personalised community placement plans
  - Service norms for housing
  - Supportive service interventions in the community

These items are elaborated on in the following sections. These processes are the guiding principles that are reflected across programs at The Banyan.
THE BANYAN: CHANGING THE MENTAL HEALTHCARE PARADIGM

Since 1993, The Banyan has been working with homeless and impoverished people with mental illnesses. It offers comprehensive mental health services to more than a million people, through acute hospital-based care, community and clinic-based comprehensive mental health solutions and social reintegration through inclusive living in rural and urban neighbourhoods. The organisation is currently active in the states of Tamil Nadu, Andhra, Karnataka, Kerala and Maharashtra.

The Banyan believes in transformative social justice for those that are marginalised on account of mental illness, poverty and homelessness. Therefore, in addition to clinical markers of recovery, The Banyan also helps those recovering from mental illness reclaim their agency and become socially, economically and culturally active.

A synopsis of its work is as follows:

- The Banyan runs Emergency Care and Recovery Centres (ECRC). These are transit care facilities designed as enabling first stops in the journey of the mentally ill towards the mainstream. An ECRC uses street-based outreach, critical time interventions, inpatient biopsychosocial care, predischarge services, reintegration and aftercare. Inherent in this model is the right of Homeless People with Mental Illness (HPMI) to dignity and choice. Individuals on the street in need of immediate support are identified through volunteer outreach programmes. These volunteers make referral calls for rescues to The Banyan. A highly trained team of social and primary care workers carry out these rescues. The Banyan ECRCs have, to date, serviced over 3,500 women and men with mental health issues. Over three-quarters have journeyed successfully back to their families all over India. The ECRC approach has been adopted by the Government of Tamil Nadu and currently, 13 such ECRCs are operational in District Hospitals. In Kerala, too, as in Karnataka, ECRCs function as PPPs with the district municipality and not-for-profit hospital, respectively.

- NALAM is a community mental health approach designed by The Banyan which recruits and trains members of the community to become mental health mobilisers. NALAM mobilisers based in villages and urban wards engage with the community, identify those in psychosocial distress and if there’s need of clinical care, escalate a referral to the closest outpatient clinic. They conduct home visits and offer home-based care to the person with the mental health issue, while working on the family as a whole. It links them to relevant entitlements and offers supportive counselling to help families deal with the mental health of its members. Employment
placements, via skills development or supported employment pathways, are offered to help people in their return to work and better personal incomes. Besides employment, NALAM offers select households in extreme socio-economic distress, social care packages that include basic income transfers, disability allowance, housing support and educational and mentorship assistance for children living with parental mental illness. The NALAM network has helped over 10,000 people access proximal, comprehensive and personalised mental health and social services. The Banyan collaborates with the Government of Tamil Nadu in two districts to transfer the community engagement components of NALAM and strengthen the District Mental Health Programme.

- Community reintegration and civil society participation lies at the heart of all Banyan interventions. Many of the people recovering from mental illnesses do not have families to go back to. To ease their journey to the mainstream, The Banyan runs supported housing interventions such as Clustered Group Homes (CGH) and Home Again (HA).

  These housing units serve as supervised, peer homes for the beneficiaries where they learn to navigate the social and economic landscape in a supervised environment. **Home Again has been adopted as a best practice by the World Health Organisation in the 2021 publication, ‘Guidance on community mental health services: promoting person-centred and rights-based approaches’, by Governments of Kerala and Maharashtra, and has now been taken to scale across 10 states in India, and in Sri Lanka and Bangladesh.**

In addition to strategic replication partnerships with Governments and civil society organisations, The Banyan and Banyan Academy of Leadership in Mental Health (BALM) engage in research, social action pilots and education, to build effective and ethical leadership in the mental health sector for vulnerable populations, and thereby bridge the care gap. Research is used as a tool to understand the implementation of services, identify highlights and challenges, and test models/interventions over time to evaluate their efficacy and effectiveness in real-world settings. Findings from research then feed into services (to develop new programmes and strengthen existing ones), training, capacity building and bespoke education-focused initiatives (towards strengthening human resources and bridging care gaps), and into nation- and state-wide policy-building efforts that The Banyan and BALM are both engaged in.
HOMELESS WITH MENTAL ILLNESS: THE GROUND FOR COLLABORATION

Homelessness in India is a systemic concern that follows from larger societal issues and individual factors. A unique subset of this universe is the homeless people with mental illness.

Homelessness can lead to mental illness and vice versa. Mental illness brings in its wake social stigma, considerable expenses and the need for unconditional and personalised care. Neither families nor the state are geared to provide this support as a result of which people with mental illness, especially those that are homeless, are often institutionalised (Dijkenhoorn et al 2018).

In the absence of individualised care and collaborative exit strategies, institutionalisation only leads to marginalisation and invisibility. Most facilities lack proper checks and balances, are overcrowded and have abysmal living conditions. Additionally, there is little in the way of post-discharge care. Most care planning does not account for follow-up sessions and reintegration support, especially financial help. Mental illnesses can impose a considerable economic burden on the client or their caregivers. A national mental health survey conducted in 2016 revealed that the expenditure incurred in accessing mental health services inevitably pushed families to experience financial difficulties (NIMHANS, 2016).

Structural barriers of poverty and marginalisation directly impact the recovery process and push people with mental illness further to the periphery and away from basic entitlements. They cannot access welfare measures and lack political and social rights. This exclusion from mainstream society forces individuals back to the streets post-reintegration, perpetuating a cycle of isolation and neglect.

The government at the central and state level has taken several initiatives, on the policy and implementation fronts to address deficiencies in mental health care in India. The Mental Health Policy (2014) is one such example. The District Mental Health Programme (DMHP) has been in place since 1996 as a district-level operational arm of the National Mental Health Program (NMHP,1982).

While policies are in place, effective implementation is an issue. Repeated reports in mainstream news and evaluations by the National Human Rights Commission (2012), throw light on the undignified living conditions in mental health care facilities. What emerges consistently out of these reports and coverage is the persistent lack of long-stay options and rehabilitation strategies. An estimated 38% of people in state mental health facilities in India stay for a duration of one or more years (WHO Mental Health Atlas, 2011).
Reports indicate that over 38% of bed strength across all mental hospitals in India is occupied by persons with long-term care needs. This typically refers to individuals residing in the hospital for one year or more. In several cases, this period can range up to 15 - 20 years within institutionalised care settings with no defined exit pathways. Other than one's family, state hospitals and non-governmental institutional spaces, the other alternative for long-term care is residential domiciliary homes that come with a fee, which is out of reach for a majority of the population.

The country also does not have enough people to offer mental health services. As a 2002 nationwide survey shows, India has only 2 psychiatrists, 1.5 clinical psychologists and 2 psychiatric social workers per 100,000 population and even these professionals are not entirely trained to deal with the complex economic and social realities that underpin the experience of illness for most Indians.

The infrastructure to deliver mental healthcare is strained, crumbling and often far removed from what people need. In a resource-scarce country, the best way to address these issues is by reimagining solutions.

Providing care does not have to be either the sole prerogative or the responsibility of the state. The fact that the community does not take on a greater role in the care ecosystem, results in many people being pushed into an incarcerated existence behind the iron gates of institutions.

This situation makes a strong case for exit strategies like supported housing and partial or total independence for those living with mental illness. This can be an important step in the rehabilitation process that provides opportunities for innovative, choice-based care models that allow the residents to have agency in their life, foster hope and to de-institutionalise their identity.

This was the meeting ground for The Banyan and Paul Hamlyn Foundation and the two organisations have been working to build a strong case for inclusive living and community care through multiple interventions.
REINTEGRATION: THE LONG ROAD HOME

A study conducted by The Banyan found that 57% of all homeless with mental health issues had been exposed to heinous crimes and grievous injuries, 22% had experienced sexual abuse, 35% had been physically injured and 57% suffered from several co-morbidities.¹

The Banyan has, since 1993 been running transit care facilities, through an innovative model called Emergency Care and Recovery Centre (ECRC). These have been designed as an enabling first stop for the mentally ill in their journey towards the mainstream. It uses street-based outreach, critical time interventions, inpatient biopsychosocial care, predischarge services, reintegration and aftercare. Inherent in this model is the right of HPMI to dignity and choice.

Individuals on the street, in need of immediate support, are identified through outreach programmes designed to increase community involvement in the issue of homelessness and mental health. These volunteers make referral calls for rescues (Critical Time Interventions – CTIs) that are then carried out by a highly trained team of social and primary care workers. After the Critical Time Intervention, the client is offered psychiatric, psychological and social care services aimed at enabling personal recovery.

An ECRC is a non-custodial care model built on the values of responsiveness, individual dignity, choice and personal care. It is a deviation from the custodial care model that is more focused on incarceration than rehabilitation. Aftercare is integral to an ECRC. Once a resident is ready and able to leave the facility, outreach workers actively work to reunite them with their families. Apart from counselling, medical and financial support is provided on a need basis, leveraging the resources of the District Mental Health Programme, welfare departments and civil society as well as community-based organisations.

The Banyan ECRCs have, to date, serviced over 3,500 women and men with mental health issues. However, there are many who are not able to go back to their families through the process listed above. The partnership between Paul Hamlyn Foundation (PHF) and The Banyan aimed to address this situation through an inclusive community living model that creates families out of peers and paves the way for independent living.

Pre-discharge

Illness management (identity and manage stressors and triggers, medication management, coping patterns etc.)

During discharge

Work with family (understand capabilities, level of support that can be offered, needs assessment and psychoeducation)

Post-discharge

First quarter: Phone follow up with first week and home visit within first month: working on dimensions of functionality based on needs assessment completed earlier.

Link to government entitlements for improved community certificate/allowance, public distribution system and identity cards

Understanding family dynamics

Follow up according to after-care package assignment

Community care-link to local resources for support (Panchayat, DMHP, NGOs, Community based workers and neighbours)

Assigning an after-care package (See table 2)

From community supportive circles and build mental health changemakers to locally support person

Figure 1: Discharge and transition process to community-based living
Part - I

Clustered Group Housing (2016-2018): Cure to Care
CLUSTERED GROUP HOUSING (2016-2018): CURE TO CARE

In 2007, The Banyan, created a model called ‘The Protective Community’ for mentally-ill women with long term care needs, which, in 2016 evolved into the Clustered Group Home (CGH), supported by Paul Hamlyn Foundation. This approach involved creating an environment where one could pave their own recovery pathways and relearn skills in an environment that mimicked real life. The Clustered Group Housing approach was not about clinical incarceration—it was about holistic progress in a quasi-institutional setting for service users with high levels of disability as a result of their psychiatric pathology and/or those with comorbidities in need of palliative care. The Clustered Group Housing project innovated along various parameters.

The Innovations

Location: The CGH, 10-cottage facility, was co-located with The Banyan Academy of Leadership in Mental Health (BALM) at Thiruporur Taluk near Chennai, Tamil Nadu. BALM ran postgraduate programs in psychology, social work and research, management and public policy. The strategy behind co-location was to enable close interaction between aspiring mental health professionals and residents, thereby bridging the gap between theory and practice. The students had a chance to interact with residents daily, and residents had the advantage of beginning their mainstream journey in the company of those with empathy and perspective.

Bespoke Care: The CGHs focused strongly on personal recovery and bespoke care while helping residents develop and expand social relationships and broaden their sphere of inclusion. In order to track progress and better plan psycho-social and pharmaceutical interventions, a clinical status was assigned to each resident. Clinical status was divided into five categories:

- Improved with stable deficit
- Improved with progressive deficit
- Remission
- Status quo
- Frequent Relapse

An analysis conducted in 2017 showed most individuals to be in the improved with stable deficits category (68%), 0.01% in the improved with progressive deficits category, 9% maintain remission and 18% remain in status quo. Another 5% experienced frequent relapses. In addition to mental illness, most individuals were diagnosed with intellectual disability, epilepsy or physical health conditions that are comorbid with their primary diagnosis.
Setting: The CGH model leveraged the long periods of stay to help the women develop and navigate relationships. The protected and enabling environment helped women across identities and geographies bond and push each other on the road to recovery. Here’s a story:

The language of kinship

M is a 45-year-old female, diagnosed with psychosis with mental retardation. She came to The Banyan as a young 30-year-old after her father had sold her for money. She recovered and chose to move to CGH where she met another woman P, with moderate intellectual disability and behavioural problems. P had a severe speech impairment making it difficult for some people to understand her. However, M and P got along almost instantly and developed an unbreakable bond. They supported each other in daily activities, and coping with stress points. In Kovalam, they also found immense joy in fishing, cooking, and sharing delectable dishes with friends.

Life skills: CGHS incorporated basic life skills into care protocols. This focused on re-training individuals with severe mental illness to manage personal and social needs. One cottage from the available 10 spaces was transformed into a “skills development unit”. This was a space where healthcare assistants and mental health professionals implemented goal-oriented interventions such as brushing in the morning, folding clothes after laundry, caring for one’s clothes, toilet training, using sanitary napkins, folding clothes, ironing them or even mending. This was later incorporated into the everyday activities of the residents within the cottages at an appropriate stage of progress. This helped contextualise the training. Cooking too was introduced in each cottage. Cooking is a task that involves multiple skills including planning, problem-solving, multi-tasking, fine motor skills and social skills. Residents planned together and divided the work among themselves. A Health Care Assistant (HCA) was present only to offer support and supervision and gradually stepped back letting residents handle the work themselves. Members of a cottage often cooked food and distributed it to other residents on a particular day.

Vocational skills: The CGHs also focussed on progressive training – this meant reacquainting residents with functional skills that would help them navigate daily life and then gradually progressing to skill sets which could help them earn a living. The initiation into life and social skills development began in April 2017 as month-long workshops on embroidery and grooming. Women were taught how to use different makeup tools, colour coordinated clothes and on freshening up during the day. The workshop was conducted by a member of staff who is also a trained beautician.

Internal job fairs: This was an innovation that simulated the real-life employment process. The job fair was an internal event where residents could sign up for remuneration-based skilling programmes. The residents had the opportunity to learn a skill and then see that skill translates into monetary value.

The ability to earn a living is critical to this goal hence the focus on learning a skill that can be leveraged. The importance of work in the life of a Homeless Person with Mental Illness (HPMI) is reflected in the story of Mahati-
Mahati – is an effervescent service user in charge of the reception at BALM. She takes care of every minute detail, involved with hosting visitors to the campus and is popular among the students en masse. She is unable to give an exact timeline of what propelled her descent into mental illness or, the protracted homelessness or the distress that followed.

However, one meeting with Mahati and anyone can figure out how her present identity is intrinsically connected to her occupation and how important the social sanction that she gets from the same is to her. She revels in the responsibility that she has been entrusted with, always has time for a quick chat and also acts as a peer advocate to other users who live alongside her on campus. She and her family maintain a mutually cordial relationship though with no prospects presently for living together. Mahati visits her parents in the village every year, gives her mother some cash she has saved up to help them with their expenses and so on and so forth. She says - ‘I used to feel insecure - not being in a relationship and the thought that I might always be single which did scare me at one point - no longer, however. I see my mother in a difficult marriage, my brother being an irresponsible son and am proud that despite my history, I have been able to progress from a fragile individual, to who I am now. The whole village stares at me every time I go back, but I don’t care - I merely stare back at them.’
**Entitlements:** In addition to capacity building for social and employment skills, the CGH intervention also recognised the importance of integration in society through ID documents and access to social protection measures. One such important document for people with disabilities is the disability card which enables one to access various entitlements and serves as identity proof to facilitate other citizenship documents.

**Table 1:** Social Needs Care at CGH by March 2016

<table>
<thead>
<tr>
<th>Social Entitlements</th>
<th>Numbers Procured</th>
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</thead>
<tbody>
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<td>Aadhar card</td>
<td>39</td>
</tr>
<tr>
<td>Voter ID</td>
<td>31</td>
</tr>
<tr>
<td>Passbook</td>
<td>29</td>
</tr>
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**The Learnings**

The CGH model suits service users who need prolonged care in a quasi-institutional set up. They work well for those who are unable to live with any significant degree of independence even in a supported environment or, have a physical ailment which needs palliative care. A protected environment like CGH, while nearer in mimicking an institutional set up than a community one, adds to the recovery process because it is gentler, more rights-based and focussed on increasing self-reliance to the extent possible.

The CGH model was primarily designed for service users who were unable to move back home to their families or into a community set up independently from ECRC. Post the initiation of Home Again – a supported living intervention in the midst of the community – many of the CGH residents wanted to move into a similar environment. They were keen to move towards social and community inclusion and function as independently as possible.

It was found that 90 percent of those who accessed The Banyan's ECRC opted for and were suited for, the Home Again model of care. The Cluster Group Housing intervention is therefore in the process of being phased out, except for select beds for those in need of palliative care. The Banyan-PHF partnership has now evolved to focus on exit strategies that focus on the long term.
CLUSTERED GROUP HOMES: TALES THAT TELL

The Librarian
S was found in an isolated housing community in Chengalpet 5 years ago when the watchman there noticed that nobody had left the house in days and there was a strange smell emerging. He alerted the local police who found her alone and in a state of confusion with the body of her mother who had been dead for several days. The Banyan was requested to intervene as it was seen that she suffered from a mental illness and she was brought to Adaikalam, The Banyan’s Emergency Care and Recovery Centre where she got better over time.

Attempts to locate her family led to the location of several distant relatives, none of whom were in a position to care for her. As S recovered, she was able to use her Teacher Training qualifications and moved into CGH so that she could work at BALM as a librarian. She has successfully completed a diploma in Community Mental Health during her stay in CGH and today, she continues to work at the BALM library, earning INR 30,000 pa.

The Gender Rebel
Sanjay is stretched against a wall in a half-restive position - a personal assistant is trying to convince her to try on a compression sleeve which will help with a congenital condition that she is facing post-cancer treatment. She agrees to do so after a dialogue and as she negotiates how long she would have to wear it, the personal assistant engages her in some routine talk.

Sanjay always felt the gaze of being a burden and in all probability unwanted.

It was during her adolescence that she started recreating her gender identity to suit the existing dominant narrative - she argues that apart from societal approval, transactionally and personally, being viewed as a man would suit her needs better.

Caught in the vortex of an exhausted, confused, extremely poor family and resultant homelessness, her health grew more complex from unresolved identity issues to visible and enduring mental health needs.

Despite a near decade of treatment and stay at The Banyan Emergency Care and Recovery Centre (ECRC), Sanjay’s options for return to life in the community remain limited due to the persistent nature of her mental health needs and lack of details that can assist in tracing the family (2016 - 2018 PHF report).
Part - II

Home Again 2016-2020: Agency and Acclimatisation
HOME AGAIN 2016-2020: AGENCY AND ACCLIMATIZATION

Unlike those suffering from physical ailments, people coping with a mental illness do not have an equivalent of a complete “discharge from hospital”. The care needs to extend beyond institutionalisation and recovery is considerably enhanced if the environment is supportive. Living independently and being functional while dealing with mental issues can be a daunting task. Recovery is slow and fraught with ups and downs; some people have to relearn how to navigate the fundamentals of modern life - from shopping for groceries to running a bank account. Others, at a more progressed state of recovery, need to be integrated economically and helped to manage their health and well-being.

However, a supportive environment is more the exception than the norm. Obstacles in the form of stigma, a lack of understanding about mental health, absence of care infrastructure and practically non-existent social and economic opportunities – add up to create a situation that is not conducive to recovery and reintegration.

The need for long-term residential support was becoming a vivid reality, independent of diagnosis, sociodemographic profiles and levels of disability. CGH as seen above was more suited to meet the needs of elderly persons or those in need of palliative care. In parallel from 2010 onwards, a group of clients from the ECRC began to rent out houses in the community, and managed their lives with little support from The Banyan, only in the form of medical care.

**Struck by its immediate effectiveness, this group of residents, along with the larger Banyan team, began to create several iterations of graded inclusive living options, to develop an approach that is now known as Home Again.**

In 2012, a cohort of 63 residents with varied levels of disability moved out of ECRC into Homes Again across Chennai and Chengalpattu Districts. This initiative began as a trial supported by Grand Challenges Canada.

Three mental health professionals were assigned to care for 60 women spread over a 10km radius. The team consisted of a programme manager, a case manager and a nurse. It also included 15 Personal Assistants who were women volunteers drawn from the community, who were erstwhile healthcare workers from the ECRC. Personal Assistants are now a special cohort trained by BALM to support mental and social health of Home Again residents.
Home Again worked well for the residents. Women loved the freedom to do what they wanted when they wanted. Some cooked and cleaned, some raised goats and hens, some were babysitters and much in demand, some drew kolam and made flower garlands, some found work in nearby homes or in the shops, some raised a garden while others just relaxed and watched TV. Soon women in the neighbourhood started dropping by and made friends with the residents. There was sharing of recipes and gossip, trips to the market and temples. Cinema was the preferred mode of outing. The research team found that as social inclusion increased, the disability levels in parallel significantly decreased.

Communities which had once shunned these mentally ill women now not only welcomed them but helped them integrate into society.

Paul Hamlyn Foundation stepped in to help The Banyan scale up this model. It was a sound exit strategy to help those seeking to move out of the limiting environment of an institution into the mainstream as socially capable and productive individuals.

Home Again has since evolved to a flagship programme both in the Banyan repertoire and in the national mental healthcare landscape.
THE HOME AGAIN MODEL

Under this programme, The Banyan rents houses both in urban and rural areas and equips them with basic needs. The homes are set up keeping in mind that the built environment has significant mental health impacts. The aesthetics and layout are largely dictated by the residents. The process of setting up the house and decorating it is participatory.

Each unit houses five residents. The criteria for movement into Home Again is six months of being in the set up with no exit options like going back home or being admitted into another institutional facility.

Each house has an on-site Personal Assistant (PA) assigned to it. The personal assistant provides supportive supervision and is in charge of immediate emergencies. While the residents are encouraged to run the household like a family, the Personal Assistant helps them with issues related to health, household management, socialisation, economic transactions, work, leisure and pursuits. The extent and kind of support extended depend on the needs of the group, the aim is to help people achieve their own sense of well-being, which may differ per individual. Diverse lived experiences colour the homes supported under the programme.
The reintegration process:

Home again is introduced and implemented through a phased process, starting with pre-engagement. During this period, prospective residents are introduced to the Home Again approach. The Banyan staff pitches the idea of independent living to the target group and encourages them to experience what it entails by moving into an already set up home.

Once they agree to the idea after their temporary stay, the team moves them to an assigned home. The personal assistant helps them set up their space and slowly nudges them into a routine. Residents are encouraged to take on different responsibilities like cooking, money management, expenditure on food, clothes and repair duties. A typical home has four to five residents with up to two onsite PAs either visiting or living with them based on need.

One of the core features of the Home Again Intervention is socialisation through the development of relationships and inclusion. It gives residents access to public resources in a vibrant neighbourhood and encourages them to navigate community life through daily activities like buying groceries and engaging with the neighbours. Those who can work are encouraged to do so, while others are tasked with running the house. The intervention is managed by a multidisciplinary team the majority of whom are non-specialist personal assistants.

Home Again has been implemented in neighbourhoods of Chennai and Chengalpattu, villages in Trichy, Tirunelveli, Villupuram and Kancheepuram districts of Tamil Nadu; Malappuram, Palakkad, Alappuzha, Kozhikode, Kottayam and Thrissur in Kerala; Visakhapatnam in Andhra Pradesh; Thane and Ratnagiri in Maharashtra; Mysore in Karnataka; Mehsana in Gujarat; Khordha in Odisha; Guwahati and Boko in Assam; Chumoukedima in Nagaland and Jaffna in Sri Lanka. Currently, 268 people live across 59 homes in Tamil Nadu, Kerala and Maharashtra. The Banyan is working with the Governments of Kerala and Maharashtra to replicate the model. The aim is to reduce 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.

The Lancet Commission on Global Mental Health and Sustainable Development, and more recently, World Health Organisation (WHO) have cited Home Again as a recommended model of care.

Guidance on community mental health services: promoting person-centred and rights-based approaches
https://apps.who.int/iris/bitstream/handle/10665/341648/9789240025707-eng.pdf?sequence=1&isAllowed=y
Home Again goals:

**Forming a collective:** Home Again residents are an example of how those living with mental illness can take ownership of their lives and play a role in the community. The programme intends to support the formation of a collective of such people so that they can engage in cross-sectoral advocacy to address issues that hinder their recovery and reintegration.

**Increase work participation and occupational roles:** Home Again aims to create an employers network to strengthen the case for employing those with mental illnesses. This will aid the process of creating an enabling environment for the latter.

**Reduce socio-economic factors engaged in predicting homelessness and recovery trajectories:** In order to understand the kinds of obstacles that facilitate or hinder reintegration and recovery, the ‘Home Again’ projects provide rich data as part of an action research project. The research teams have documented the intervention and the rich narratives in order to identify and counteract socio-economic challenges concomitant to the user’s history of mental illness and homelessness.

**Increase social networks:** The Home Again programme seeks to create a dense social network for its residents. Residents are assisted to expand the scope of their interaction beyond acquaintances in the vicinity. Inter-house and community interactions across different sites are encouraged, as are transactions with panchayats, SHGs and other community institutions.

**Manage effects of sustained trauma:** The care programme at Home Again incorporates a framework that is not dismissive of user-recounted histories and cumulative effects of accumulated trauma. This allows for the creation of a meaningful path to sustained recovery.

**Supported self-management:** Carers are equipped to implement supportive strategies that involve residents exercising agency over their lives and care routines. An individualised care plan (ICP) is developed for each user in a participatory manner. It incorporates the user’s personal directives for care and reintegration.
HOME AGAIN: REPLICATION, OUTCOMES AND LEARNING

The Home Again programme was first implemented in the year 2013. Housing agreements were formed and other required documents were structured.

After its success in Tamil Nadu, the programme was considered for replication in 10 States of India and parts of Sri Lanka and Bangladesh. The transition to Home Again emerged with the need for social inclusion and to foster independent living for an effective community re-integration.

The partnerships allowed for the exploration and development of personalised non-familial community placement plans in an Indian context, across disability levels from low to high. Without any presupposed parameters of ‘community readiness’ people with psychosocial disabilities institutionalised in facilities across the states of Tamil Nadu, Kerala and Assam were offered the option to live as part of shared homes in the community with the necessary, individualised levels of support.

Following this, the Phase 2 replication began in the period of January 2017, in Thane Mental hospital in Maharashtra. Meanwhile, a pre-enrolment assessment of homes in Kochi was conducted between the period of February-April 2017.

During the period of 2016 - 2017, 152 people accessed the services offered through the Home Again project across the districts in Tamil Nadu, with 34 women and 5 men living in Home Again houses in and around Chennai. In Trichy, beginning with a small number of women, the program, consisting of 6 homes, flourished and more women moved into the homes in this neighbourhood.

In the period 2016-2018, 138 individuals were newly transitioned to Home Again across three sites - Tamil Nadu, Kerala and Assam. Both rural and urban neighbourhoods were considered for replication of the intervention in this phase. During 2019-2021, there were 209 service users across all Home Again sites, including Tamil Nadu, Kerala and Assam. An average of 103 residents accessed skills development and employment services, across all Home Again sites during this period (2017).

Of the new cohort who are accessing care at the programmes, 138 individuals were screened and allotted to the housing with supportive services intervention. Of the 138 screened, 21 dropped out and chose to return to the Emergency Care and Recovery Centre (ECRC).
PROGRAMME OUTCOMES THUS FAR

The Home Again intervention has seen both structured and unstructured inter-house transactions across sites and the formation of natural bonds between residents.

Bonds grew out of natural interactions, conversations and sharing of life experiences, among residents from different backgrounds and with different abilities and levels of functioning. The skills development, employment and engagement efforts were also restructured to offer more incentives, opportunities beyond the usual variables. Social entrepreneurship training such as making pickles, dry powders and rice crisps for sale is seen in full swing across the HA sites.

Participating in activities created a visible change. Residents were encouraged to take directives individually and from peers to manage activities of daily living. Supervision at sites was gradually reduced and the residents were encouraged to reach the point where they could exercise and navigate choices. Three homes at Thirupurur taluk, Kanchipuram took a step closer towards independent living with the removal of personal assistants after 2020.

The four years of partnership brought to the fore several benefits of the Home Again model. An impact assessment for the period 2016-20 for the partnership with PHF was conducted by The Banyan across multisite Home Again programmes. Four domains, namely community functioning, psychological health, quality of life, stigma and discrimination were studied using the following instruments: Community Integration Questionnaire (CIQ) (Willer et al., 1993), WHO - Disability Assessment Schedule 2.0 (WHO-DAS12), Quality of Life Inventory (QoLI - 20) and Discrimination and Stigma scale (DISC 12) (Thornicroft et al., 2009). These are the primary findings:

Cost: Comparing the costs of Home Again with institutional facilities (Care as Usual) in Tamil Nadu reveals that Home Again’s cost of care per client per month ranges from INR 8750 - INR 14000 per person per month (contingent of multiple factors including location of homes and age and disability range of residents), and is more economically efficient than institutional care (INR 20000 per person per month) in improving collective recovery.

Community Integration: Data has shown that Community Integration had improved significantly in Home Again over time with a mean effect of 4.74 improvements and statistically, 99 out of 113 people (87.61%) reported increased community integration scores (2016-18). Similarly, in an analysis of outcomes comparing 113 people enrolled in HA vs 113 at Care as Usual over 12 months (2018), HA was found to offer significant gains in community integration and disability at a fraction of the costs of a lifelong stay in an acute care facility. Community Integration, which constitutes the variables specifying participation in work, home and social activities, improved significantly in Home Again over time (p<0.001) with a mean effect of 4.74 improvements on community integration scores. Disability decreased significantly over time with a mean effect of 3.21 decrease in disability scores (p<0.05). Part of this is because HA draws up individual care plans for new residents. Also, insights and feedback gathered from the homes were shared freely between sites leading to a deeper understanding of the residents. Training, supervision and triangulated discussions on a case-to-case basis with the Project lead, case manager and Personal Assistants were implemented to pay individualised attention to the interwoven social constructs.
**Decrease in disability:** 69 out of 113 people (61.06%) demonstrated a decrease in disability scores. In Generalised Estimating Equation (GEE) models, comparing participants in Home Again and participants in Care as Usual over time with one another in pairs shows a significant interaction effect of time with intervention. Those receiving the Home Again intervention experienced a mean decrease of 3.21 in WHODAS scores compared to Care as Usual and the interaction effects of Home Again over time were observed to have a significant improvement in the participant-rated psychological well-being measure Brief Inventory of Thriving (BiT).

In 2016, at the start of the grant, 88 individuals were residing at the housing with supportive services programmes. This includes 44 individuals at the Clustered Group Homes (Supported by PHF), and 40 individuals at the Home Again Thiruporur programme (supported by Grand Challenges Canada). As on 2018 March, there were 73 individuals accessing care across all the housing with supportive services programmes. This included 48 individuals at the Clustered Group Homes (CGH), and 125 individuals across 25 houses in four sites - Thiruporur, Mogappair, Trichy and Malappuram.
## HOME AGAIN (2013 - 2023)

<table>
<thead>
<tr>
<th>Specification</th>
<th>Outcomes</th>
<th>Source/Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of houses secured for shared housing</td>
<td>121 homes in total</td>
<td>64 homes across Tamil Nadu (2017), Kerala (2017), Maharashtra (2019) and Andhra Pradesh (2021) are run directly by The Banyan. 57 homes across Tamil Nadu, Kerala, Maharashtra, Gujarat, Karnataka, Assam, Nagaland, Odisha &amp; Sri Lanka (2022) are run with Partners</td>
</tr>
<tr>
<td>Number of people with mental illness, who accessed shared housing</td>
<td>559 people (inclusive of newly transitioned and the dropout rates)</td>
<td>Service records of enrolment and service users who remain in housing (including continuous hospital stays for less than 12 weeks) Users who enrol and later require continuous hospital stay of over 12 weeks (i.e. do not return to housing) are excluded</td>
</tr>
</tbody>
</table>
Figure 2: Active client numbers in Home Again across states in India & Sri Lanka
Active aftercare clients across India

Figure 3: Active Aftercare clients across states in India
THE LEARNINGS

Finding a house to rent for mentally ill residents can be a challenge. Considerable time and effort are needed to sensitise not just the prospective owner but also the people in the vicinity.

Several brainstorming sessions are needed on possible approaches that can serve as an inroad into the community. Since all geographies are not the same, there are times when despite the outreach team’s best efforts, no houses can be rented. In the absence of a supportive community, it is best to look elsewhere.

Not all clients want to continue to access services at Home Again. There are instances where either the client is unable to adjust to a home environment or prefers an institutional set-up. Even though clients move to Home Again of their own volition, they are unable to engage with other members in the house and prefer to be disengaged. This affects the dynamics of the house and therefore such clients are moved back to ECRC.

Residents should be allowed to form their own affinity groups. Most choose friends with whom they have been with in the institutional set up. Sometimes, however, they are unable to take the decision due issues related to functionality. In such cases, the team needs to step in and find the home which would be the best fit for them.

Sustainability of the intervention is an area of concern. The Banyan has been working on various sustainability strategies including those that leverage the local government institutions and schemes. Long-term engagement and advocacy with the local government are prerequisites for the health of this programme. Social cooperatives can also be a way forward.
In most cases, the goal of interventions by The Banyan is for the individual to be reunited with the family. Home Again also serves as an enabling junction from where residents find the road home.

**Padmavati**

Padmavati is profound and philosophical without even trying and loves contemplating and discussing existential dilemmas. During one such chat, she revealed suicidal ideations that throttled her when she experienced her first turbulent episode of mental illness after marriage. While on a trip to Ooty with friends, she survived an attempt to take her own life, but her injuries were severe and doctors were forced to amputate her left hand. Like many families who hope to find solace, comfort and reprieve in their faith, Padmavati’s family approached a witchdoctor, who in her opinion made her ‘episodes’ much more problematic and it was during one such day of non-lucidity, that she wandered too far away from home, and ended up at the institution in Kerala.

It took her 120 days in Malappuram before she started responding to the positivity in the environment around her. Memories of life with her husband - Krishnan, of working in the fields, legs ankle deep in the wet soil, of giving birth to two sons (teenaged now), of neighbourhood chatter - the finer points that made up her life, before she came to Kerala, started to drift back towards her. She slowly began to provide specifics about her home, the village, her husband and her children.

As is The Banyan’s philosophy, the Program Lead at Kerala decided to leave no stone unturned and attempted to trace her home and family back to Elakati, Sathya Mangalam. And that was how a journey that suspends all disbelief led Padmavati back to her village. She was regaled, and her sons and husband embraced her. This is how hope manifested and the light at the end of the tunnel finally came about, for Padmavati. The Kerala project team continues to be in contact with Padmavati through aftercare services that include postal medication and home visits.
Madam M

M is an experimental and expressive resident who can break the intermittent quiet in Kovandakurichi (Trichy HA Site) by just being who she is. M is focussed when it comes to work. The anxiety to finish the work is palpable on her face and is obvious through her grunts, which are quintessential to M. She believes that the home’s functioning depends on her doing her work and she is not quite wrong.

Talks happen with random neighbours who stop by for a chat, M gives a salute as a way of wishing good morning, hurries along, hollering out to users - alternating between requesting and assigning work to them to join in and help with the work that rolls the home along forward. M was a resident at CGH in Kovalam, Tamil Nadu before moving to a home and engaged in MGNREGS work regularly.

After her move to Trichy, she says she is even happier if that is possible. She says - ‘Life is work, Amma, I have to work for the house and for myself, that is what will keep me company.’ The only time she abandons work is when she is visited by Jimmy – a dog who has been M’s mainstay for giving and receiving affection – or when she walks down to the small kadai (shop) at the end of the street to buy something to eat. Life for M consists of conversations about love, heartbreak, exchange of experiences, engagement with people around, and routing the insipid away by gaining comfort from work, money and shopping.

Home Again allows the residents to develop social roles and expand social connections beyond the organised mental health ecosystem. This can play a very important role in the recovery process by giving people a sense of purpose and agency as is evident from the story of M.

“Life is work, amma, I have to work for the house and for myself, that is what will keep me company.”
HOME AGAIN SCALE UP

In addition to the Home Again replication being conducted in collaboration with CSOs and Government partners, The Banyan has created a cadre of peer counsellors, activists and nurses. This initiative started based on direct feedback and requests from former clients of The Banyan, who have experienced a state of homelessness and mental ill-health themselves. They indicated a critical need for long-term care services in their region, and also expressed the desire to plan, lead, and manage the Home Again programme in collaboration with the residents and the community.

Amali care for 44 people living in 9 homes in Kovandakurichi and surroundings, aided by 10 staff members who hail from backgrounds of distress. In addition, they were able to create supportive communities in the villages, through mutual support and respect.

Their work has been recognised on national television and they won the prestigious Changemaker Awards. Their lives were captured in The Banyan’s first children’s book ‘Jacklin & Amali’, illustrated by Anushka Madhavan and written by Rega Jha.

Amali and Jacklin’s stories - Peer Leadership

Amali and Jacklin are two sisters who faced severe adversity in their younger years, including loss of their parents and loss of a child. They both experienced mental illness and homelessness before coming to The Banyan. After receiving treatment, they both decided to work with and help other people experiencing mental illness.

After initially providing nursing services in their communities, they requested to anchor the implementation of Home Again in their hometown Kovandakurichi, a village an hour away from Trichy, Tamil Nadu. The Trichy site being entirely peer-led allows the scope for niche therapeutic communities to develop, service user leadership to evolve and take a lead in defining and redefining the idea, paving a meaningful path to scale. As leaders with lived experience of mental illness and homelessness, they are in a unique position to lead a project like Home Again that focuses on self-determination, choice and creating personal bonds. They were able to foster inclusive living spaces for women with long term needs in homes in the community. The homes provide spaces for women to develop deep personal bonds and family-like relationships. Together, Jacklin and

Kovindakuruchi Transactions - Stories of Inclusion

Several villagers of Kovindakuruchi transact with the Home Again clients regularly. Papathy Akka lives next door to one of the homes and sometimes brings mangoes, half-ripe/half fruit for the residents. There is a house owner, referred to by all as Amma, who has non-biological relationships with all the residents - she lends them her earrings, takes them on temple trips and resolves conflicts. Albert, who comes once in a while, strikes a joke, shares some food, and converses a bit. Every time he comes by, Albert and Mary Shantini salute each other with a signature hand movement. A grandmother who lives opposite another home allows the residents a free run of the wide patio outside her home. There are also the sisters who run the grocery shop, who identify small jobs for the residents.
Part - III

NALAM: (2020-22)
The Comprehensive Wellness Approach
NALAM: THE COMPREHENSIVE WELLNESS APPROACH

The ideal situation for the mental health landscape of any community is where symptoms of mental illness are recognised early and treated with care. For this to happen, community engagement and a participatory approach to the problem is very important. NALAM is a community mental health approach designed by The Banyan which looks at mental health from the lens of social issues, and community response as equally crucial to wellbeing, as clinical interventions.

From the early experiences of The Banyan with reintegration and community care, the organisation realised that only institutional services will not be sufficient to deal with mental health issues. If a community displays high amounts of stigma and mental health services are unavailable, returning to the institution or homelessness is a frequent occurrence and a vicious cycle. To address these issues, The Banyan initiated Community Mental Health Programmes in Urban (Chennai) and Rural (Chengalpattu) locations. These began as aftercare clinics for reintegrated clients, and evolved into a robust outreach programme that created identification and treatment referral pathways for the general population in psychosocial distress. As we began engaging the community through awareness programmes, panchayat collaborations, volunteers, especially women from the community came forward to refer children and adults with severe mental disabilities. Some camps were established in collaboration with the Panchayats and Self-Help Groups, when footfalls organically began to increase for mental health issues as well. These volunteers also began to to carry out follow ups with families and initiated conversations with Primary Health Centres for more regular clinics. NALAM as a model took shape during this period, from 2003 to 2012. It was once again tested as a trial supported by the Grand Challenges Canada in 2013, in Thiruporur Block, Chengalpattu District, with 50 volunteers.

Under the NALAM programme, The Banyan recruits and trains members of the community to become mobilisers. NALAM mobilisers based in villages and urban wards engage with the community, identify those in psychosocial distress and if in need of clinical care, escalate a referral to the closest outpatient clinic.

What is important to The Banyan’s approach is that NALAM workers also conduct home visits and offer home-based care to people with mental health issues and their families. The approach works on the family as a whole because it recognises that a stable and supportive family is the safest institution for those with mental illnesses. One of the main obstacles to reintegration of people with their families post-institutionalisation is the fact
that the caregivers are not mentally and economically equipped to look after the family member. Therefore, NALAM workers consider, for example, family dynamics, economic issues and social identities related to caste and gender while assessing and prioritising cases for attention.

The NALAM strategy is to link families to relevant treatment, social entitlements and welfare schemes, as well as linking them to supported employment. Select households in extreme socio-economic distress are offered social care packages that include basic income transfers, disability allowance, housing support and educational and mentorship assistance for children whose parents suffer from mental illness.

**What the NALAM approach delivers**

- community engagement
- Identification and referral of people with mental illness
- psychiatric emergency response engagement with homeless people
- awareness programmes
- family counselling
- child and adolescent mental health interventiosn
- support group meetings
- linkages to government social protection schemes like disability cards, widows pension, livelihood opportunities and education.
- culturally sensitive interventions for those who are marginalised, discriminated against and are facing socio-economic distress.
- financial mainstreaming through access to private and government loans self-employment aid, and skills development training (for those with mental illness)
- network with community stakeholders in order to advocate for the needs of clients.
- after school services to children at risk in select locations.

NALAM rural offers inpatient and community integration. Outreach clinics are operated at The Banyan health centre at Kovalam (a south Indian town/panchayat close to Chennai), and in low-income urban areas in Chennai city. NALAM mobilisers are involved at length and data indicates 92 per cent penetration in the area. NALAM urban services are predominantly constituted in low-income areas in Chennai city.

The Banyan has implemented the Pudhuvaazhv positive mental health project in Kundrathur block. The Pudhu Vaazhv project (PVP) is a poverty alleviation and empowerment initiative of the Tamil Nadu State Government; with assistance from the World Bank (WB). Pudhu Vaazhv Mental Health Project is a new initiative that envisions the inclusion of Persons with Mental Illness (PWMI) into the PVP sphere. The Banyan also implemented NALAM along with the National Health mission to strengthen the District Mental Health Programme in Sriperambathur block, Kancheepuram district, between 2015 & 2019.
Thiruporur and Kundrathur are considered rural blocks, and despite being in the High Development Indicator (HDI) state of Tamil Nadu, have very poor access to all the basic amenities – water, appropriate nutrition, connectivity, infrastructure, livelihood options, and education. Government welfare schemes have not percolated downwards, and thus poverty is perpetuated. Gender and caste based discrimination is deep rooted, substance use among youth high, educational achievements low with a high rate of dropout, and thus high rates of migration with very little conversion in terms of socioeconomic upliftment. Furthermore due to rapid acculturation, and the breakdown of community based safety nets, there is an increased sense of alienation, loss of identity, and breakdown in the socio-cultural fabric and thus, experience of greater distress. Thanks to the NALAM network, over 10,000 people have accessed proximal, comprehensive and personalised mental health and social services. The Banyan collaborates with the Government of Tamil Nadu in two districts to transfer the community engagement components of NALAM and strengthen the District Mental Health Programme. In order to address these issues, NALAM workers operate in and around their own villages, addressing the population of two or three villages, with a population of approximately 10,000–15,000.
A DEDICATION TO MR. CHIDAMBARAM

Over the last 30 years since the inception of the organization, The Banyan family has seen numerous clients, and caregivers pass through the system. Amongst all the stigma and misconceptions, amongst families who chained clients and ill-treated them or abandoned them, one man stood out and defied all expectations, as a caregiver as a service provider. This story is a dedication to our beloved colleague, friend, and family Mr. Chidambaram.

Mr Chidambaram was a father of 4 daughters, living with his wife after giving away his children for marriage. It was the year 2006 when Mr. Chidambaram first walked into our outpatient clinic. He came seeking care for his eldest daughter Mrs. Uma. They had attempted treatment at other institutions before that, but having heard about the Banyan's services in their neighborhood they decided to reach out to the organization. At that time, Uma was married but her partner couldn’t support her. He would leave her with her father whenever her symptoms emerged. Mr. Chidambaram would take it upon himself and did everything he could, including taking her for OP visits, holding discussions with the care team, and assisting in managing her distress at home. He got very familiar with the system, so much so that he knew the exact rack where his daughter’s file was kept, up to the precise location. He even quit smoking, acknowledging the importance of his well-being for being an ideal caregiver. His dedication and involvement in his daughter’s care inspired not only the staff and volunteers, but also other caregivers/families who used to come to our OP clinics. During clinic visits, he would engage in conversations with other families narrating his experience which gave them strength and motivation. His efforts were widely noticed and everyone in the organization knew of him, and was ready to support him in any means possible.

He was offered the role of a Community Worker at the NALAM daycare center which expanded his reach further. He would assist in the management of symptoms and rehabilitation for service users, OP activities, and home-based care. He improved upon his knowledge of mental illness and care processes which he then imparted to others in the form of psycho-education. Circle rounds were conducted during OP where professionals held discussions with clients and their attenders in the waiting room. Mr. Chidambaram’s power-packed speeches based on his knowledge and lived experience broke preconceived stigmas the attenders came with. Their experiences and struggles were validated, and they left with the drive and passion to do their best for their families. He always strived to provide for service users as best as possible, even beyond the capabilities of the organization. Once, Mr Chidambaram was tasked with home visits to review clients and their environment, assist in problem-solving, facilitation of social entitlements, and offer other home-based interventions such as family counseling and individual sessions. During one such visit, it came to his attention that the client’s family was struggling financially to the extent that they couldn’t afford to eat store-bought rice. He then took it upon himself and arranged for 10kgs of rice for their family.

The organisation was grateful to have him work with the team for nearly 10 years before he retired in 2017. Multiple members of his family also sought care in times of distress, and they continued to stay in touch.
Tragedy struck their family during COVID. Mr. Chidambaram had developed wheezing which then exacerbated into severe lung infection in 2021. His health quickly deteriorated, and he had to be admitted. Vijay, our aftercare lead who closely worked with Mr Chidambaram fondly recalled his visit to the hospital for his cherished colleague and friend - “When we went to visit him he was in the ICU, and couldn’t open his eyes. It gave us a lot of pain and grief. It felt as if a huge support system was lost... When he passed away we couldn’t bear it. Other clients and families would question us about him and it broke us to give them the news of his demise..... I learned a lot from him over the years. We would have small small fights but always made up and worked together with ease...I feel very proud to have known him and worked with him”

His story continues to be a carrier of strength, determination, and hope to all those who have known him. He will forever remain in our hearts as the exceptional caregiver, service provider, and human being he was.

**Stories of change - Complexities in caregiving**

The narrative of Mrs. Leela and Mr. Vishwanath is a memorable and effective example of how providing holistic and continued care necessitates support for the family/caregivers of direct service users.

Ms. Leela was houseless for a week before she was rescued and brought to the Emergency Care and Recovery Centre. Within 3 months, the care team was able to successfully identify her husband based on his name and his area of work. Her husband, Mr. Viswanath was delighted to have her back home. Ms. Leela was a service user from the initial years of The Banyan, a period ridden by stigma towards mental illness and myths/misinformation. She had a caregiver like no other, and this is what makes her story a happy one. For over 25 years Mr. Viswanath had diligently supported his wife’s care and periodic reviews. Caring for his wife was not as simple as expected. His was a family of 3 consisting of his wife and a 10-year-old son (at the time of reintegration). As a sole earning member of his family with no support from relatives, he had to do everything - earn an income, care for his wife, rear his son, and also do all the household work. Due to the care needs of his wife, his work was irregular, and had to change jobs multiple times. It was clear that he was the linchpin of the family's well-being. Without him, his wife's care and son's childhood would go for a toss. He found the periodic home visits and emotional support beneficial, and he actively sought the team out for help. When he tried sharing his concerns with his friends for support, he sensed they couldn’t empathize with him. They advised him to put an end to his struggles by leaving his wife in some institution. There were times when he even began to consider this, but came to realize that it would do no good for his wife's recovery. He was candid with the care team who helped him through difficult times. Over the years he managed to care for his family and himself with continual support from the organization. His son continued to stay with them and provide for them with his income after his father’s retirement. During the initial COVID period, Mr. Vishwanath started showing signs of liver function deterioration. After evaluation, it was found that he needed regular dialysis.
Mental health institutions focus on providing care for the clients and no further. In the case of Mr. Vishwanath, if the focus was only on his wife, his distress would have gone uncared for. He might have suffered to bring up his son and his ill wife and may have even listened to all the voices around him insisting his problems would be solved if he institutionalized his wife.

When Mr. Vishwanath fell ill, his son had to care for both his parents and also work, which was arduous. Taking his father for regular dialysis was a huge concern. Identifying the need, the care team supported them by accompanying Mr. Vishwanath to his regular dialysis sessions. The son was thus able to care for the mother. In this manner, the continuity of care was ensured for the client.

It is pertinent for Health systems to understand the complexities of caring for an individual with mental illness. Their well-being may be intricately linked to their support systems thus warranting extended care inclusive of such systems as well.

Peer-led services
Ms. Thiruselvi has been working at The Banyan as a community mental health worker for the past 11 years. On the outset, she comes across as a highly empathetic and sincere service provider, intrinsically motivated to ensure care access to those in her town. It was she who initiated service provision in that Town. Her motivation to engage in such work stemmed from something that had deeply impacted her life.

Ms. Thiruselvi and her then 2 year old son had been rescued in the year 2004. As she recovered at the institution, she was encouraged to think about her future aspirations.

“If I had received care in my own village, I wouldn’t have wandered into another city and become homeless...” - she said. And it was for this reason she decided to take it upon herself to help others access care and reduce the treatment gap in her native village.

She received support to complete her masters degree in Psychology. She moved to her town with her son and began working as a community mental healthcare worker. Using insights from her lived experience and knowledge gained through further reading, she was able to efficiently identify individuals in distress, psychoeducate them on illness and care processes, and link them to appropriate services. She is also actively engaged in providing home-based interventions, facilitating social entitlements, identifying individual capabilities and linking them with vocational opportunities. She continues to help clients in finding and reclaiming their identity.

“If I feel very happy to see that I am able to provide service to others in distress because of which many families have benefitted... it prevented people from becoming homeless... and they are able to lead a happy life “

Thiruselvi has now expanded her reach to four districts in Tamil Nadu (Tirupur, Erode, Coimbatore and Nilgiris). She currently provides end-to-end comprehensive support to 13 clients and their families. Her son is currently pursuing undergraduate studies for which the organisation was able to assist in scholarship support. Thiruselvi is an example of how peers can be very powerful and intrinsically-motivated service providers.
THE NUMBER STORY

The main outcomes that were progressively achieved include integration of long-term care, overall community re-integration, access to social entitlements and the peer-led initiative in Trichy.

Data from the Primary Survey (2019) conducted by The Banyan on the impact of NALAM services in the community showed that the majority of clients reported improvement in their clinical symptoms such as suicidal thoughts, hallucinations, anger, sleep and appetite, self-talk, concentration, seizures and wandering tendency. A reduction in disability was observed with a mean 3.21 decrease in disability scores.

Banyan’s services, when compared to 12.5 per cent of clients in urban areas.

Current well-being among clients was assessed using the Cantril Self-anchoring Scale. The following figure shows that nearly two-fifth of clients reported low well-being, i.e. in the suffering category. Only 28.9 percent of clients stated that they were thriving, with a larger share of clients in urban sites (35.2%) than rural sites (21.8%) under the thriving category.

**Figure 5: Client distribution in rural and urban neighbourhoods and the Cantril scale category**

At NALAM-rural, nearly 40 clients were part of the home-based livelihood programme of The Banyan, whereas at NALAM urban, 43 active clients were enrolled in the three-day care centres.
CENTRE FOR SOCIAL NEEDS AND LIVELIHOODS (2020-22): FOCUS ON SUPPORT NETWORKS

The Banyan’s community-based programmes were integrated into the Centre for Social Needs and Livelihoods (CSNL) in 2020. The Centre operates across Chennai, Chengalpattu and Trichy in Tamil Nadu, Malappuram, Thrissur and Ottapalam in Kerala, and Aghai in Maharashtra. The Centre is unique in putting the family at the core of all programmes and works to build a care ecosystem that aims to reduce the socio-economic factors that lead to re-institutionalisation or homelessness.

Social needs facilitation is provided in the form of:

- Outpatient mental health clinics
- Open Dialogue and other psychological services
- Family facilitators
- Employment facilitation and social cooperatives
- Covid support and financial assistance

CSNL uses social networking and continued care to prevent re-hospitalisation. It facilitates a time-bound, home-based family intervention for a period of three to six months. A mental health team visits the identified families for intensive engagement at the household level. The family as a whole is as much the focus of rehabilitation as the individual member suffering from a mental illness. The intent is to reduce pathways to long-term institutionalisation by building the capacities of the family to help sustain supported self-management and increase social integration.

The goals of the Programme of Continued Care are:

- To increase work participation and occupational roles among people with mental illness and histories of homelessness discharged from psychiatric tertiary care facilities
- To mitigate factors engaged in predicting homelessness and recovery trajectories among people with mental illness and histories of homelessness discharged from psychiatric tertiary care facilities
- To manage the effects of sustained trauma among those with mental illness and histories of homelessness
- To promote supported self-management such that carers learn supportive strategies that involve users in exerting will and preferences over the care and lives
To increase social networks - size, locations and depth - for people with mental illness and histories of homelessness discharged from psychiatric tertiary care facilities

To foster user-carer leadership in the sector by increasing capacities for supported self-management and advocacy and offering fellowships for engagement in action in local geographies of interest and convenience

The Programme of Continued Care has three main components:

Family Systems based Outpatient Care

Under this programme, the outpatient clinics have been reworked to adopt a family-systems-oriented approach to care. This approach includes offering comprehensive healthcare services with collaborative discharge planning, open dialogue, and trauma-informed interventions. In addition, there has been cognitive restructuring to address concomitant psychosocial issues, and familial dynamics and to create an environment conducive to recovery. 220 families access outpatient clinics with individuals who have histories of homelessness.

Home-Based Family Intervention (HBFI):

The Banyan views recovery as a collective process, one which takes into consideration the needs of both the clients and caregivers. The Home-Based Family Intervention uses the ‘open dialogue approach’ to catalyze collaborative visions of recovery involving service users and families. It looks to expand local networks of care and social support that can be leveraged by the families; these interventions are intended to reduce the unplanned use of inpatient services.

Successful return to work strategies, including occupational roles, household-level socio-economic and interpersonal capacities for care and managing effects of sustained trauma, are important to ensure that recovery is supported in the transition from inpatient care to living with families.

Based on trends observed in the geographical distribution of clients returning to families from institutional facilities (The Banyan shelters as well as state mental health facilities in Kerala), about half of the clients originate from within the state and the other half are largely from Bihar, Andhra Pradesh, West Bengal, Maharashtra, Telangana, Uttar Pradesh, Karnataka and Madhya Pradesh.
Work Participation and Employment Initiatives

This component focuses on increasing occupational roles and the capacity to return to work among those with serious mental disorders and histories of homelessness, through two initiatives:

- Employment modules for employers and service users that sensitises and repackages opportunities in formats accessible to people living with mental illness.

- Seed capital and support to initiate small businesses and social cooperatives as part of a group or individually. Case managers work closely with service users and carers to build these micro businesses into viable income-generating units. The service user led enterprises allow for the development of hubs that generate economic returns and public interest and cultivate a network of supported employment opportunities.

**Outcomes of CSNL**

- Decrease in the proportion of people reintegrated to families or communities returning to homelessness.

- Reduction in re-hospitalisation/institutionalisation rates

- Increase in work participation by 80% of those enrolled in continued care in engaged household occupational roles, and by 40% in paid work

- Grassroots resources developed within families and select communities in low resource geographies

- An understanding of correlates and factors engaged in homelessness and long-stay progressions across varied geographies

- A module on Community Mental Healthcare packaged as a Diploma Course

**Statewise distribution of clients reintegrated**

![Statewise distribution of clients reintegrated chart]

[Graph showing statewise distribution of clients reintegrated]
CSNL: SOCIAL COOPERATIVES

While facilitating access to mental health is a necessary component of community care, supportive measures need to include support to help people progress towards their aspirations and goals in life. One way of doing this is by reconnecting people with mental illness to their rightful access to resources and thereby renewing their sense of well-being. Care plans need to include economic rehabilitation to allow people with mental illness to participate more fully in their communities. Every person should be offered the opportunity to resume the education or work that they may have had to discontinue during a period of serious illness.

The Banyan Collectives are a step in this direction. They enable work and employment opportunities for people with psychosocial disabilities through social co-operatives and enterprises. Banyan also employs its clients in its offices and shelters. They are a part of the front office, housekeeping, health care services, data entry and research. Sometimes bespoke opportunities are created in sync with the person’s interests and abilities.

The first social cooperative at The Banyan began 15 years ago with a small eatery within The Banyan premises. The number of income generation activities has since increased manifold.

NALAM Chapati Kadai
This enterprise run by 21 women passionate about cooking, makes chapatis (flatbread) and sells them on the BALM campus to students and staff. Profits are reinvested in the business to ensure a self-sustaining model.

NALAM Tea Kadai
This is a one-stop place for mouth-watering Indian tea-time delicacies. The tea kadai is managed and staffed by residents at the Cluster Group Housing. The small business is on its way to becoming completely self-sustaining.

NALAM Beauty Salon
An independent client continuing to access The Banyan’s services chose to start her own business after working with high-end parlours for over 15 years. This is supported by The Banyan team. The parlour is set up at the CGH site and is accessed by residents, staff, students and faculty.

Thinnai Café
A group of eight women run this eatery. It is located near The Banyan’s Kovalam Health Centre and serves lunch, breakfast and beverages to its community customers and BALM students. Thinnai cafe has also created D’Lite Masala, a set of delectable powders to accompany a range of South Indian Dishes.

Ruchi kitchen
Co-located with the KK Nagar ECRC, Ruchi kitchen provides food to clients and visitors, under the guidance and training of the chief cook. The kitchen was unable to register as a cooperative since it was located inside a Chennai Corporation premises. To solve this issue, The Banyan facilitated the formation of a self-help group, which allowed the group running the kitchen to open a bank account and run their business.
Hygiene products
A co-op in Kerala produces hygiene products and supplies these to The Banyan sites, leading to cost reductions for the organisation. The co-op aims to produce all required hygiene products across all sites.

Moments of Pride - Anu, Nandini and Annamary recognised by the Government of Tamil Nadu as trainers, and entrepreneurs.

Arts and crafts
Arts and crafts are now one of the largest production units at The Banyan, with pre-pandemic sales averaging Rs. 15+ lakhs every year. Orders for The Banyan’s wire baskets, loom dining kits, handbags and so forth are made in stalls, through word of mouth, the website and from donors and volunteers.

CSNL and financial assistance - The COVID Years
Even though a focus on livelihood generation is an important component of CSNL, it is undeniable that urgent financial needs exist that cannot be alleviated with livelihood facilitation alone. A consistent need arises to support clients financially with immediate needs. Supported employment opportunities and social cooperatives are not always accessible to all clients and families. In addition, they do not solve immediate financial needs families may have. In order to address this issue, monetary packages have been distributed to users with dire financial needs. These are provided in the form of Conditional Cash Transfers (CCTs), which are linked to treatment adherence.

Figure 9: Financial assistance and direct bank transfers
As part of the ongoing support to clients aimed at empowerment, inclusive recovery and capacity building, the team works towards enabling access to social care, in addition to disability allowance and access to social entitlements. An example of this is the education support in partnership with Paul Hamlyn Foundation that is provided to residents and supportive services to their families. In the State of Maharashtra, the support is received by 26 individuals and in urban Maharashtra, it is received by three individuals. The total bank transfers for 2020 - 2021 are mentioned in the figure below (PHF Reallocation).

**Figure 11: Total Direct bank transfers (PHF), Project and year wise.**

Accessing social entitlements requires identity documents which clients are not always able to produce. The Banyan helps them procure identity documents and access social entitlement schemes provided by the government.

**Figure 12: Social needs and entitlements facilitation**

Social entitlement facilitation and number of beneficiaries
**SUSTAINED, HOLISTIC SUPPORT SERVICES**

Rajalakshmi is a 51-year-old woman living with her son. She has been a service user of The Banyan for over 20 years. She was rescued from the streets by the outreach team and provided care at the Emergency Care and Recovery Centre. As part of discharge planning, the care team identified her relatives for reintegration but they refused to take her in, due to past conflicts. To ensure she gets to stay with her son as desired, she was provided housing support. Although she had been completely weaned off of medications, she had been in regular follow-ups for extended psychological & social care support. She was psychoeducated on identifying early signs and symptoms which helped her to be proactive in seeking help when needed. Her son was even offered a job at The Banyan and worked for a year in administrative tasks when he was unable to find a job after graduation.

Over the years, both mother and son had been through numerous jobs to support themselves. Although they had difficulties staying in one organization, they were able to independently identify vocational opportunities through employment agencies. In 2020, both of them relocated to the state of Andhra Pradesh for work. Within a few weeks, the entire nation plunged into terror over the speed of the COVID virus and was put in complete lockdown by the central government. With no opportunities to make ends meet, R and her son were on the edge of becoming houseless. She had reached out to The Banyan at the time of her crisis. Through funds from PHF, the care team was able to prevent homelessness, continue her regular care, and also ensure the well-being of her support system through tough times. Through the facilitation of a monetary safety net, they felt supported while they searched for stable income. Rajalakshmi went on to find a vocational opportunity as a cook, while her son, having experience as a caregiver, put it to use as a professional caregiver for the elderly. However, as their income is only sufficient to manage their everyday expenses, they are continued to be supported by The Banyan’s disability allowance which covers any costs incurred while bringing the client for review. This ensured uninterrupted service usage and in-turn, overall well-being.
PHF-THE BANYAN: A COLLABORATION OF LEARNING AND INNOVATION

The Banyan-PHF partnership has resulted in the shaping and strengthening of many scalable interventions with the potential to reshape the mental health landscape. As with most of the TheBanyan programmes, these too were based on the needs observed and stated by clients, families and staff. The common thread across these programmes was that of innovation - of processes, resources and approaches. A snapshot of these innovations is presented below:

Innovation: Inclusive Living Options with graded levels of support in clustered and scattered housing options
This involves helping persons with mental illness slowly ease their way into the mainstream by giving them the choice to stay in inclusive living spaces with a range of supportive services tailored to help them achieve their own unique sense of well-being. These persons are encouraged to form affinity groups and live together in homes in the midst of the community. The shared space mimics a familial environment.

Staying in a family-like environment with clinical continuity, helps the clients work on their social and economic skills, gives them a sense of self and confidence and importantly, helps them make an informed choice about going back to their families or communities of origin.

The care model at these homes is expanded to include allied supportive services such as linkages with relevant government welfare programmes, capacity building for social and economic reintegration and on-site personal assistance. The innovation is executed by a multidisciplinary team, a majority of whom are non-specialist personal assistants (or mental health stewards)

Innovation: Non-technical workforce
The Banyan has been training and employing a non-technical workforce much before it was a common practice. Young women, trained as Personal Assistants (PA) work at The Banyan’s Emergency Care and Recovery Centres (ECRC) as well as the Home Again sites. They receive classroom and hands-on training on general and mental health and best practices on how to assist women at the centres. The PAs generally hail from marginalised communities themselves, including being caregivers to family members with mental illness. The Banyan strives to provide fair payment throughout the years for these types of positions, thereby supporting the women and their families (Balagopal & Vivek, 2019).

Innovation: Democratic processes
An integral aspect of the recovery and care practices at The Banyan is democratic care planning. People have choices available in various aspects of their lives, including food, preferred living arrangement, daily activities, livelihood options, clothes and friends. This is at the heart of the living arrangements in institutional and community settings.

The Banyan processes mainstream the emphasis on choice throughout services and practices. Cases are peer-reviewed at staff training programmes, there are grievance redressal mechanisms in place with a robust process of addressing the concerns put forth by clients. In addition, The Banyan has been conducting resident surveys for many years in order to shape their services better and create as bespoke an array as possible.

This is a deviation from the common “one size fits all approach” where people experiencing homelessness and poverty have no say in what they get to eat, learn or activities they engage in.
advocacy programs at a grassroots level and documentation of the progress made. Similarly, efforts are made to build a supportive ecosystem with government agencies at the local and state level, such as the Department of Health, the Department of the Welfare of People with Disabilities, and the Department of Social Welfare. A supportive ecosystem is required for programs to be successful and to access the existing resources to the greatest extent possible.

**Innovation: Synergy between education and practice through The Banyan Academy of Leadership in Mental Health (BALM)**

The Banyan Academy’s aim since inception is to create a workforce that can address mental health issues in low-resource settings in India. In order to achieve this in the context of the Paul Hamlyn Foundation supported project, BALM has run diploma courses for non-technical/grassroots level mobilisers for engagement towards outreach in institutional and Home Again settings.

Mobilisers are trained to be informed about the identification and referral options for persons with mental illness. Courses are run to prepare participants for work in either institutional or community settings (such as the NALAM project). The diploma courses integrate a theoretical understanding of the clinical and social settings in which they operate, and practical training in skills relevant to the setting, such as conflict resolution, clinical management, advocacy, rapport building, mental health care in the community, and social care needs assessments.
Future Forward
Service User Leadership in Mental Health Care
FUTURE FORWARD - SERVICE USER LEADERSHIP IN MENTAL HEALTH CARE

The Banyan’s philosophy prioritizes on fostering the future of each individual who has lived through mental illness and homelessness. This segment of Banyan’s work focuses on not only facilitating opportunities for PWMI, but also documenting and capturing their unique experiences that can further be used in the way we understand mental illness. The attention towards enabling an independent, creative and insightful future for an individual will be transformational in recognising and rethinking aspects of mental illness, recovery model and systems involved in this process.

Exit pathways like Home Again, Clustered group home have been supportive housing and living models that have enabled people to come together to coexist with affinity and build community and independence. This has been foundational to building a sense of home beyond ‘housing’, leadership and social support amongst service users. Through this model, peer led groups have emerged from communities of recovered (and recovering) service users. Over time, this has initiated several other peer led movements that are founded on storytelling, advocacy and problem solving. One among them, has been ‘Namakku Name’ (Together for each other), a peer advocacy collective started and run by service users.

Initiatives like Namakku Naame, ensure the continuation of the work done by The Banyan. It sustains care and builds community and agency among those with lived experiences of mental illness. This group is initiated by service users for themselves. Currently, it has 85 members across 3 states, Tamil Nadu, Kerala and Maharashtra. There are 15 peer leads in Tamil Nadu, 3 in Kerala and 3 in Maharashtra. This initiative involves regular meetings with other members with lived experiences that include discussions on advocacy, social entitlements, employment, personal recovery, meaning, quality of care, need for and interest in employment, psychoeducation classes, financial stability, accessing entitlements and job opportunities, and advocacy with local governments to name a few. In addition to creating a safe platform to share, these meetings have also built a cohort of peer leaders, eager to co-create knowledge, engage in participatory research, and offer peer-led comprehensive mental health care.

The service user led movement has also sparked the need for documentation and research in the way we understand recovery models. This has led to the need to pay careful attention to the needs, desires and voices within the peer led movements. This has paved the way for the ‘Center for Participatory Action Research’. People with lived experiences have direct understanding and knowledge of illness, recovery, social needs, issues and everyday events that impact their own recovery. Their voice is the fabric of how we can understand mental health. Their participation in research and training is vital to reimagining mental health care. This center at BALM aims to conduct participatory action research to build evidence-based interventions and empower marginalized communities like PWLEs, tribal populations and homeless people. The center primarily aims to work with homeless people with mental illness who are accessing the Banyan services across regions. Further it aspires to ensure that each individual with lived experience can foster their own future and contribute to the collective understanding of mental health care.
The Banyan envisions that peer leaders and other partners will also come together to collaborate and form a collective that will advocate for social entitlements such as housing, medicines, allowances, employment and disability benefits. These are fundamental to ensuring sustained care for service users that will enable them to be independent. Further, this will encourage more service providers to adopt inclusive living approaches that will enable more creative deinstitutionalized pathways for recovery and social inclusion.

**Creating a cadre of peer leaders – The Recovery College Approach**

This initiative hopes to nurture and foster the growth of what is to come, a cadre of service user leaders who can redefine the language of mental health, illness and advocacy. This will enable a space to create communities specific to recovery that go beyond the conventional pedagogy of the ‘user-carer’ model. It will expand social interactions and allow for the framing of identities that are personally resonant and independent of diagnostic categories.

In order to make this a reality in the complex population that The Banyan works with i.e. homelessness and mental illness, there is a need for resources and training that can enable this vision. This will help create leadership roles in advocacy, service provision, research or other choice-based vocations that can be sustained over a period of time. In so doing, it will promote financial independence and challenge the prevailing perceptions around social roles and capabilities of persons with mental health issues.

The Banyan is extremely grateful to enable these innovations through the tremendous contributions of Paul Hamlyn Foundation, and looks forward to many decades of meaningful collaboration.
About the Paul Hamlyn Foundation (PHF)

PHF
The Paul Hamlyn Foundation (PHF) was established by Paul Hamlyn in 1987. He left most of his estate to the Foundation making it one of the largest independent grant-making foundations in the United Kingdom. It invests in people and organisations with the potential to catalyse change and create a just society in which everyone, especially young people, can realise their full potential and enjoy fulfilling and creative lives.

The Foundation uses multiple approaches including partnerships and innovation in grant-making to create a contemporary philanthropy model that is peer-focused, responsive and flexible. The PHF therefore also works with other groups and organisations besides those it funds. Accordingly, it actively welcomes partnerships – with other funders, with central and local government and business – and builds communities of interest in the fields that it supports.

The Foundation encourages its grantees to improve their impact and practice by developing their own partnerships locally and nationally. The Foundation work is driven by core principles:

Collaboration and connection
PHF believes in the power of working together to achieve a greater impact. It aspires to create a network of communities, through different areas of its grant-making, that share common goals. In order to create these strategic networks, PHF works to develop deep knowledge of the fields in which it funds.

Trust
Trust is integral to robust collaboration. Without it, the power dynamic between funder and funded can undermine progress towards social change. To build trust PHF focuses on delivering its commitments, and on being resilient and consistent over the long term.

Openness
Openness is key to building trust and enabling collaboration. PHF processes are straightforward and transparent; it shares its data freely. The Foundation is open to receiving feedback to improve relationships with different stakeholders. It believes in honest communication and constant improvement.

Thoughtfulness
Every decision has an impact on someone, so PHF believes in thinking about others with kindness. It seeks to be attentive and careful in exercising judgement and to create the time and space for deep conversations and learning. Being flexible and responsive to the needs of those it funds is integral to its funding approach.

PAUL HAMLYN FOUNDATION IN INDIA
PHF funds programmes that keep the target community at the centre of all design, planning and implementation. These programmes “enable some of the most vulnerable and poor communities to take control of their own development needs and challenges by improving their own understanding of their realities and facilitating processes that enhance their capacities to bring in a change process; a process that is just, inclusive and ensures their dignity”.


India is the only country outside the United Kingdom that the Paul Hamlyn Foundation works with. It has been doing so since 1992 with communities across the country. The Paul Hamlyn Foundation mapped a new strategic plan for India at the beginning of 2013 to work with vulnerable communities. PHF has attempted to address the conditions that surround grant access and availability to many small and medium NGOs working with vulnerable communities in especially chosen geographies. PHF has helped them to bring in more rigor and greater professionalism in their work. This has included areas around financial management and governance and more importantly helping NGOs approach work with a clearer perspective and a better estimation of what they would like to achieve and the philosophy that will help them get there. With communities benefitting from the intervention more actively involved with the designing of the project and measuring outcomes, the approach to community led transformation processes have been encouraged and strengthened.

PHF has around 70 partners at any point in time. More on PHF is available at [www.phf.org.uk](http://www.phf.org.uk)