THE BANYAN - AZIM PREMJI FOUNDATION EMERGENCY CARE AND RECOVERY CENTRE

STRUCTURE, PROCESS AND OUTCOMES

The Banyan
I exist therefore I am

balm
BANYAN ACADEMY OF LEADERSHIP IN MENTAL HEALTH

Azim Premji Foundation

Authored by: Akshita Vaidyanathan, Mrinalini Ravi, Lakshmi Narasimhan, Nisha Vinayak, Archana Padmakar, Preetha Krishnadas, Kamala Easwaran, Leelavathy Philip, Shwetha Abigail, Rishabh Anand, Tanya Joseph, Priyanka M, K.V.Kishore Kumar, Vaishnavi Jayakumar, Vandana Gopikumar.

All content including images and data represented in this manual are the intellectual property of The Banyan. It may not be reproduced, displayed or reprinted in any form without the authors' consent.

Consent has been obtained from all individuals featured and depicted in this manual, both visually, and in writing (pictures and case studies).

For more information or queries regarding The Banyan approach, please contact:

smt@thebanyan.org

Table of Contents

Overview **4**
Who are we? Here's our Vision **9**
Value Deck **9**
Individuals We Serve **13**
Amli & Jackulin 13
Emergency Care and Recovery Centres (ECRC) and Homeless Shelter Based Services (HSBS) **14**
Phase 1 - Critical time intervention, safety planning and harm reduction 17
Phase 2 - Welcoming the client 21
The Welcome Kit 22
How does Social Architecture and focus on institutional design help lift mood? 23
Phase 3: Engagement with the client 26
Periodicity of Review 28
Support Group Meetings 29
Phase 4- Focus on Social Role Valorisation - Pre-discharge stay in recovery Hubs 32
Reintegration and Aftercare Process **34**
Dissemination of Reintegration and Aftercare Options at Institutional Facility 34
Discharge Readiness Screening 34
Pre-discharge - Working towards Social Inclusion 35
Reintegration Steps 37
Aftercare Packages 39
Quarter 1 41
Quarter 2 41
Quarter 3 41
Quarter 4 42
Skills **43**
Skills Development, Vocational Training and Livelihoods Facilitation 43
Goals 43
Skills and Employment Training 44
Employment Placement 45
Social Cooperatives: 47
Salary Structure 47
Monitoring & Evaluation Processes **48**
M&E: ECRC 48
Quality audits 52
Internal Audits 52
Integrated Care Pathways **53**
Social Care Systems 54
Psychological Services 71
Disorder-Specific Psychological Interventions 80
Trauma & Homelessness 82
Psychiatric Services 83
Depressive Disorders 85
Psychotic Disorders 86
Substance Use Disorders 87

Stress Related Disorders 88
Epilepsy 89
Intellectual Disability 90
Department of Nursing 106
Lay Health Workers 108
Appendix 109
Quality Audit (Example) 109
Preference List 111
Repeated Scales 113
Modified Colorado Symptom Index. 113
Social Functioning Instrument - Staff Rated 121
Pre- Discharge Home Visit Report 129
Discharge Summary 131
Reintegration Report 140
Reintegration Report 140
Post Discharge Follow Up Form 151

Overview

The Banyan is a registered public charitable trust, founded in 1993, that offers comprehensive mental health solutions for persons homeless or living in poverty with severe mental disorders. The Banyan services a million through its hospital based services, inclusive living options and mental health units across three States *(Tamil Nadu, Kerala and Maharashtra)*, and has partnered nationally and internationally with civil society organisations, user-caregiver groups, Governments, and academic institutions. The Banyan Academy of Leadership in Mental Health (BALM), founded in 2007, is a mental health and social science research and teaching institution, that has trained over 400 students in social work, community mental health and applied psychology. BALM aims to bridge treatment and care gaps, using action and transdisciplinary research methods that facilitate model building, human resource development, social entrepreneurship and intrapreneurship, and mental health service user engagement.

Our Programmes

Care and facilities offered by *The Banyan* are channelled through a user-centric, evidence based and adaptive mental health system framework. Treatment options at The Banyan are executed by multidisciplinary mental health and social care teams *(psychiatrists, social workers, psychologists, occupational therapists, health workers, community mobilisers and personal assistants, medical officers, vocational trainers, and development practitioners)* such that an individual's evolving needs are well supported. Our services are directed towards promotion of capabilities, participation in social life and attaining a sense of agency, as well as achievement of clinical, functional, social and personal recovery. We want our mental health service users to feel well, supported, confident and positive about their future.

The Banyan and BALM incubate the following centres and programmes:

Emergency Care and Recovery Services - These centres are located across 2 hospital based settings and a shelter for men, and serve over 150 individuals at any given point. A multidisciplinary team offers clinical, psychological, and social care at these centres with focus on personal recovery and social inclusion. Notably, these collaborative and user driven services also include open wards, user-led service audits, human rights cell and grievance redressal bodies to ensure accountability and transparency. In addition, our recovery services enable exit pathways to families of origin or working women's hostels, independent living and supportive housing in the community. Over 4000 individuals have accessed these services over the past 25 years, and, approximately 60% have returned home. This approach to care now stands as a benchmark for holistic and humane care for homeless persons with mental illness.

NALAM: Centre for Mental Health Systems - The Centre for Mental Health Systems focuses on promoting convergence between health and social care services such that social distress and structural barriers such as gender based violence, pervasive poverty, livelihood instability and homelessness can be tackled. The Centre for Mental Health Systems has strong interlinkages with the Government of Tamil Nadu, the panchayat, and other civil society organisations working in the sector, and works in conjunction with them to ensure that resources are optimised, and a tight network of care is fostered. The Center for Mental Health Systems incubates The Banyan's NALAM programme - a well-being oriented, community based mental health care programme driven by grassroots workers who offer multi-tiered, multi-interventional packages of mental health care, that range from tracking progress on symptom reduction and securing economic stability, to pursuing personal aspirations. Our rural and urban mental health programmes service a population of over 10 Lakhs across 3 States and 6 districts through 17 mental health service access points/or mental health care units (MHCU). We have registered over 10,000 clients to date, and over 800 children access our youth clubs, pre-adolescent workshops, and tuition centres.

Centre for Recovery Science and Inclusive Development: Development as a concept has evolved from focusing on economic growth, to one that encompasses a broad range of well-being goals, such as social justice, education, housing, health and the notion of promoting individual capabilities to achieve a life that each individual finds meaningful. Mental health and poverty are inextricably linked, and are bi-directional in cause and effect. This nexus makes it imperative that mental health programmes are multifaceted and aimed at improving allied goals of nutrition, poverty reduction, educational attainment, and promotion of redistributive justice. The inclusion and reflection of mental health as a key agenda in achieving the Sustainable Development Goals (SDGs) reiterates this paradigm shift in the notion of development, and stresses the urgency to develop approaches to care that facilitate positive mental health gains and social inclusion. The Centre operationalises three programmes that are embedded in this philosophy, and enables access to a range of inclusive living options such as:

Home Again - Inclusive Living Options: Graded care packages are available for persons living with moderate to severe mental health issues, ranging from cottage styled assisted living to a model that emulates a homelike environment and enhances participation and experience of agency. These long term care options encourage social inclusion in rural and urban communities and operate across 6

districts in 3 States. Today, 220 individuals, in 49 houses, live in friendly neighbourhoods experiencing enhanced social mobility and socio-economic and cultural participation.

Skills and Social Enterprise development: Choice and interest based vocational training and employment options can promote inclusion, facilitate financial security and a sense of personhood and purpose/meaning. At The Banyan, training and work placement is offered across three verticals - arts & crafts (*wire and jute products, carpentry, tailoring etc.)*, hospitality services *(housekeeping, beauty services, laundry, waitstaff etc.),* and healthcare *(personal assistants, community based mental health workers, peer advocates, programme managers etc.).* Income enhancement is certainly a key goal, and employment kiosks offer an opportunity for clients accessing any of our services to register for the same. Small and medium scale grants are also awarded to aspiring entrepreneurs, to federate into social cooperatives and run small businesses. These include *The Banyan Bistro and Veedu* - the hostel that services BALM, *The NALAM Café*, *Xtreme Cleaners* etc. 60% of our clients are currently engaged in some form of gainful and productive work.

Sustaining well-being - Aftercare services: The aftercare programme ensures continuity of care, and access to clinical and social care. It seeks to strengthen networks of care by building a coalition of civil society organisations, Government agencies, and individual functionaries *(community health workers/peer advocates and activists)* with capabilities to offer integrated mental health and social care interventions. Besides access to medical and psychological/counselling support, social care facilitation such as problem solving, work placement, access to social entitlements and local community support circles are also essential components of our aftercare programme.

The Banyan Academy of Leadership in Mental Health

Tata Institute of Social Sciences (TISS) at BALM: To ensure that some of The Banyan's models can be fine-tuned and taken to scale, a collaboration was fostered between BALM and South Asia's leading social science institute,the Tata Institute of Social Sciences, to offer 3 full time masters' level programmes in social work and applied psychology, as well as diploma programmes in institutional and community based mental health care, with the goal of building human resource capabilities. The BALM-TISS campus in Kovalam is co-located with the Clustered Group Homes (CGH), some of staff at the CGH are former residents who have

recovered - this model encourages interaction between students and residents, and illustrates the philosophy of BALM that aims at bridging the gap between theory and practice. Practitioners and international and experiential experts from transdisciplinary backgrounds have trained over 450 students in an inclusive ecosystem where persons with mental health issues live and work.

Centre for Social Work Practice, Development Studies and Social Policy: The Centre for Social Work Practice and Social Policy hosts the Department of Social Work that offers a full time masters' level programme in social work practice in mental health, and diploma programmes for community based mental health workers. The programmes' course offering includes modules on critical and clinical social work practice, community organisation, social welfare facilitation, community based mental health, social policy and planning, marginalisation and human rights, research methods in social work, epidemiology, social work and development, counselling and therapeutic interventions, and leadership and management among others. The Centre for Social Work Practice and Social Policy is rooted in constructivist teaching methods, and ensures that each student spends over 1000 hours in practicum over the course of their programme at BALM. The diploma programme in community mental health to train the non-technical workforce is a collaboration between The Banyan - BALM - TISS and the University of Pennsylvania School of Nursing. This programme will be used to train multiple cadres of mental health professionals including community based rehabilitation (CBR) workers, voluntary health nurses (VHNs), auxiliary nurse midwives (ANMs), etc. In 2019, the centre will launch international diplomas in 'Homelessness and Mental Ill Health: The role of State and Society' and 'Behavioural Economics and Health Systems', offered by global faculty from TISS, The Banyan, BALM, NIMHANS, University of Pennsylvania, New York University, Temple University, Aman Biradari, Koshish, Healthcare for the Homeless, Boston University etc., and the other in 'Social Entrepreneurship in Mental Health' with Ashoka Innovators for the Public and TISS. The Centre also offers short courses on anthropological thinking in social work with New York University and Cornell University; social inclusion, social mixing, prejudice and mental health with Temple University;self enhancement therapy, open dialogue with the Department of Mental Health - Trieste (World Health Organisation (WHO) Resource Centre); arts based therapies; etc.

Centre for Behavioural Sciences: The Centre for Behavioural Sciences at BALM hosts the Department of Applied Psychology that offers full time programmes in- Clinical and Counselling Psychology The programmes' course offering includes modules on quantitative psychology, health psychology, developmental psychology, cognitive psychology, social psychology, and medical anthropology, among others. The centre provides the opportunity to build and hone clinical skills across multiple settings, and grapple with dilemmas associated with the formation of the therapeutic alliance. Further, the centre offers specialised courses and certification on therapeutic practice in collaboration with international agencies. They include Cognitive Analytic Therapy (CAT) with the International CAT Association (ICATA); Buddhist Psychology in collaboration with ARTH Clinic, Mumbai; and Dance and Movement Therapy in collaboration with Sanved, Kolkata, among others.

BALM-Sundram Fasteners (SFL) Centre for Research and Social Action: The BALM-SFL Centre for Research and Social Action showcases a unique collaboration between a corporate powerhouse and a not-for-profit think tank. The centre aims to develop and innovate responses and solutions to some of the most pressing challenges that impede social justice. The centre uses action research and field practice as tools to scale up services and increase access to value-based, comprehensive mental health services, particularly for vulnerable groups. It leverages The Banyan's experience and expertise as a thought leader to diffuse and scale up values and approaches to care, in collaboration with multiple partners *(government, funding and research agencies, and not-for-profits)* to revitalise and strengthen mental health systems across the country. It features collaborations with multiple national and international not-for-profits and academic partners including Rutgers University, New York University, Cornell University, University of Pennsylvania , and the Department of Mental Health, Trieste *(WHO Collaborating Centre)* among others.

Who are we? Here's our Vision

We believe it is our responsibility and commitment to society to build '*An inclusive and humane world that promotes capabilities, empathy, equity and justice'.*

Our Mission is focused on: *Enabling access to health and mental health care for persons living in poverty and homelessness through comprehensive and creative clinical and social care approaches embedded in a well-being paradigm. The needs of those who live in the margins are our collective responsibility.*

Value Deck

Value based care in health/mental health as coined by Prof. Michael Porter of Harvard is defined as, *"a care model in which incentivisation, efficacy and effectiveness of programmes is measured based on patient health outcomes. The 'value' in value-based care is derived from measuring health results that matter for a patient's condition across the care cycle, as against the costs of care for a patient's condition over the care cycle."* In effect, the goals of value based healthcare are to improve patient outcomes while reducing the cost of care, in a manner that results in collaborative care planning, improved patient outcomes, greater patient satisfaction, and overall resource optimisation.

While The Banyan adopts facets of this approach, in terms of ensuring resource optimisation without compromising on patient satisfaction and outcomes, the notion of value based care here moves beyond the economic model, into the sociological and organisational development definitions of value. Emile Durkheim posited that, *'values enable individuals to feel that they are a part of something larger than themselves'*, and can be deemed as '*general standards, and higher order norms'.*

What purpose does being a value based organisation serve?

Organisational *values* drive the way individuals influence each other, interactions between members of a team, resolutions of conflict, and most importantly social cohesion that enables a group of people to achieve a shared vision and goal(s). Our values are not our key roles and responsibilities; they are unseen drivers of behaviour that are based on deeply held beliefs that influence decision making. Strong organisational value sets and the collective behaviour of all members of a team make up the organisational culture, loosely defined as an organisation's *'DNA'* or '*the way we do things around* here'. A value based organisation reflects a living, breathing culture of shared core values,

offers higher goals or ends for all members to aim for, stabilises and provides for a sense of uniformity in group interactions, and hence creates a sense of belongingness, and acts as a guideline for responsive practice particularly in health care, more so mental health care. Those who find alignment between their personal values and organisational values create a unified and motivated workforce with higher performance outcomes. This is particularly relevant in the social and development sectors where there is a need for commitment, passion, and persistence in the face of unyielding and complex problems.

We see this in action at The Banyan, where value based care refers to the deep rooted belief systems upheld in a resolute manner by individuals across all cadres. The Banyan encourages creativity, innovation and contextualisation, however, there is an expectation of a high degree of fidelity to the ethos and core values of the organisation. We have identified cross cutting foundational principles to assist in the translation and articulation of vision and values into practice:

Guiding Principles

1. **User centric care paradigm:** All of our services, in their design and delivery, are centered around the needs and priorities of the primary group that we serve: persons with mental illness and their families. We focus on facilitating personal recovery goals, and believe that all persons, irrespective of disability or diagnosis, are able to achieve their own sense of wellness. We have created systems and processes that draw from lived experiences, such that appropriateness in care, collaborative decision making, participation in the organisation's growth and development are encouraged. User led service audits are an essential part of our programmes such that the value of responsiveness and inclusion is instilled across all cadres.

2. **Promotion of personal recovery:** All services and pursuits at The Banyan incorporate approaches and options that infuse lives with meaning, hope, fun, and aspiration irrespective of age, diagnosis, level of disability or prognosis. All professionals at The Banyan seek to highlight strengths, and present opportunities wherever possible such that individuals have the chance to aspire and feel that their dreams are within reach.

3. **Focus on dignity, participation and experience of agency:** Human dignity may be defined as, "*a state worthy of honour, respect, equal status and it is inherent connected mentally with human life irrespective of caste, creed, sex, colour, status, of the person".* The right to dignity is an inalienable right wherein every individual has the right to live a life free from discrimination, entitled to claim equal respect from fellow citizens and the State. However, while this is a constitutional right, it is not upheld in practice. The Banyan focuses on setting right this imbalance and focuses on reclaiming human dignity and the right to agency, and ensuring participation in social and cultural life as an entitlement and norm.

4. **Promotion of social justice and inclusion:** The Banyan's mental health system is cognisant of social determinants of mental health such as extreme poverty, gender or caste based discrimination, inadequate housing, and seeks to systematically tackle it through targeted interventions that reach the ultra poor and vulnerable. Services acknowledge socio-

economic structural barriers, work with a positively biased focus with such populations, and deliver care plans that incorporate clinical and social recovery pathways to eliminate inequity and lift people out of extreme poverty.

5. **Cross-sectoral, transdisciplinary approaches to care to maximise and optimise gains:** Services across the continuum will adopt a transdisciplinary care planning approach that incorporates interventions from diverse disciplines, and equally **depends** on the service user to drive the many goals of recovery, be it inculcation of a positive approach, enthusiasm to collaborate and participate in work and socio-cultural life or influence policy. Cross-sectoral collaborations with the disability and social welfare departments and agencies will be fostered, and are essential to comprehensive service delivery, enhanced outcomes and therefore decreased costs on account of ill health over a period of time.

Values - Being embedded in a philosophy of capabilities promotion, justice, equity, and unconditional care:

Active empathy and radical acceptance: **Inculcating a climate of trust**

While working with any human being - not just persons with mental health issues - it is imperative that we channel active empathy. Not just 'putting oneself in another's' shoes, but truly understanding their perspective, circumstances, and suspending your own notions and opinions about the same during the process. In a therapeutic relationship with a person with mental health issues, it is critical that a sense of trust, belief and faith in the narrative is built during the initiation of the therapeutic alliance. This allows for every individual to share unabashedly, and build trust in the therapist. Experiencing a sense of unconditional support will aid in the formation of relationships based on trust and interdependence.

Sustained engagement and responsiveness

It is imperative that mental health professionals foster an environment in which distress is normalized, while still ensuring the client has a safe space to cycle through her ups and downs, and regain stability. Owing to the nature of mental illness, our clients move between good and bad days, and the care team must ensure that they are supported and have a space in which they feel comfortable experiencing their emotions without judgement. Similar forms of engagement and responsiveness can also be seen in families wherein individuals do not 'let go of' their loved ones, but continue to engage despite strong insistence to the contrary.

Building a culture of interdependence

Every individual wants to be needed, and feel like they contribute positively to another's life. At The Banyan, we foster this culture of interdependence. Be it having pets, being caregivers to their friends, offering support to staff, or lending a shoulder to cry on, mental health service users at The Banyan are never only *'receivers*' of services. Contrary to the popular notion in theory that advocates for a professional distance between a mental health practitioner and the client, we see that organic and symbiotic bonds between mental health professionals and clients result in more honest and authentic engagement, and greater change in the mental, emotional and psychological well-being of an individual. It also reduces burnout and fatigue rates for the practitioner, and ensures a stronger investment into the client's well-being.

Fostering choice and agency

At The Banyan, we strive to enable access to the everyday choices that an individual makes. This includes choices on clothing, leisure, food, religion, spiritual practices, friendships, engagement and withdrawal, intimacy or even expression of anger. It is important that you value client choices, just as you would your own.

Finding the joy in 'small' things: Infusing hope

Looking forward to small joys and celebrating every positive occasion that comes our way stimulates one's senses and infuses hope. It helps counter negative thoughts and barriers, and gives us something to look forward to -- a future, a plan, a goals - however small or large they may be. This can be facilitated in simple ways - the applause at the conclusion of a finished product during vocational training, or the cheering after a successful hosting of a gathering, and even continuing to care for plants in a garden are important transactions that promote aspiration. Encouraging individuals to feel that sense of accomplishment through simple gestures, and to feel a sense of contentment at the end of a task are important and must be focused on. This is true not just for mental health service users but for members of The Banyan team as well, who are embedded in an ethos of tackling hardships with a sense of lightness and ease, so that they are not overburdensome, and celebrating seemingly small changes and wins such that fatigue and burnout doesn't set in.

Innovation and curiosity

We encourage our staff, clients and caregivers to be involved in the innovation process that takes place at The Banyan. We are continuously monitoring, auditing and changing our programmes to match the needs of the individuals we serve.

Representation

At The Banyan, we strive to include individuals from all walks of life in our organisational structure. Of course, this includes individuals with mental health issues as well as those from a variety of class, caste and socioeconomic backgrounds. We make sure to have diversity across our staff, senior teams and board in order to have an array of perspectives and voices when it comes to making clinical, social, and structural decisions in The Banyan.

Persistence and Resilience

The Banyan values the strength of persistence and resilience that we believe every individual is capable of, with a little bit of help and support. We motivate our clients to face their distress, overcome challenging barriers, and persist through the difficulties they face externally and internally.

Individuals We Serve

A glimpse into the lives of the people that we serve! Our teachers, our inspiration…

Rani Bhaskar

One rarely sees Rani without her army of dogs; she cares for them and loves them, as they love and protect her. Celebrating relationships.

Akoli

Exuding warmth everywhere she goes, Akoli is a beacon of hope. Having won many battles against her inner demons, she has found meaning in being a mother, and today derives a sense of purpose in seeing her daughter grow. Celebrating motherhood.

Bala Aunty

Bala Aunty, one of the most distinguished people we know can often be found curled up with a Dickens novel and a heartwarming smile. Her dignity hasn't been robbed by ill-fate, and she remains optimistic despite the many losses that she's suffered. Celebrating spirit and courage.

Chengamma Paati:

Chengamma Paati is who we aspire to be. To her, age is just a number, she stays active making chapathis, and she remains young at heart. Her work is the secret force that keeps her going. Celebrating self-reliance.

Amli & Jackulin

Our programme in Trichy is led by experiential experts, Amali and Jackulin, who themselves suffered both homelessness and mental illness. Their personal experiences that included loss of parents to ill health and consequently loss of all support networks, abandonment, abject poverty, segregation by their neighbours and other village folk, as well as the loss of a child and loss of husband to suicide and trauma, did not crush them dry of hope. Instead, these experiences infused in them passion and spirit extraordinaire, leading them to form a chapter of The Banyan in their home community in Kovandakurichi (Trichy), with the mission to educate those very persons who had shunned them.

They have built a programme that provides a home and long-term care for 32 women. Their ability to be naturally conscientious to the needs of their residents comes easily, having themselves broken barriers of demarcated social spaces. Being in the moment and looking ahead is what they practice, besides kindness and light heartedness. This certainly helps heal and inspire!

Emergency Care and Recovery Centres (ECRC) and Homeless Shelter Based Services (HSBS)

Some of the ECRC's unique attributes include

Focus on social role valorisation: The dynamic learning process led by consumer feedback of services has led to the evolution of a comprehensive care model that is a unique amalgamation of social and clinical interventions. The emphasis on social care as a therapeutic approach through the promotion of work participation and employment assistance; recreational activities like music, theatre and dance; setting up of support groups; and the facilitation of social and economic welfare benefits through liaisons with Government machinery, is an essential part of the care package. The organization functions on a wellness and development paradigm and takes into account structural barriers and one's social context affecting mental health and well-being, such as poverty, deprivation, intimate partner violence and the lack of access to basic housing, sanitation and financial services. In all its interventions, maximising potential and capability, and promoting social mobility are priorities.

Innovative Living Spaces and user centric approaches to care: There is an innovative social order at The Banyan's institutional setting wherein consumers reside in one of four living spaces depending on levels of functionality. Interaction between residents is encouraged, and those with increased awareness, wellness and independence act as 'agents of change', providing inspiration and instilling a sense of hope amongst others. The Recovery hub that houses growth labs, social skills hubs, vocational skills hubs, and multi purpose spaces that host support group meetings and peer support opportunities are an essential part of The Banyan's clinical, personal, social and functional recovery centred treatment plan.

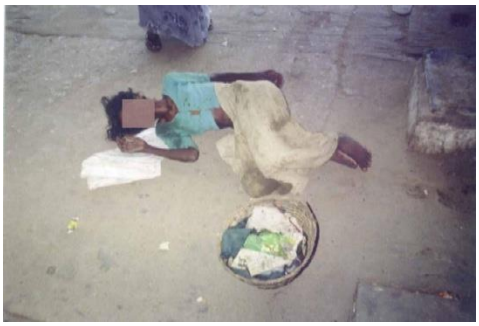
Co-production and Participatory Planning of Services: The cornerstone of The Banyan's care services rest in the ideology that the right to choice is fundamental, and that clients are full participants in the process of recovery and rehabilitation. In addition to periodic reviews of The Banyan's institutional and community facilities conducted by various experts in the mental health sector, The Banyan conducts an internal review solely based on service user's feedback. This not only enhances the organisation's service offering but also contributes extensively to existing literature on human rights in institutional settings, since studies including services users are few and far between. Further, every resident at the Centre has access to a human rights cell comprised entirely of external members, a grievance cell, a legal aid cell, and has the ability to self-discharge when they deem fit. Globally, there has been a shift towards delivering collaborative care that is lead primarily by the mental health service user. Our approach mirrors this trend, and seeks to set benchmarks in the Low and Middle Income Country (LMIC) context, while remaining culture sensitive, and ensuring personalisation of services to respond to individual needs.

Continued care and problem solving support: The Banyan's reintegration process evolved in response to the aspirations of residents to trace steps back to their home and family of origin. Returning to place of origin after an extended period of homelessness, and care in an institutional

setting is a difficult transition both for the client and their family. The Banyan seeks to reduce the extent of these barriers, by ensuring the resident has continuity in care through individualised aftercare plans tuned to support six domains - psychological health, disability, quality of life, caregiver strain, socio-economic status and community integration - over a period of 12 months of a resident's return to family. Networks of influence are also identified in the area to help offer clinical or social support and ensure continuity of care. Ensuring contact and engagement with a care provider will reduce readmission, and prevent a descent into a state of ill-health/homelessness once again.

Formation of a highly-skilled non-technical workforce: Globally, among other factors, the severe human resource crunch in mental health and social sectors require constant innovation to ensure effective and quality care. Non-specialist health workers, otherwise known as lay health workers or community workers, are increasingly becoming the most invaluable resource especially with regard to mental health services. Studies show that lay health workers trained in collaborative, integrated mental health care can reduce the prevalence of common mental disorders, suicidal behaviour, psychological morbidity and disability burden. The Banyan's health care workers and community workers are undeniably the backbone of the organisation, and account for **60%** of staff strength. They are from local communities, and are trained to identify mental health issues within communities, ease referral pathways, facilitate socio-economic entitlements and most importantly engage with clients to help them navigate the challenges of managing their illness and achieve their own subjective notions of wellness. Additionally, this model enables livelihoods and aids in poverty reduction by creating jobs amongst poorly resourced individuals.

The Recovery Hub: The Recovery Hub seeks to enable people with mental health issues to access the same opportunities in life as everyone else does. The endeavour is to support each individual's personal journey towards a meaningful, full life, where the ability to experience joy, build relationships, find hope and meaning, exercise choice and agency are crucial elements.



The 110 bedded emergency care unit or psychiatric nursing home located at Mogappair, North Chennai, the 15 bedded inpatient service in Kovalam, Kanchipuram District or the homeless shelter run collaboratively with the Corporation of Chennai in Santhome, Central Chennai, are often the first points of contact with a formal mental health care system and supportive social care services for a homeless individual experiencing their first psychotic break or episode of distress. These facilities and the mental health and crisis care teams should therefore be sensitive and mindful of the multi- dimensional vulnerabilities including possibility of physical and sexual assault, starvation, infliction of severe maggot ridden wounds, lacerations and injuries including broken limbs that such individuals may have been exposed to. Their compromised emotional and physical states of health and inability to engage with individuals or systems of care as a result of fear, ostracism, negligence and chronic ontological insecurity may further distance them socially- their primary identity becomes that of a person lacking citizenship, personhood even, a dependent, beggar, vagrant or a scruffy, disengaged loser or trouble maker.

Unfortunately such societal perceptions, attributions and language have largely influenced attitudes and state and society level engagement or disaffiliation. When we serve this group that sits on the

margins, we must pay attention to every said and unsaid word, make note of gestures and other non verbal cues, and take all the time needed to make the person feel safe. Always respond with concern, respect and empathy. Pay attention to the language used when addressing the person or referring to the person when speaking with passer bys. We must not be in a hurry to establish contact, build rapport or confidence. Ensure that body posture, gait, demeanour and conversational style are friendly, non intimidating or judgemental.

ECRS offer access to a range of services that best suit a client's individual's needs. These include:

1. Street based outreach services
2. Critical Time Intervention (CTI) and admission to The Banyan's In Patient (IP) services
3. Referral services to best attend to specific non mental health needs (eg. care for elderly people)
4. Health Care and nursing services to address co-occurring disorders or comorbidities (such as skin issues, diabetes, TB and other communicable and NCDs)
5. Services of a personal assistant, health coach or an institutional carer
6. Psychiatric care and pharmacological interventions
7. Psychological care and therapeutic services
8. Social care and problem solving services
9. Case management services
10. Skills development (social, functional, economic) and vocational training options
11. Employment and placement services
12. Facilitation of social cooperatives, livelihood and entrepreneurial options
13. Grievance redressal mechanisms and Legal Aid services
14. Reintegration and Aftercare services (continued care)
15. Family support and Family therapy services/Access to recovery Hubs and Family Therapy units
16. Inclusive Living Options (graded) for persons with long term needs (independent, quasi institutional and supported)
17. Support group access or peer support contact facilitation
18. Recreational services and social mixing options

The following sections presents an overview of every phase in hospital and shelter based care from critical time intervention to pre-discharge care in the recovery hubs. Every step mentioned is essential as it meets specific goals of recovery and well-being. However, case managers and Mental Health Professionals (MHP) are encouraged to also think laterally and innovate when required, and personalise solutions keeping The Banyan's fundamental ethos and the client's needs and comfort in mind. In doing so, ensure adherence to non- negotiable aspects outlined in the protocols to be followed.

Phase 1 - Critical time intervention, safety planning and harm reduction

Stage 1	Call for support from concerned person/ volunteer, NGO, Police
Stage 2	Outreach and crisis support
Stage 3	Confidence and trust building to enthuse effective health seeking pathways
Stage 4	Community Education and Interface
Stage 5	Legal and Statutory Compliances

Stage -1	**Outcome**	**Process**	**Tracking Progress**	**Human Resource**
Rescue Call	Assessing caller need to plan appropriate response	Helpline team prepared with response tools or support through referral services Crisis team and intervention kit mobilised, comprising basic subsistence items such as: 1. Clothes 2. Food articles and fluids (warm tea) /water 3. First aid kit 4. Blanket/Shawl 5. Information on organisation	Rescue call register	Any Banyan representative or team member trained in effective and prompt information sharing

Stage -2	Outcome	Process	Tracking Progress	Human Resource Involved
Outreach and crisis Support	→ If client is found to be mentally ill and experiencing extreme physical, social and psychological distress, offer MH first aid and emergency care in a psychiatric nursing home or mental health facility when needed → If client does not have a severe MI, offer support in the form of food clothing and temporary shelter and counselling or problem solving services	Harm reduction, safety and care planning by understanding and assessing nature of personal/ social/emotional/ psychological/medical crisis/distress or concern	Rescue call register and case file (if client is admitted) or referred to shelter: documentation of nature of problem and outcome	Mental Health care worker trained in first aid; driver trained in MH work and first aid; MH service user trained in outreach work and counselling.

Stage - 3	Outcome	Process	Tracking Progress	Human Resource Involved
Confidence and trust building to enthuse effective health seeking pathways Suggested Script: Start by introducing yourself and ask for her/his name. Are you Ok? Would you like a cup of tea/food/water? 1. We've been observing you for a while, looks like you're experiencing some difficulty or am I wrong? 2. If she/he says yes, then follow it up with what form of support she/he would like. Based on the individual's response, introduce services/support you can offer through The Banyan -indicate especially access to safe space and food etc, care for brief	Promoting client's rights to care, dignity and safety. Harm reduction	Establish contact by striking a conversation enquiring into status of individual's well-being, avoid gathering of crowds and too much attention, be subtle in offering support and show humility in all forms ranging from body posture to dialogue involved in offering support Peer user to share information on personal experience of accessing services and be involved at every point.	Client's feedback on rescue processes during case management session and/or grievance cell meeting after 4th week and through the user service audit	MHP MH service User trained in outreach work and counselling General community Tea shops and previous supporters of homeless person - family near by, auto driver , police etc.

periods with goals of self reliance, opportunity to go back home, if lost or wandered away and missing family. 3. If he/she says no, but is scantily clad, in danger of being harmed or has serious physical injuries and in need of medical help and not in a position to manage her life on the streets, the CM can use the following script: "We have a facility where you'll have a place to stay, food to eat, earn money and if you want, seek treatment. Most importantly you can get some rest. Our wish is that you feel better, and we really want you to do what makes you comfortable and happy or what gives you peace, whether that means finding a job, going back to your family or anything else you have in mind. We do hope you consider coming with us- we can promise you that we will do our best to alleviate or decrease your distress". Mental health service user from CTI team can speak about their experience on the streets and with The Banyan, and about related positive outcomes and use their personal narrative to and persuasive architecture to encourage the individual in distress to seek treatment. Apply gentle pressure but never resort to physical coercion.				

Stage - 4	Outcome	Process	Tracking Progress	Human Resource Involved
Community education and interface	Building trust in the organisation's capability and expertise, and enthusing motivation in general public to respond to the needs of others experiencing similar distress or mental illness, even on the streets, by offering them water, food, occasional shelter, problem solving and even work when possible; and most importantly friendship	Sharing of literature on organisation and basic information on mental health for engaged bystanders and attempt to build support networks for future engagement	Rescue calls from same location, increase in volunteers making rescue calls or seeking KPHC[1] membership or pursuing further engagement with The Banyan by enrolling as MHCM or forming a community support circle to offer after care services in coordination with The Banyan	Driver trained in MH work and first aid Mental Healthcare worker trained in first aid and community relations

Stage -5	Outcome	Process	Tracking Progress	Human Resource Involved
Legal and statutory compliances		Obtain Police memo from jurisdictional police station. Intimation of jurisdictional police station of institution/shelter Visit from concerned police officials (at the discretion of local police authorities) Certification by psychiatrist Contact Magistrate, file details as elicited in standard format as per MHCA (2017) Statutory Compliance as per mental health act of 2017 - the individual needs to be assessed by a psychiatrist and a MHP (SW/Psychologist) within the first	Reception order register with details on date of admission, date of renewal Magistrate visit register Forms duly submitted to MHRC following adoption of new state rules, and record of the same in client file	Social worker (in the case of ECRC, shelter, HC)* *All hospital and shelter based services

[1]Kind People Happy City: An initiative from the Shelter where volunteers reach out to homeless persons with mental illness for services including food and supplies that they need, if there is a need to admit them then they are admitted.

		72 hours following which information has to be shared with the mental health review commission appointed by SMHA. If there is an extension beyond a 30 day period, a representation has to be submitted/ made to the MHRC, following which an extension will be permitted upto 180 days or more if required.		

Phase 2 - Welcoming the client

Focus on dignity, enhancing support networks and social architecture

Stage 1	Customise welcome based on time of day, client's disposition
Stage 2	Offer welcome drink, food and other articles that the client may desire- always treat the client as a thinking, person, capable of independent decisions, regardless of current health issues
Stage 3	Introduction to care team, services available - information sharing on the facility and its services is critical, regardless of the mental health status of the individual
Stage 4	Offer overnight kit, grooming services
Stage 5	Walkabout of premises (during the day)
Stage 6	Icebreaker events (if client is open to it) to introduce him or her to other members of the facility
Stage 7	Medical care

The Welcome Kit

Customise reception (based on personal inclination and day/night time) - if person seeks privacy and a quiet entry, provide the same. However, if reinforcement of safety and a hotel/rest-house like ambience is to be shared, use the following measures:

1. Offer a beverage of preference (coffee, tea, milk, water or cool drink)
2. Introduce yourself by name and enlist all services you will provide
3. Focus on the semantics: when you list services, do not use technical terms or jargons. Make your language fun, friendly and restful, example: we offer a bed, with a crisp, clean, new bed sheet so you can sleep well at least for this night. When you wake up rested, we can together decide on the next steps and on whether you wish to seek support and care for a brief period at The Banyan or if you choose to opt for other alternatives. You will also have access to a clean and private toilet with water 24/7. We also have round-the-clock medical staff if you experience any medical distress through the night. In addition, we have a social worker on call who will be more than happy to offer you any support or respond to any of your queries regarding your safety or other concerns through the night. Be assured that all that we do, we do in your best interest.
4. Basic overnight kit - one set of clothes, soap, powder, earrings (in case of women), bar of chocolate or biscuits or peanut candy, a bottle of water and a flask of tea or coffee based on preference. Also a preference of God's photo if they desire to be placed by their side
5. Introduction to observation room staff, by name and vice versa.
6. Enroute to the observation room and after the drink, let the peer counsellor or the MHP very casually point in the direction of the dining hall or the gym or the television lounge and, most importantly, the prayer space, so the client recognises that rest, care and safety are assured (typically closed spaces could denote nefarious activities and mention of a spiritual space may lend a sense of calm)
7. If the person enters the premises during the day, the process of grooming could be initiated post an empathic, transparent and private chat with the MH service user, MHP and client in a counseling suite. Be particular about spaces you use. Typical questions in the suite would include, "How was last night? Are you feeling refreshed? How long have you been alone? Have you been able to access food and water, when did you last shower, when did you have a good night's sleep, do you have any person or number you want to reach or call? Based on the client's response, continue with the conversation. Typically conversations go like this, "Would you like to have a meal, and what do you say, after the meal, we can go to the clothes room and pick a set of clothes based on colours that you like and then shower" (many persons who enter the premises may experience florid symptoms, may choose not to communicate and may take a while to build trust). Regardless, run through these conversations, because our experience indicates that every resident remembers the first few days and interactions. This sets the tone for much of the interventions to follow. Remember, that the person who has entered the premises is unaware of your intentions, and is in a strange community of people from diverse backgrounds that can be intimidating to anybody.

How does Social Architecture and focus on institutional design help lift mood?

In keeping with the philosophy of the emergency and recovery centre being a restful, therapeutic, trusting and fun space, ensure that the lounges, the dining spaces, the skills hubs, the human rights committee rooms with grievance box are adequately showcased. In addition, ensure the following are in place:

1. Salon/grooming area filled with photos of actors across different parts of India for them to indicate their preferred hairstyle. This will elicit clues as to client's place of birth, background, interest and even most recent residence.
2. Clear signages (multilingual and visual) indicating the function of every space, like counseling suites, MCU, support group meetings, grievance cell, lounges, etc. can ensure the place is accessible
3. Care team spaces are personalised such that photographs of family, pets, favourite food, friends can be used as unorthodox methods in breaking hierarchy and encouraging trust building and equal sharing of information. These articles can also serve as cues for themes to be initiated for conversations that involve family, social backgrounds, likes and dislikes etc. so that the life history of the client is the focus and thus the totality of one's experience and not solely psychopathology or ill health indicators.
4. All communication is multilingual and visual in case barriers of literacy exist, including care processes. Use of videos in different rooms may help. In the common area - reception, corridors, animated videos of services offered at the ECRC and shelter may be used; in the observation room where the client will spend their first night, service user testimonies of their experiences at the ECRC with pictures to be shared.
5. Music is an adored form of entertainment and emotion that has generally uplifted the mood and environment at The Banyan. Music of different forms and different languages are played. During festivals, clients love dancing to tunes and during the weekends, it provides great fellowship over tea time. Playing music gives way to physical exercise and also a certain form of venting through one's body movements. Use of music in different spaces has been useful. Listening to radio while working has also helped in a great way at our skills unit.
6. Pets at our campus have helped our clients to develop a deep sense of "ontological security". Many of our clients adore them and see them as buddies. The sense of unconditional affection one receives through a pet is very rewarding, and some clients have taken pets on as a personal responsibility.

Stage of engagement and observation period (3 - 36 hours)	**Outcome**	**Process**	**Tracking Progress**	**Human Resource Involved**
First day: 1. Self care and grooming : Bathing, hairstyling and cleaning	Preservation of client's' bodily integrity and right to privacy, choice and dignity	Use of private space, where after obtaining consent from client to help clean and dress wounds, help discard old and soiled clothes, help clean body, private parts and hair, help with oral hygiene. Make it relaxed and a spa like experience. Take client to the salon in the ECRC and HC and to the grooming area (shelter) and show them different hairstyles to choose from- have books handy with stars they will identify from from various regions. If client explicitly states that he or she does not want a haircut, wait two to three days. Take them to clothes room after to pick three sets of clothes they like, figure styles, culture, colours etc. Alter clothes if need be. Joint meal with other clients (from ward for ECRC), and ice breaker events such as self introduction or intro of best friend with description of likes/dislikes) and make the environment more welcoming, first in smaller groups, perhaps in the lounge or in the common area or the terrace. Take client on a walkabout of the centre	Rescue (critical time intervention) register records, Client's testimonials in files, grievance redressal and human rights committee meetings.	Preferably only two people, the healthcare worker and MHSU, so continuity of care is offered.
2. Basic Amenities: Food, shelter and affiliation	Trust in the institution and care team, reduction of distress and fear of a strange place. Inclination to stay on and seek treatment. Relationships built with roommates		Rescue register records, Client's testimonials in files, grievance redressal and human rights committee meetings. Also make sure feedback is documented in group meetings, in case file and in service audit.	Social worker, nurses, health worker, volunteers
3. Medical care	All physical health concerns addressed and monitored		C1 form in case file	Nurse/ MH service user

		(if they were admitted at night and were not in a position to do the tour), show them essential spaces - support groups, gym, shops, prayer spaces, toilets. If they prefer to stay alone the first night, in the ECRC, then they can stay in the observation room. At the shelter, they usually would stay in the night shelter room. Check for lice, maggots, broken bones, skin lesions; blood work for diagnostics to be obtained the following morning and indicate purpose when doing so.		

Values most critical on Day 1
Bring in concept of **bodily integrity, freedom and choice** from the moment client enters the institution, as paradoxical as the latter two aspects may seem. Empathy and **validating distress** – anyone coming to a new environment is bound to experience anxiety and fear. Living on the streets with a mental illness – marginalized and/or abused, the individual's anxiety level will still be high. It's not easy to be in a space with 100 other people, confused, being asked questions and feeling alone and alienated. The mental health professional's **empathy** level has to be at its highest on this day, along with unconditional acceptance of however the client is going to react to your support. **Information sharing** to lend clarity on each step of the care process is critical, however ill the client may be. This includes physical health checkups and drawing blood for diagnostics, such that treatment can be offered for physical health conditions the client may suffer from. **The following actions are completely unacceptable, contradictory to The Banyan's core values, and will put the staff member under scrutiny: physical coercion, undressing client in public, using abusive language, patronising behaviour.**

Phase 3: Engagement with the client

Working towards Recovery: Addressing precipitating and perpetuating factors: focus on self awareness, grit and resilience training - self directed care

Stage 1	Personal care made interesting, orientation to services, general and psychiatric health reviews, ensure cultural congruence in care provision - clothing, food, communication, spirituality, etc.
Stage 2	Social ecology of mental disorders considered
Stage 3	Understanding hierarchy of needs, aspirations and beliefs
Stage 4	Formulating intervention/individual care plans - customised MH solutions with focus on triggers, conflicts, strengths and recovery goals - all worked on collaboratively with the client and the MDT Self Awareness - understanding self, family, community, society, support and reference networks
Stage 5	Observation and formulating biopsychosocial assessments and psychological and social interventions/focus on domains of functionality using case management, SFBT, Task centred practice, MI and other methods, etc.
Stage 6	Understanding socio-economic profile, income pathways, aptitude mapping - focus on self reliance
Stage 7	Vocational and social skills training to ensure income level gains and enhancement and intangible self esteem level gains - focus on stages 4,5, 6 continues
Stage 8	Referral to pre-discharge hub (going home, moving to home again)

Stage 2 Engagement (weeks 2-7)	Outcome	Processes	Tracking Progress	Human Resource Involved
Clinical Interview and Mental State Examination (MSE)	Management of acute symptoms	History taking, diagnostic formulation, understanding thought processes in depth	MSE to be done weekly, interventions to be modified based on the MSE findings	Case manager - can be social worker, counseling or clinical psychologist Nurse, Occupational Therapist

Stage 2 Engagement (weeks 2-7)	Outcome	Processes	Tracking Progress	Human Resource Involved
Assigning care team Case management: Focus on subjective well-being (SWB) and functionality Counselling/ assessments/ psychological therapies Improving self esteem and addressing trauma Medical care Skills training Add recreation- pets outing, friends, music, etc	Creating a life story of distress, loss, meaning and hope - building an identity Understanding challenges and motivations around functionality and SWB; building larger level insights, learning more sources of distress, ill health, control, society and indeed life, collaboratively Nurturing a positive self view, and practicing self-compassion; Strengths assessment - right from day 1; consistent reinforcement of the same, highlighting positive attributes, rebuilding sense of self and value that the individual can bring to his or her ecosystem, highlighting their uniqueness Offering opportunities to pursue occupational/ leisure activities that provide meaning and purpose;	Biopsychosocial assessment; storyline reconstruction, social functioning, psychiatric and psychological scales, ethnographic observation. Preparation of collaborative individual care plan - access to physical, psychosocial and peer driven services: setting short, mid and long-term goals using motivational interviewing. Psychological therapies commonly employed including CBT, Behaviour therapy, MCT, CRT, narrative therapy, reality therapy etc. ICP will be reviewed from the 1st to 3rd month (end of 2nd week) fortnightly, and then on a monthly basis for the next two months and then once a quarter if required. The ICP focuses on short to mid term goals, efficacy of medical, psychiatric, and then progresses to use social interventions and psychological therapies and focus on independent living and improved QOL. Based on one's progress we can either plan for short to mid term goals or move on to long term goals. **During the third month, the social functioning scale is introduced to focus on micro aspects across domains of self care, ill health management, home care, socialisation, work and meaningful engagement.**	Case files Case presentation sessions and action on feedback Scales: mGAF, QoL, BPRS, EPSRS. SFS Grand rounds; Chart meetings and reviews VT and employment register and enhanced incomes and participation Stronger friendships, communication and development of valued social roles. Planning for recreation	Case manager - can be social worker, counseling or clinical psychologist Nurse, Occupational Therapist PA Psychiatrist Psychologist VT Trainers Peer counsellors

		CM team meets independent of client to review progress and then with the client. VT team to join to initiate process of building self reliance based on aptitude and interest. Support group meetings with other clients so sharing can help arrive at better understanding and coping strategies. Skills training offered ranges from healthcare to hospitality, handicrafts production, or federating into social co-ops and initiating social businesses. Physical health rehabilitation - monthly BMI checkups, indicators for anemia, TB, diabetes, skin infections and lesions- so general health improves.		

Periodicity of Review

Timeline	Multidisciplinary Team	Frequency
Day 1 to 1 week	Case Manager Health Care worker GP/Psychiatrist Nurse	Daily Daily Weekly twice Weekly twice
End of 1st week to 4th week (1 month)	Case Manager Health Care worker GP/Psychiatrist Nurse	Weekly thrice Daily Fortnightly Fortnightly
1st month to 3rd month	Case Manager Health Care worker GP/Psychiatrist Nurse	Meetings - weekly, review once a month or more based on need assessment of 1st ICP Once in a week, but daily contact Monthly once Monthly once or as per need
4th month to 6th month	Case Manager Health Care worker GP/Psychiatrist Nurse Skills DEPT Reintegration Dept	Based on 2nd ICP Weekly Monthly once Monthly once Monthly once DAILY

Support Group Meetings

ECRC

Day	Week 1	Week 2	Week 3	Week 4	Week 5
Monday	Family therapy Yoga and guided meditation Support group for Clients living with schizophrenia	Family therapy Support group for clients from the Recovery Hub	Yoga Art based therapy Support Group for clients hearing voices	Group therapy Music and Dance - Client directed recreational activity	Family therapy Yoga Support group for clients with mood affective disorders
Tuesday	Home again – Continued Education and Problem Solving for Staff Home Again – Support Group Meetings / Storytelling Yoga	Continued Education and PS Lecture : How do I care better for myself?	Group therapeutic community sessions Case management sessions Learning from clients : theme based lectures and sessions - Peer educators and residential members	Continued ED Work Options - Career Counselling	Home again – Continued Education and Problem Solving for Staff Home Again – Support Group Meetings / Story Telling Yoga
Wednesday	Aftercare clinics, support group meetings, case management meetings	Aftercare clinics, support group meetings, case management meetings	Aftercare clinics, support group meetings, case management meetings	Aftercare clinics, support group meetings, case management meetings	Aftercare clinics, support group meetings, case management meetings
Thursday	Group therapeutic community meetings- Focus on Service Audit: Co production of services Primary care Sleep Toilets Secular fabric Dignity Skills Client Directed/Led Recreational activity/Sharing/Peer Support	Persons with ID: Focussed attention enhancement Skills Yoga	Yoga Family meetings Support group meetings for persons living with Schizophrenia – Hearing voices, Delusions and meanings I make	Persons with ID - focussed attention enhancement tasks Yoga	Group therapeutic community meetings Creative Arts Therapy: Drama/ Dance/ Music - Client Led activity

Friday	Group Therapy Lecture -2 How do I manage my moods? How do meds and counselling work? Deconstructing my illness.	Work Facilitation Awareness on social entitlements and Rights	Caregivers support group meeting	Going home- What does it mean - Discussion	Group Therapy Peer Support group: returning home to work and kids - challenges and gains
Saturday	Movie **Tamil** Outings, excursions, visits to friends' homes, temples walks, festivals other celebrations- add them as options - also new art : kolam, etc etc	Movie **Hindi**	Movie **Bengali/ Other regional films**	Movie **Telugu/ other regional films**	Movie **Tamil**
Sunday	Movie Family meetings	Dance	Music/Dance	Movie	Movie Family meetings

Shelter

Days	**Weeks 1- 7**			
Monday	Support group for persons living with schizophrenia - hearing voices, making sense of my voices and beliefs; importance of medication- orientation to medication management	Support group for persons living with schizophrenia - hearing voices, making sense of my voices and beliefs; importance of medication - orientation to med management	Support group for persons living with schizophrenia - hearing voices, making sense of my voices and beliefs; importance of medication - orientation to med management	Support group for persons living with schizophrenia - hearing voices, making sense of my voices and beliefs; importance of medication - orientation to med management
Tuesday	Continued Education and problem solving for home again staff, PAs and nurses Service audit with staff and clients - VT room, toilets, corridors, dorms Lecture: How do I care better for myself, by myself?	Continued Education and problem solving for home again staff, PAs and nurses Service audit with staff and clients - VT room, toilets, corridors, dorms Lecture: How do I care better for myself, by myself?	Continued Education and problem solving for home again staff, PAs and nurses Service audit with staff and clients - VT room, toilets, corridors, dorms Lecture: How do I care better for myself, by myself?	Continued Education and problem solving for home again staff, PAs and nurses Service audit with staff and clients - VT room, toilets, corridors, dorms Lecture: How do I care better for myself, by myself?

Wednesday	Support group meetings for social skills, orientation to public transport, behavior in the workplace	Support group meetings for social skills, orientation to public transport, behavior in the workplace	Support group meetings for social skills, orientation to public transport, behavior in the workplace	Support group meetings for social skills, orientation to public transport, behavior in the workplace
Thursday	Career counseling and money management	Career counseling and money management	Career counseling and money management - Visit to employment sites , skills kiosks	Career counseling and money management
Friday	Support groups for persons with mood disorders and ID - medication management for those with mood disorders	Support groups for persons with mood disorders and ID - medication management for those with mood disorders	Support groups for persons with mood disorders and ID - medication management for those with mood disorders	Support groups for persons with mood disorders and ID - medication management for those with mood disorders
Saturday	Yoga therapy, grievance redressal	Yoga therapy, grievance redressal	Yoga therapy, grievance redressal	Yoga therapy, grievance redressal

Phase 4- Focus on Social Role Valorisation - Pre-discharge stay in recovery Hubs

Stage 1	Joint Narration of Journey thus far - bibliotherapy, open dialogue, etc. user-focus on strengths, user MI
Stage 2	Check boxes in care
Stage 3	Understand preparedness and readiness in all functional domains[2]
Stage 4	Understanding and address apprehensions - pre discharge planning and assessment/understanding
Stage 5	Revisit domains of independence and self awareness- health / ill health management, conflict identification and resolution or management, identify stressors and triggers and patterns of relapse into ill health
Stage 6	Building resilience, grit and stress/ ill health effective coping and management techniques
Stage 7	Simulate real world environment and challenges in recovery hubs
Stage 8	Fulfilling goals, aspirations, meaning and purpose -living a full life (remember every life is unique, different and precious) Peer support group members to lead

Stage of engagement - week 8	**Outcome - towards personal recovery**	**Processes**	**Tracking Progress**	**Human Resource Involved**
Individual's reference and support network - reorientation to dominant social thought and family, cultural and societal ecosystems he/she will be returning to Understanding apprehensions and	**Social role valorisation** - Understanding details on premorbid life, challenging the client with kindness and cautious optimism. Is she returning home with better understanding of her own self, her	Treat the recovery centre as they would their home- the responsibility to maintain surrounding spaces Timetable designed collaboratively for cooking cleaning, washing, purchasing groceries from	Case files Case presentation sessions Grand rounds Chart meetings Scales: mGAF, QoL, BPRS, EPSRS. Employment	The Department of Reintegration will anchor these activities in collaboration with the case manager. The team will also work with other Departments in enhancing the clients' ability to maximise her potential and

[2] Use Social Functioning Scale; Discharge Tool (See Appendix)

perceived challenges, expressed emotional needs - confidence building, managing conflicts, skills in assertiveness, safety and managing stress and conflict Understanding aspirations and goals - values of interdependence, responsibility, accountability and reciprocity Collaborative safety planning and goals consolidation Finding meaning and purpose fulfilment	needs, her strengths and better insights into her ill health, gritty and prepared to be resilient when required? Preparing to live a full life, celebrate family, community and interdependence, exercise choice and control at the same time. Awareness on stressors, ill health patterns and strengths Fostering hope and personal responsibility	nearby store, money management (domains of functionality) Interaction with neighbours, visit to HA, outings with friends, decorating HA once in two weeks as per their preference, teaching a language to PA and other clients, grooming in salons. Sexual health, safe sex practices (real world issues and safety planning) Counseling, Therapie Simulating potentially stressful situations Stress management techniques - meditation Collaborative strengths mapping Pre-employment training, money management through bank accounts Spending money on friends, family	register HA visit registers Cantril (from stage 2 to now)	participation. The care team and co-residents are her cheerleaders and reinforcers.

Reintegration and Aftercare Process

Dissemination of Reintegration and Aftercare Options at Institutional Facility

- Small group meetings to disseminate reintegration and aftercare concepts to residents and care staff (across all cadres) at the institutional facility.

Discharge Readiness Screening

1. File review of all residents of wards identified to work with
2. One on one interaction with residents of wards identified to work with - those with homelessness antecedents/non-family admissions/admissions originating with police/involuntary commitment. Conversations on life prior to hospital, any recollections of how they came to the hospital, prospects of moving back home, known family, relationships and what they seek to reconnect with from the past life. Screening form to be completed.
3. **Determine prospects for community re-entry through reintegration with family:**
    a. *Clinical (physical and mental health) status:* This domain reflects the level of recovery achieved by the participant. Key components assessed are symptoms, functionality and disability.

    b. *Expressed Intent and ethical considerations (self-rated needs, personal preference for future):* This domain includes the participants' age, type of family members, number of dependents, duration of stay in emergency care centre. It is conceivably important for individuals in their productive years, with more number of dependents to be discharged on a priority basis and therefore receive a higher score.

    c. *Social capital (individual, familial and community resources available to cope post discharge):* Discharge from the hospital and care in the community must take into account various practical challenges that exist within prevalent socio-political systems. In such situations, access to hospitals, engagement of supportive caregivers, access to employment, peer networks and support groups are considered as resources in addition to the individual's own capacity to manage her ill health, plan her life and problem solve when needed. Therefore, this domain assesses the individuals' resources in the community that will promote recovery and impede relapses or deterioration in mental health. A higher score is given to those who have higher social capital (those with lower social capital are offered greater support).

d. *Safety planning*: This domain assesses the level of vulnerability to being exploited in one or more ways; an individual meeting all criteria of discharge may still be vulnerable in community spaces and therefore require close engagement to ensure safety. Interviewers are encouraged to use discretion and not be risk averse in evaluating the individual. For example, past attempts to die by suicide while concerning may not influence current scores if episodes of self harm have been negligible in the recent past.

e. *Organizational capacity*: This domain assesses The Banyan's capacity to locate family and/or facilitate after care, post discharge. This, though a criterion for discharge, has least weightage. Organizational resources can be created based on need, when necessary.

4. If criteria above are fulfilled, open a file at project for client. File in the screening form and additional sheets with sessions.

Pre-discharge - Working towards Social Inclusion

1. Complete social functioning instrument combining hospital staff report, observation and resident report. Identify areas that require additional inputs to maximise independent functioning prior to discharge.
2. Pre-discharge is a period of 4 weeks that aims to help residents retain skills, build on or acquire new skills for independent living. In this process residents will be helped to identify challenges (anticipated) in home environment and prepare for risks.
3. Week 1:
    a. Care of Self and Activities of Daily Living (Hand-washing, Oral hygiene, Bathing, Hair care, Toileting, Directing a routine) - Identify routine/s to pursue once back home, structured demonstrations and engagements, debriefs with client to identify how these will be fulfilled and sustained in Home Environment
    b. Home Management - Cleaning (sweep, mop, dust, clean kitchen dust and grime, basins, bathrooms, make bed, take out garbage, etc.), Laundry (wash, dry, iron, fold, simple sewing)
    c. Health - Awareness of symptoms and management (sessions to help client identify their chief troubling symptoms and patterns of when they fall ill and whom to

contact if their symptoms were to escalate), awareness of concurrent health conditions and how these may impact mental health, medication (acceptance, independence in consumption, removing negative associations, identifying side effects)

4. Week 2:
    a. Continue Week 1 focus, introduce complexity and more independence.
    b. Home Management - cooking (plan, execute, serve, clean up), shopping
    c. Economic Transactions- Sessions (group and individual) on understanding denominations; insight into the concepts of trading/barter/payments; initiating economic transactions; savings
    d. Reinforce health related messages

5. Week 3:
    a. Continue Week 1, Week 2 - Caring for Self and Home Management. Assess level of independence and need for assistance.
    b. Reinforce health related messages. Assess risks of treatment nonadherence.
    c. Reinforce concepts required for economic transactions - offer opportunity for independent/facilitated purchases. Assess level of independence and need for assistance.
    d. Social functioning, sessions and activities to focus on reorientation and reconnection with family; reconnecting with social roles and norms; identifying role of self within family, group activities; initiating and maintaining conversation; identifying sources of challenges; methods to deal with interpersonal issues and conflicts personal boundaries (self and others).
6. Week 4:
    a. Sessions to focus on social functioning, adapting to home environment (bonding, caring for others, socialising, accountability etc.) and coping strategies for anticipated challenges
    b. Revisit daily routine/s planned and collaboratively plan how client will continue to fulfill basic needs and sustain functioning once home
    c. Revisit important health messages and relationship with medication
    d. Plan for continued work engagement, potential employment possibilities to be explored once back home

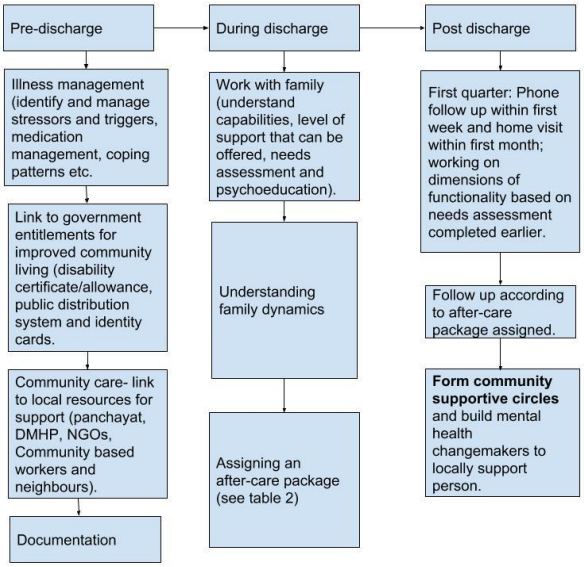
   e. Personal safety planning - understanding location, address, and telephone numbers, day/night orientation, insight into mode of touch, and escalation in case of sexual harassment, safety processes in cases of emergency
   f. Complete social functioning instrument again at the end of Week 4
7. In meantime, network with nearest police station or local government or NGO in location indicated by client and request them to identify family and put in touch.
8. Prepare a discharge summary:
   a. Known history of client (onset, homelessness, critical incidents)
   b. Treatment during stay at hospital
   c. Client current status
   d. Level of support required to be offered by/to family for community reentry through reintegration with family
   e. Proposed living arrangements and aftercare plan

Reintegration Steps

1. Consult with treating psychiatrist and escalate for formal discharge.
2. Facilitate an appointment for the resident with discharge committee. Once committee approves, get a family visit authorised by Director/person authorised to discharge with medication details signed off by treating psychiatrist. We will also facilitate access to government social entitlements such as the disability allowance, public distribution system (PDS), employment and housing support will in order to achieve better outcomes of community living.
3. Family may come down or if not identified a reintegration trip may be planned.
4. Packing for reintegration: basic minimum set of assets, money on hand for client, medication for three months as per last advice, completed aftercare kit, consent form for family to sign.
5. Once family is identified and located, offer details of client's illness and current status, educate on nature of mental illness, the necessity of medication and reinforce do's and don'ts.
6. Identify and plan for service arrangements - access to medication (postal/local) and nature of follow up. Explain the continued services plan and when and how to escalate. Set recovery expectations.
7. Offer client history (including homelessness) and treatment only to the extent client is willing to share with family.

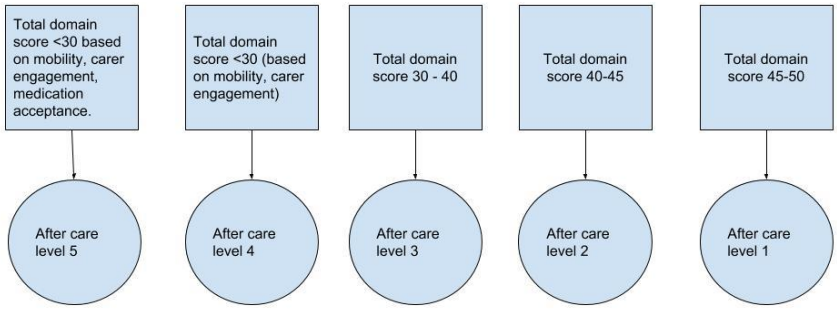
8. Help client identify living arrangements and logistical issues (using bathrooms/bathing/household chores/transport etc.)
9. Assess family readiness/preparedness to absorb client and fulfill ongoing care needs in a manner that doesn't compromise well-being.
10. Elicit detailed introductions to all members of the household and identify any dynamics in relationship with client.
11. Observe client in home environment for two days, problem solve with family and client for any emerging challenges.
12. Identify and gather contacts of engaged neighbours, nearest post office (and specific postal personnel who visits), VHN/ANM/ASHA worker, panchayat/ward member, other grassroots agents. With consent of client and family, narrow down contacts who are identified as local social network, and brief them on assistance they can provide with follow up by offering us feedback telephonically on client status.
13. Accompany client and key carer to nearest facility for psychiatric review and/or medication and introduce to the health care provider.
14. If reintegration is successful, get the prepared summary signed by the treating psychiatrist for medication and make two copies - one for filing with institutional, one for local project case file.
15. The scores from the pre-discharge screening will feed into the aftercare plan.

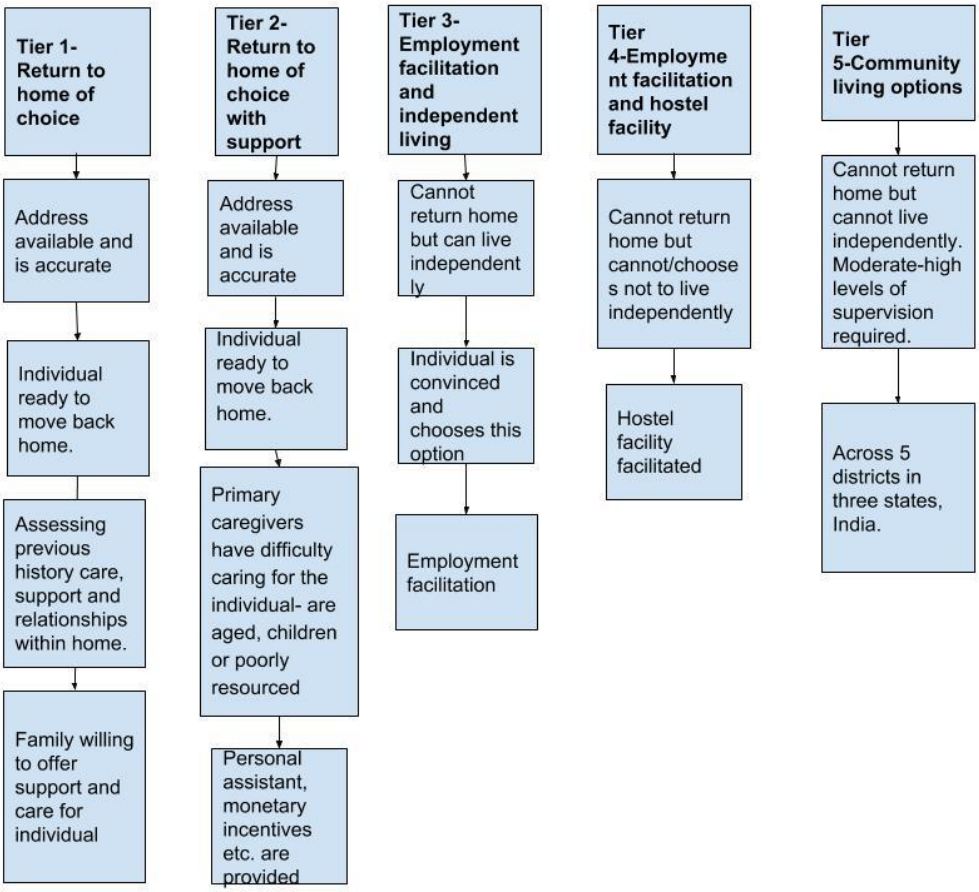
Aftercare Packages



The scores from the pre-discharge screening tool - each domain is weighed out of a maximum score of ten, except for 'social capital' and organization capability which are assigned a score of 15 and 5 respectively to account for resources that can be built even if not available. For example, organizational capability can often be restructured or built to facilitate discharge, and therefore receives a lower weightage.

Scores from each domain are consolidated and consequently linked to aftercare packages:





	High Needs Client	**Low Needs Client**
High Carer Resources	Level 2,3	Level 1
Low Carer Resources	Level 4,5	Level 2, 3, 4

Quarter 1

Weekly phone follow up for the first month post reintegration, and fortnightly thereafter, till the first quarter ends. Fortnightly visits by the identified NALAM mobiliser for the first quarter.

Goal: Self care & ADL

- Weekly phone follow ups for the first month and F/N thereafter:
    - Medication intake regularly
    - Adjusting to the new food/understanding how to use new bathrooms
    - Family Dynamics, care arrangements
    - Home management – Simple – folding clothes, folding the bed after sleeping/ making the bed, arranging utensils after they are washed, sweeping
    - What is her daily routine? Consistency needs to be established over the 1st quarter
    - Self Care – combing, toilet, bathing, clothes changed if dirty
    - Educating the caregiver on monitoring symptoms and possible side effects
- Bonds need to be established between The Banyan and the caregiver to help strengthen the monitoring and reporting of such symptoms/side-effects.
    - Possible photo/video sharing if caregiver possess easy access to smartphone
    - Once a month phone call to address caregiver strain and explore possibilities together to help lessen it
    - Discuss engagement activities with client and caregiver

Quarter 2

Monthly phone follow up from The Banyan reintegration team in the second quarter, and monthly visits by NALAM mobiliser.

Goal: Adapting to the environment

- Consistency with regular medication
- Transportation, transactions
- Role of client within family
- Home management – complex, cooking, shopping for vegetables
- Continuing VT activities if they have resources
- Harassment assessment – enquire if clients feel safe or threatened at home/neighbourhood
- Develop coping mechanisms – Is she able to articulate her needs? How does she manage her needs are not instantly fulfilled?
- Develop a proactive relationship with caregiver such they can provide follow ups when they feel the need

Quarter 3

Bi-monthly phone follow up by The Banyan Team, and monthly visits by NALAM mobiliser

Goal: Preferences identification and articulation

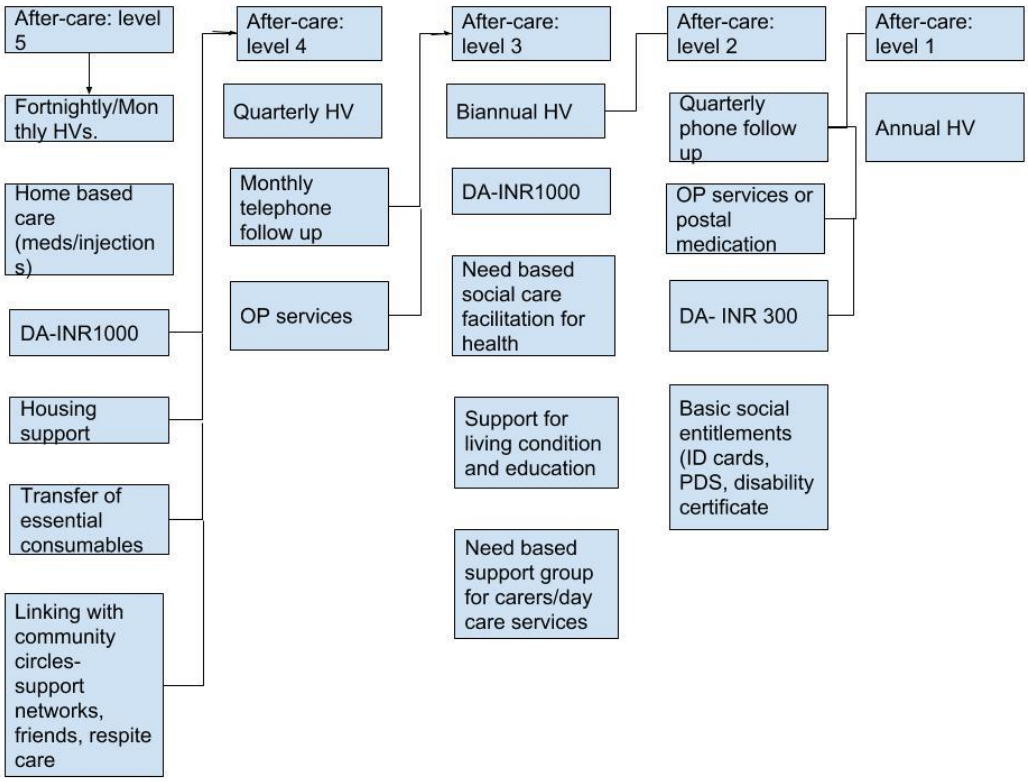
- Money management
- Daily Routine
- Discuss socialisation with client. Assess and talk about improvements that can be made
- Satisfaction of client – with food, herself, family members, home space
- What is her favourite food so far? Is she able to cook it? Who is she closest to in her family/outside family – make enquiries to client to encourage individuality
- Interest in art/music/food/sports/dance/religion – identify and pursue slowly

Quarter 4

Bi-monthly/need based phone follow up by The Banyan Team, bi-monthly visits by NALAM mobiliser
As individuals begin showing improvement or in some case deterioration with community care, packages assigned may change and individuals may receive higher or lower levels of care, as the need may be.

Goal: Sociocultural integration

- Independent Medication
- Is she able to mingle with people outside her immediate family? Has she formed any bonds outside that have lasted over 8-9 months?
- Discuss with client about:
    - Employment interests
    - Contribution to household
    - Her point of view on illness and recovery
- Discuss with caregiver about need for a supportive home



Skills

Employment and Recovery

- Gainful employment and consistent income have shown empirical gains to **personal recovery**;
- Clients report that employment **distracts them from negative thoughts and voices**;
- Employment also helps clients **battle feelings of inferiority and internal stigma;**
- Consistent income **fosters agency, security and participation in family and larger society**;
- Employment **reduces opportunity costs for clients and caregivers alike;**
- Employment plays a transformative role in **shattering stigma and common stereotypes** of persons with mental health issues, thereby facilitating **social inclusion**.

However, there are several barriers at individual, systemic and societal levels that lead to very few people being placed in employment and high percentage of attrition. It is therefore essential to structure training programs that are customised to client needs, facilitate placements based on interest and mutual understanding between client and employer, and consistent re-sensitisation and follow through with employers.

Skills Development, Vocational Training and Livelihoods Facilitation

"Employment is very important to gain respect in society. I earn money now and don't need to depend on anyone for anything. It makes me feel good."

- Mrs. S, The Banyan

15% of clients accessing treatment at The Banyan are employed, with 9% consistent in employment for a minimum of three months (data from March 2018). There are several clients who have expressed a need to work and have been placed, but attrition rate has been high due to many factors. In order to meet these challenges, clients, caregivers and case managers have offered the following suggestions:

1. **Sufficient training** prior to placement - both **soft skills and technical skills**.
2. Reduction in time spent travelling and/or **provisions for travel support**.
3. **Sensitization to employers** to accommodate specific needs of clients.
4. **Caregivers to be adequately oriented to the importance of clients' gainful employment**, so they can provide additional support when challenges occur and discourage them from dropping out.
5. **Options for home-based work and support for independent businesses**.

Goals

The Banyan is a training and placement agency that also employs persons with mental health issues at Personal Assistant, Peer Advocate, Program Manager and Senior Management level. Persons with mental health issues are also employed as vocational trainers, housekeeping assistants and caregivers.

1. **Wide range of skills training modules** will be accessible to clients.
2. Trainings will be **inclusive, enjoyable and useful**.
3. Training will **facilitate promotion of capabilities**.
4. **Options for home-based work and entrepreneurship opportunities** through social cooperatives will be offered to clients and caregivers.
5. Employment placement will be based on **mutual comfort between employer and employee**.
6. **Ensuring no harm or exploitation will befall the client** at his/her place of employment.
7. **Placement and support kiosks will be available every week** for clients and caregivers across projects.
8. Placement will help the client attain **financial security**.
9. Training and placement will systematically **increase number of PWMI in the workforce**.
10. **Increase the number of PWMI working as mental health professionals/peer advocates/caregivers**.

Skills and Employment Training

Skills Training has been divided into the following categories:

1. Arts and Handicrafts
2. Housekeeping and Services
3. Health and social care

Additional training to increase work performance and prevent attrition:

1. Cognitive Remedial Therapy for work (from week 1 onwards)- working memory, focus/attention, money management, stress management, side effects management.
2. Soft skills - interview skills, communication skills, conflict resolution, negotiation, flexibility, teamwork and problem solving.

Timetable, Work Hours, Special Classes

Activity	**Regular Timings**
Arts and Crafts	10 am - 5 pm
Housekeeping and Services	7am - 3pm; 10am - 6pm; 11am - 7pm
Health and Social Care	7am - 3pm; 10am - 6pm; 11am - 7pm

(30 minutes for tea and 1 hour for lunch). 24 work days in a month - 2 saturdays off, 4 sundays off, 1 sick leave day and 1 casual leave day

Special Classes

Activity	**Class Timings**
Tailoring	10am - 11am (Monday-Wednesday)
Loom	10 am - 11 am (Thursday-Saturday)
Cooking	2pm - 3pm (Monday-Wednesday)
Health and social care	2 pm - 3pm (Thursday-Saturday)
CRT	3m - 4pm (HC+ CGH - Monday; Shelter & Stella Maris - Tuesday; ECRC - Wednesday; SRTC - Thursday; Rural Home Again - Friday)
Soft skills training	4pm - 5pm (HC+ CGH - Monday; Shelter & Stella Maris - Tuesday; ECRC - Wednesday; SRTC - Thursday; Rural Home Again - Friday)
Employment support kiosks	10 am - 12 pm (HC+ CGH - Monday; Shelter & Stella Maris - Tuesday; ECRC - Wednesday; SRTC - Thursday; Rural Home Again - Friday)
Social cooperatives meetings	12 pm - 1pm; 2pm - 3pm; 5:30 pm - 6:30 pm (HC+ CGH - Monday; Shelter & Stella Maris - Tuesday; ECRC - Wednesday; SRTC - Thursday; Rural Home Again - Friday)

Employment Placement

Functions of The Banyan's placement agency
1. Skills and employment training (duration 3 months, extension as needed): technical and soft skills 2. Sensitisation and training for potential employers 3. Placement through weekly kiosks at all projects 4. Orientation for clients, and employers 5. Appraisals, problem solving and follow through (addressing challenges and attrition) Job fairs

Placement Support Kiosks:

Clients interested in work will meet with the placement coordinator along with case manager/health worker. The checklist below will support the client and the CM in understanding training and employment related needs:

1. Interested in - employment/home based work/social cooperatives
2. Vocation - arts and crafts/services/health and social care/other
3. Preferred area of employment
4. Disclose illness to employer - Y/N
5. Preferred work hours
6. Special provisions and concerns - many clients have requested an hour post lunch to rest owing to dizziness from medication. Others prefer not to lift heavy items on the job
7. Travel support - Bus pass/share auto
8. Interested in coordinator/HCW/peer advocate accompanying them to work for the first week - Y/N
9. Interested in The Banyan periodically keeping in touch with employer - Y/N
10. Interested in working alone/with a group of clients

Training, Sensitisation and Orientation with employers:

If employment placements are coordinated through The Banyan, sensitisation sessions will be conducted with the employer and team. These sessions will contain overall information on mental health, specific information and requirements of client (after obtaining consent from client to share information) and emergency management. A healthcare worker will travel with the client for the first week, after which the client will start traveling alone, should they prefer it. A share auto can also be organised for clients traveling to the same area for work, upon request. Healthcare worker and employment coordinator will be first responders in case of emergencies. Any complaint of abuse or assault will be attended to within 24 hours with police intervention as needed.

Appraisals, Problem solving and Follow through :

Week 1 - Everyday with healthcare worker and client
Weeks 2 - 4 - Weekly follow-ups with healthcare worker, client and employer
Week 4 onwards - monthly follow-ups with healthcare worker, client and employer
Healthcare worker will be responsible for updating case manager regarding progress and direct queries to employment coordinator as needed.

Addressing Challenges and Attrition:

The SD/VT department will address challenges during weekly/monthly follow up sessions with healthcare worker and case manager.

Job fairs:

Job fairs will be conducted every quarter (March, June, September and December) across projects in an effort to sensitise employers, facilitate placements and share success stories.

Current List of Employers
1. The Banyan 2. The Banyan Academy of Leadership in Mental Health (BALM) 3. Oriental Cuisines 4. Xtreme Cleaners 5. MGM 6. Physis Energy Pvt. Ltd 7. Qube Cinema Technologies Pvt. Ltd 8. Eve's Beauty Parlor 9. Wire & Co. 10. PS Apparel 11. Sunbeam Healthcare and rehabilitation Center 12. AtmaNirbhar 13. Kromatiks 14. Vijaya Pharmaceuticals Ltd.

Social Cooperatives:

Social cooperatives are federated across projects to offer psychosocial and economic support to clients working in similar jobs and geographies. These groups will address:

1. Issues with work
2. Issues at workplace with colleagues - managing internal and external stigma, discussions on disclosure vs. non-disclosure
3. Issues with travel (if applicable)
4. Money management, increasing income, collective savings for emergencies, new business opportunities
5. Attendance, leaves and substitution (replacing a colleague temporarily when they are indisposed)

Salary Structure

Current Salary structure:

Exemplary performances of clients at skills and employment training will be acknowledged with a financial bonus every month, in the following categories:

1. Arts and Crafts
2. Housekeeping
3. Health and social care
4. Running social cooperatives

Winners will be offered prize money/gift from The Banyan Collective - a spa day/movie ticket with friends/trip to a place of their choosing/ prize money and certificates worth Rs. 500. The best performing cooperatives will be chosen quarterly and felicitated at the job fair.

Monitoring & Evaluation Processes

Good program planning, along with a robust monitoring and evaluation system, is needed for creating a quality program and obtaining real and meaningful learnings that can be fed back into improving implementation. It is essential to produce this kind of insight for quality enhancement - to better manage resources; for sustainability and reproducibility; to be accountable to ourselves, our partners, the community; and most importantly, in ensuring that optimum care is provided to the people that we serve.

Monitoring and evaluation is an ongoing process that reviews progress, and identifies highlights and challenges. The purpose of such a system is to make data driven decisions within programs. Data is collected utilising forms and registers and entered into databases at every level, for all programs generating outputs, outcomes and impact indicators that are analysed at various time intervals. Information is disseminated to the projects in the form of monthly statistics reports, quarterly reports, presentations and at project team meetings.

As the programs change and evolve, the data collected, the outputs, outcomes and impacts evaluated also change. The tables below reflects the registers and databases currently used at the acute and inclusive living facilities and at the community clinics.

M&E: ECRC

Registers and Database	Definition	Output and Outcome Indicators
Call Register and Database	The register is filled as and when we receive calls. Database is filled at the end of the month or the beginning of the next month. The calls are categorized into rescue, whether referred to another organization, referred to another facility within The Banyan, donations etc.	➔ Number of rescue calls ➔ Number of calls resulting in admissions
Personal Items Register	This register is maintained to keep a track of items (money, jewellry etc.) that our clients have on them at the time of admission.	None
Legal Aid Register and Database	If any legal issues may arise, the registers note the issue and the solution provided by the advocate. The database is filled at the end of the month or the beginning of the next month.	➔ Number of cases discussed
Reception Order Register	The register is maintained to identify renewal of reception orders for out clients.	None

Client Master Database	At the time of admission, within the first week of stay, the demographic details, symptoms, diagnosis, medication, etc. are noted in the client's files and then entered into the database. The database is filled simultaneously.	➔ Sociodemographic Indicators ◆ Age ◆ Marital Status ◆ Language ◆ State of Origin ◆ Religion ➔ Diagnosis ➔ Personal Hygiene at admission
Attendance Register and Database (Primary Care Database)	Daily Attendance in each ward in the morning, evening and night is noted in the register. The database for the attendance is filled on a weekly basis, noting if they were present on that day.	➔ Number of new admissions per month ➔ Admissions as per target ➔ Average occupancy per day ➔ Bed Occupancy Rate
Transaction Register and Database (Primary Care Database)	The transaction register records the client movements within the banyan apart from admission and discharge.	➔ Number of new admissions, readmissions ➔ Number of people in reintegration trial ➔ Number of people discharged/reintegrated
Service Utilization Register	Every transaction that our clients have with the psychiatrist or the case manager is noted in this register as and when it happens. The database is filled at the end of the month or in the beginning of the next month. The database is filled based on the entries in the client's file and cross-checked with register.	➔ Number of psychiatric sessions per month ➔ Number of case manager sessions per month ➔ Number of people who had dental reviews per month ➔ Number of general physician review per month
Hospital Visits Register and Database	This register is filled whenever our clients access services from hospitals apart from own. They are noted as hospital visits which are outpatient visits like for blood tests or consultation, and hospitalizations which are inpatient admissions. The database is updated at the end of the month or the beginning of the next month.	➔ Number of hospital visits ➔ Number of hospitalization
Vitals Register and Database	The register records the clients vitals like Respiratory Rate, Body Mass Index, Blood Pressure. The database is updated on a monthly basis	➔ Number of people who are overweight/obese/underweight ➔ Number of people with high or low blood pressure

		➔ Number of people with improved BMI after administering a diet or exercise over a period of time
Comorbid Conditions Database	This database updated with results of the tests administered either monthly or tri-monthly depending on the condition	➔ Number of people with diabetes/anaemia/ thyroid etc ➔ Number of people showing improvement
Psychology Register and Database	The register is updated by the psychologists as and when an assessment or therapies take place. The database is updated on a monthly basis at the end of the month or in the beginning of the next month.	➔ Number of Therapies ➔ Number of Assessments ➔ Number of GTC ➔ Number of Group Therapies
Skill Development Register and Database	The attendance register of those participating in occupational and vocational training are updated on a daily basis. The database consisting of the type of work, the department, number of days worked, salary earned etc is updated at the end of the month or the beginning of the next month.	➔ Number of people involved in OT,VT,Outside Employment ➔ Average Salary ➔ Improvement in Salary ➔ Consistency in work
Scales - Physical Forms and Database	Scales are performed by the case managers and psychiatrist on a tri monthly basis and sent to the team to be noted in the database. The scales administered are Brief Psychiatric Rating Scale (BPRS), Extrapyramidal Symptoms Rating Scale (ESPRS), Clinical Global Impression (CGI), Quality of Life (QOL), Modified Global Assessment of Functioning (mGAF), Social Functioning Instrument (SFI)	➔ Scales are evaluated over a period of time of having utilized services provided by The Banyan to determine improvement in symptoms, functioning, clinical status etc.
Reintegration Forms, Register and Database	The reintegration department maintains register with information on the clients who are doing pre-reintegration sessions, reintegration trials, home visits and discharges. The reintegration department maintains a database of intervention specific services provided to those in the pre-discharge hub The reintegration department is responsible for filling out the discharge summary and reintegration report. The database is updated on a periodical basis as and when reinegrations take place.	➔ Number of pre-reintegration session ➔ Number of home Visits ➔ No of phone follow up ➔ Number of discharges with family,NGO etc ➔ Average length of stay in the facility ➔ Reintegration Rate ➔ Transition Rate

Aftercare forms, registers and database	The aftercare post discharge follow-up forms must be updated by the aftercare team performing the phone follow-up or home visit. The registers are filled by the pharmacy team for all those who are being sent medicines via post. The database is maintained as and when home visits, phone follow-ups, postal medicine, OP transactions happen.	➔ Percent of people with follow-up received as per protocol ➔ Number of home visits, number of phone follow-ups ➔ Number of people on postal medicine ➔ Number of people who have remained on the same medication without any follow up ➔ Number of readmissions
Shelter - Soup Kitchen and Street Engagement Register and Database	These registers note attendance or the number of people we have accessed these services.	➔ Number of people who we have reached out to through street engagement ➔ Number of people who have accessed soup kitchen services

Quality audits

All our services are rooted in the ethos of empathy, responsiveness, social justice and personal recovery. In keeping with this foundation, all quality audits during site visits led by managing trustees, the director and senior management will check for the following:

1. **Aesthetics and hygiene**: all living and functional spaces (including store rooms), kitchens corridors, dormitories and toilets (most critical).
2. **Dignity and care**: coordinated clothes, size fits, importance to preference of colours, undergarments.
3. **Nursing and health care checks and outcomes**: oral hygiene, body odour, quality of hair and skin, hair, teeth, ears, nails checks, cracked heels, dry skin etc.
4. **Lighting, decor, management of clients' personal spaces:** bed sheets, pillows and pillow covers, cots, lockers etc[3].
5. **Information on care and escalation of problems:** clearly marked signages in different languages with fire exits, information on The Banyan, options for grievance redressal, emergency phone numbers and list of clients' rights and responsibilities.
6. **Interaction between clients and staff:** communication with clients on available services such as personalised therapy, choice in clinical team case management sessions, support groups, therapeutic communities, work options, social cooperatives, other social entitlements, inputs on outings and exit options.
7. **Documentation:** doctors, case managers, nurses and personal assistants' reviews. All file reviews will look into clients' physical health parameters, symptomatology, personal distress, expresesed needs, aspirations and how they were responded to, by clinical care team.

These quality audits are conducted across all locations and sites by our co-founder and managing trustee, Dr. Vandana Gopikumar. Summary notes[4] are sent to all relevant staff and shared and reviewed by the executive committee.

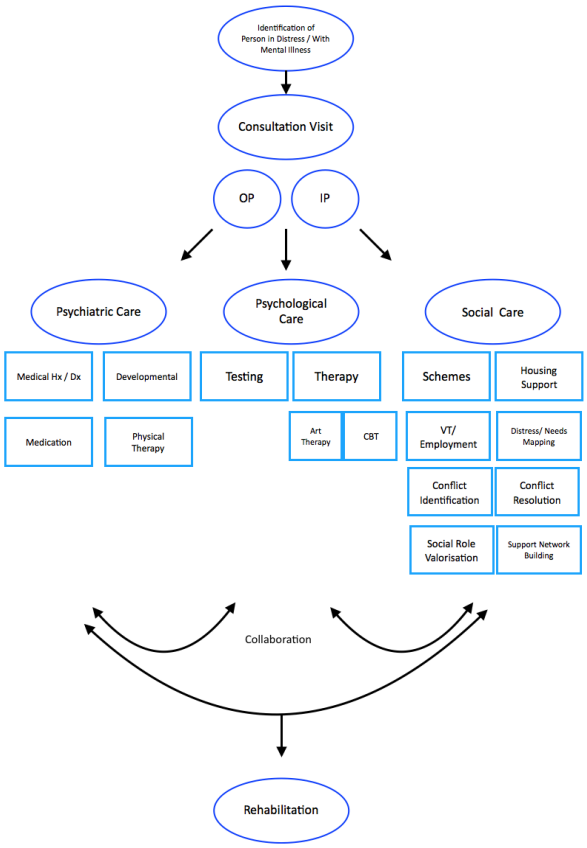
In addition to quality audits, random surprise checks are also conducted by project heads and managers once a month. Reports are shared with project teams for problem solving which (barring emergencies which need to be responded to within 24 hours) are to be completed within a week. In case of complex issues that cannot be managed by the care and project team, the senior management, director and executive committee step in.

Internal Audits

Every quarter an external auditor (KPMG) completes a thorough audit of our finances, administrative and human resource documentation and practices. The report that they provide to us is then reviewed by the **executive committee** and if needed, further action or modifications in the system are made.

[3] See preference list (Appendix)
[4] See Quality Audit Example (Appendix)

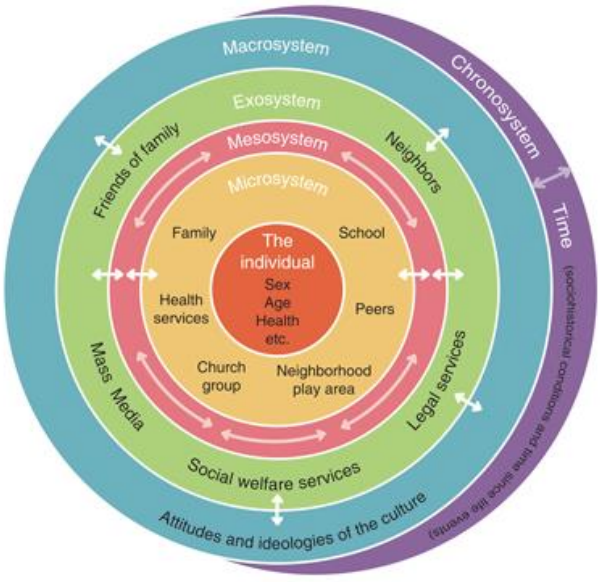
Integrated Care Pathways



Social Care Systems

Social workers are ubiquitous across the spectrum of services and range of care provided at The Banyan. The Banyan's theoretical underpinnings focus on social factors- be it at individual, context, family and community levels. We believe that while the social, psychological and cultural are intertwined, psychological distress may indeed be precipitated and/or perpetuated by the social. Typically, the social worker binds all care packages, using case management, strengths based approaches, problem solving techniques, brief therapies, self enhancement techniques and grit training and pursues goals of personal recovery, well-being, social inclusion, self efficacy, participation, identity reconstruction and social role valorisation. Thus, understanding the client's social context and her ill health trajectory - be it her symptoms, stressors and triggers or mapping her needs, strengths, social capital (resources, networks, relationships), and cultural affiliations - assumes great importance.

Social workers focus on the goal of equality and equity, are advocates of the person in care, who by virtue of their ill health, disability and distress, could be vulnerable, marginalized and thus feel segregated and sometimes hopeless. Listed below are the responsibilities of the social worker in mental health practice. Some of the foundations of social work practice in mental health are located in the **Ecological Systems Theory** developed by Urie Bronfenbrenner. Bronfenbrenner believed that a person's development was affected by everything in their surrounding environment. He divided the person's environment into five different levels: the microsystem (closest to the individual; those who make direct contact), the mesosystem (those in the microsystem who interact with one another e.g. a parent and a teacher), the exosystem (settings that the individual does not have an active role), the macrosystem (cultural context), and the chronosystem (environmental events and transitions).



The Indian Context

- According to the World Health Organisation (WHO), three quarters of the global burden of disease, is accounted for by neuropsychiatric disorders in lower and middle income countries (LMICs) with these countries also being home to two-thirds of the world's ultra-poor (Insel, World Economic Forum, 2011; WHO, 2011).
- The World Bank states that those with disabilities are among the poorest worldwide (World Bank, 2013) and those particularly vulnerable are women, and persons who are homeless (World Bank, 2013).
- There is extensive empirical evidence that indicates the pervasiveness of mental ill health in poverty stricken areas, and the role of relative poverty as a strong predictor of mental health problems (Read, 2010; Koenen et al., 2007; Gururaj et al., 2016; Lund, 2010).
- Comorbid health and mental health issues contribute to a significantly higher mortality rate among this population (Yim et al., 2015) and living on the street with a mental illness puts an individual at risk for malnutrition, skin disorders, physical or sexual trauma, substance abuse, HIV, and hepatitis amongst others (Institute of Medicine, 1988).
- The most recent National Mental Health Survey (2016) in India, estimates that 150 million people are currently in need of interventions for a mental health issue. Further, it also posits an estimated treatment gap of 90-95%, indicating that only 1 out of every 10 individuals has access to a mental health care service.
- The National Human Rights Committee (NHRC) report points to a growing crisis of long stay across forty three state mental hospitals, with a significantly large percentage of long-stay clients being homeless (Murthy et al., 2016).
- The problem is extensive in states such as Maharashtra, Tamil Nadu, Kerala and West Bengal, and the NHRC report also states that a total of 3,408 individuals have been in these hospitals for over a year, 3,025 individuals have been in these hospitals for over 5 years and that 1,588 of the long stay patients are homeless.
- In February 2017, the Supreme Court of India, in an order in a case pertaining to issue of long stay at various hospitals in Uttar Pradesh, directed the Centre to frame a policy for rehabilitation of people recovered yet living for long periods in these facilities.

Values and approaches

- Alliance (e.g. informed consent, relationships, therapeutic alliance, dialogic relationship)
- Aims (clearly specified and positive outcomes)
- Action sequences (specified sequence of actions)
- Critical practice (e.g. disruption, critique of current social assumptions)
- Rights (human rights, cultural respect, equality, sustainability)

What is a Biopsychosocial framework?

The biopsychosocial framework combines and takes into account findings from initial interviews with clients and family members, medical findings, reports from other agencies and professionals, results of psychological and rapid assessment tests and findings of social assessment tools.

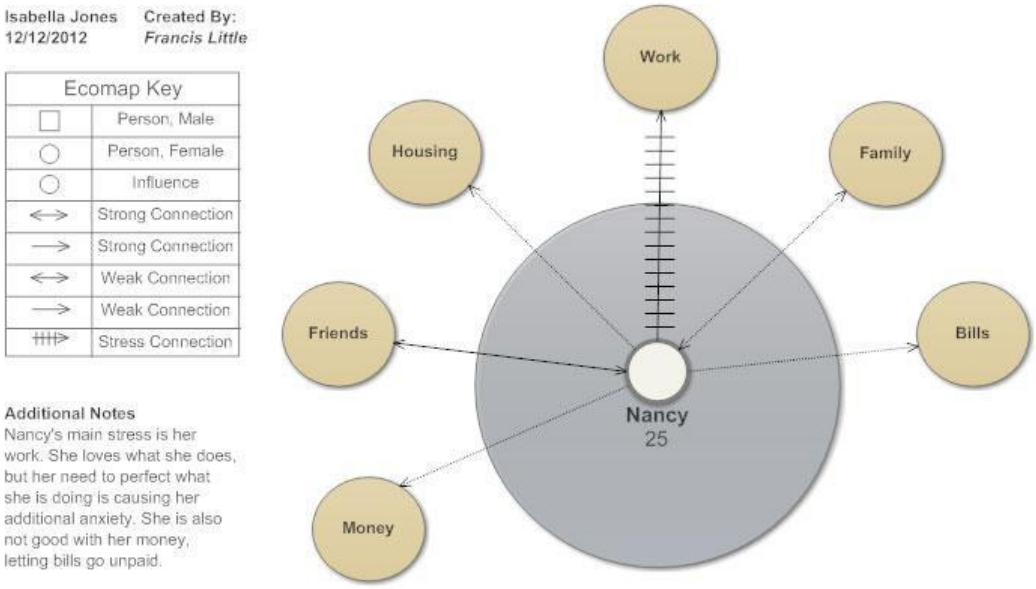
- Comprehensive view of a client's life and their social context
- Identifying information
    - Demographics, interviews with the client, information from outside sources
- Presenting problem
    - A detailed description of the problem as presented by the client, who is involved; past experiences relevant to the current problem; other recent stressful life events
- Current situation
    - Family dynamics; social network; economic situation; physical environment; significant issues/activities
- Previous Mental Health problems and treatment
- Background information
    - Family background, marital status, education, employment history, substance use history, health issues, cultural background
- Mental status examination
- Detailed analysis of information that is gauged
    - Key issue, seriousness, functionality, what factors are contributing to the problem
    - Identification of stressors, obstacles, vulnerabilities and needs
    - Client's motivation level and potential benefit from intervention
- Recommendations and intervention planning
    - Types of intervention: case management, individual, family, group therapy, environmental level or social system level intervention
    - Referrals to psychiatrist for assessment for medication
    - Other referrals
    - Advocacy

As a result, the 4 Ps are essential for a social worker to understand an individual's psychopathology, distress and mental health concerns using a biopsychosocial lens:

	Biological	**Psychological**	**Social**
Precipitating factors	Genes Family History Substance misuse Organic conditions	Dysfunctional parenting Cognitive distortions Maladaptive behaviours Psychodynamic factors	Childhood abuse Bullying Poor social support Poor housing Unemployment
Predisposing factors	Substance misuse Organic conditions Non-compliance Pattern of sleep	Stress Bereavement/loss	Life events
Perpetuating Factors	Substance misuse Organic conditions Non-compliance Pattern of sleep Treatment Resistance	Poor insight Cognitive distortions Maladaptive behaviours Psychodynamic factors High expressed emotion Lack of confiding relationships	Stigma Poor coping skills Poor social support Poor Housing Unemployment
Protective Factors	No family history No substance misuse Responsive to medication Compliant with medication	Good insight Motivated Confiding relationships	Good premorbid functioning Good social support Employment

Arriving at a diagnosis and intervention plan

- Social work practitioners, even as they follow diagnostic criteria under the ICD 10 (international classification of diseases) or DSM 5 (diagnostic statistical manual of mental disorders), may engage in social prescribing and should challenge any discriminatory practice including labelling and segregation.
- Social workers pay heed to semantics and language as it could influence behavior, and care staff must be trained in inclusive practice.
- As much as social work practitioners assess vulnerabilities, equally they focus on social capital, strengths, etc.
- Promoting clinical, social, functional and personal recovery through goal setting and collaborative planning is an essential part of a social worker's mandate.
- Building self esteem, confidence and the ability to trust and participate in social, cultural and economic life (amongst clients) are key goals in clinical social work practice.
- Mediating between clinical and critical social work practice is key. Thus, focus on individuals rights, capabilities, identity, spaces, social architecture, intervention planning, value decks is an essential part of social work practice.
- A social worker works towards enhancing support networks - use of ecomaps help in this process *(An ecomap is a diagram that shows the social and personal relationships of an individual with his or her environment)*



- Working on the **domains of functionality** is one of the most important tasks of a clinical social worker.
    - Ability to communicate his or her needs to others.
    - Ability to use public transportations
    - Ability to take care of physical needs independently:eating, bathing, dressing, using the toilet (unaided)
    - Ability to handle and manage money: budgeting, counting change, shopping
    - Literacy: ability to read, reading level
    - Physical mobility: walking, climbing stairs, transfer from wheelchair to bed
    - Social skills: ability to interact with others, ability to initiate, develop and maintain relationships
    - Ability to manage a household independently: cooking, cleaning, laundry, dishes, making bed.
    - Occupational/employment skills and experience: work skills, ability to follow directions and accept supervision, ability to get to work on time
    - Ability to assume responsibility for taking own medication consistently
    - Sensory functions: sight, hearing and so on.
    - Ability to protect self and others from fire.
    - Ability to protect oneself from involuntary sex, assault, and other kinds of exploitation.
    - Use of leisure time

Social Work theories and therapeutics

Used by social workers during the identification/treatment phase.

Theory Group	Social Work Objectives	Contribution to practice
Psychodynamic	Problem-solving	Emphasizes the importance of people's internal feelings and conflicts in generating behaviour and in resolving the problems that they face
Crisis and task centered		Focuses on brief, highly structured models of intervention with clearly definable problems that will respond to active efforts to resolve them
Cognitive behavioural		Emphasizes the importance of rational management of behaviour in understanding the source of people's problems and managing it
Systems/ecological		Integrates interpersonal work with individuals with interventions with families, communities and social agencies
Macro practice/social developmental/social pedagogy	Problem Solving/Empowerment	Gives priority to the social and educational factors, engaging people with shared interests and concerns to work jointly to overcome them
Strengths/solution/narrative	Empowerment	Recasts clients' and families' apparent problems, seeking strengths that enable them to build positively for the future
Humanistic/existential/spiritual		Emphasizes personal development through shared experience as a source of individual and group empowerment
Empowerment/advocacy	Empowerment/Social Change	Creates experiences and alliances that empower people to achieve a greater understanding of their lives and changes in them
Critical	Social Change	Offers critiques to the present social order that analyse and deal with social factors that underlie problems or social barriers
Feminist		Explains and respond to the oppressed position of women in most societies through collaborative dialogue and group work to achieve consciousness of issues affecting women's social relations
Anti-discriminatory/multicultural sensitivity		Develops an understanding of cultural and ethnic barriers, conflicts and difference, and practice that respects people's identities

Tools for screening or understanding your client.

Tool	Purpose
Patient Health Questionnaire (PHQ)	For screening, diagnosing, monitoring and measuring common mental disorders
Mental Status Examination	To understand an individual's psychological functioning at a given point of time
Clinical Interviews	To understand an individual's mood, cognition and psychosocial history
Cantrill's Ladder	To understand subjective well-being
WHODAS	To measure disability level
GAF	To measure psychological, social and occupational functioning

Integrated Care Pathway

- The social work practitioner is aware of the broader framework that promotes well-being, and links threads of the individual's life to collaboratively develop goals and address impediments that may come in the way of achieving those goals (recovery, well-being, participation, mobility, independence, income enhancement, healthy relationships and social life, pursuit of capabilities, etc.). In the Indian (or LMIC) context in particular, social workers have to be aware of deprivation related to multi-dimensional losses and attempt to minimize them, especially since mental health outcomes could be influenced by one's social context and structural barriers.
- Social workers must also equally work with individuals, families and communities to understand concepts of normalizing, social mixing, diversity and subjective well-being.
- Focus on enhancing Quality of Life
    - Self awareness: insight into stressors and triggers, patterns of ill health, attributions, coping techniques, healthy help seeking behaviour
    - Work (income enhancement; empowerment; identity formation) and self reliance (increased independence, self-esteem and agency)
    - Relationships: awareness of healthy and harmful relationships - interdependence is key to build empathy, kindness and equality
    - Social and cultural life: enthusing participation and socialisation
    - Identity drawn from many dimensions: defining and reconstructing social roles, focus on social role valorisation
    - Meaning and purpose: pursuing higher order needs
    - Control and Power: assessing the locus of control and supporting agency development

Working with Care Teams

The SWP is involved in all stages of clinical care, ranging from the case formulation, arriving at a diagnosis if helpful and needed, to pharmacotherapy, psychological care, referrals to other specialist services (health or rehabilitative), to improving domains of functionality and social inclusion. Side effects and related queries, management and support are critical, as these often present as reasons for opting out of care and for poor treatment commitment. Knowledge of the medical domain may help the SWP challenge diagnosis if required, and make recommendations to the treating team regarding options for medication. The social worker also plays a key role in working with the meso- and macro-systems that an individual lives in and thus works with families, communities, health and social care systems and prospective employers, as well as at the policy levels to make legislation and programmes/plans more responsive, informed and inclusive. Some of the key areas that a SWP works in include:

Social Care Facilitation

- Government disability allowance: an allowance for those with moderate to severe disability living below the poverty line
- Work & employment facilitation with extra support
    - Through incentives, career fairs, skills training, vocational training hubs, integration into MGNREGS and other government facilitated schemes, home-based work, social cooperatives; focus on providing extra support and allowing for flexibility
- Welfare entitlements and schemes offered by the Government
- Healthcare access
- Citizenship paperwork
- Housing facilitation
- Writing up advance directives and collaborative goals of recovery

Continuity of Care

This is essential to make sure that well-being is maintained in clients, and so we must be aware of any recurrence of severe symptoms that may be precursors to self-harm, aggressive behaviour or even a descent back into homelessness.

- Must be maintained through outpatient care, home visits, telephone follow up
- Safety planning and social capital matrix is useful, keeping in mind that the SWP is also responsible for continuity of care and in providing options for persons living with low-to-severe disability. These options may include long-term care, as well as inpatient care. Social workers must thus have information on:
    - Services that the state and other service providers offer
    - Legislative frameworks and policy to ensure that the client can access her constitutional rights
    - Human rights instruments
- Aftercare for those reintegrated (details can be found in the aftercare section of this document)
- Long-term care for those with long-term needs (details can be found in the Inclusive Living Section of this document)

Policy Level Advocacy

- Social workers attempt to affect policy by mediating between clinical and critical social work
    - Critical social work - constructive dialogue in the interest of achieving social justice
- Moving from task centred practice to:
    - Ensuring that pathways to ill health are addressed at systemic levels - working on prevention of distress and promotion of good mental health; cross sectoral lobbying - working on the well-being and rights of the ultra poor and marginalised sections of society
    - Reducing the incidence of mental illness through early identification and clear and available care pathways, by ensuring an equitable and appropriate health systems approach
    - Promoting social mixing: supporting those with severe mental disorders and high levels of disability by enhancing functionality, decreasing disability and ensuring space and opportunity for ALL in mainstream society ; addressing prejudice and stigma through social mixing, expression of diversity, and radical acceptance

Person-Centered Approaches to Care

- Information is transparently shared and the person accessing care/treatment is informed of the care plan and participates in it, regardless of the assumed mental health condition of the person, both in OP and IP services.
- Power hierarchies are identified and addressed either between the institutional care provider(s) and the client, or between the informal/ family caregiver and the client.
- Processes and care packages are non-intimidating, non-bureaucratic and non-fragmented, and presented in a manner that is acceptable to the client.
- Client directs her care and recovery from the very beginning. Towards this diverse notions of recovery are shared from the third or fourth session, both by the social worker, other members of the MDT and through peer support groups or role models.
- The SWP is responsible to facilitate and catalyse a safe, nurturing and therapeutic environment, where respect for all is mandatory and dignity, a given.
- Supporting confidentiality of clients.
- Co-developing services with clients.
- Using a rights-based approach that offers opportunities for grievance redressal.

The Role of Community Health Worker

- To connect people to health services
- To counsel individuals
- Values:
    - Work with honesty and integrity
    - Have a non-judgemental attitude
    - Use confidentiality
    - Follow the Health Care Ethics principles:
        - Autonomy and respect boundaries
        - Beneficence (do the greatest good)
        - Do no harm
        - Justice

Goals of CHW:

- Promote mental health and well-being
- Care for those living with mental illness
- De-stigmatize mental illness by teaching the community that mental health is not scary or frightening
- Educate those with mental health problems on ways to help take care of themselves

CHW will use the stepped-care pathway approach to care. In order to help as many people as possible, a team (CHW, social workers, psychologists, nurses, and doctors) will have to work together. This collaborative care approach is used because each person has an important role in helping the client.

Social Work Practitioners often resort to the following methods while working with clients with mental health issues in conflict or distress. At The Banyan our approaches to care are person-centric, and we make sure to follow the values that are inherent to our organisation. Social work practitioners are aware of when to switch between clinical practice and critical practice.

Interviewing Techniques

Motivational Interviewing OARS Technique

An "empathic, person-centered counseling approach that prepares people for change by helping them resolve ambivalence, enhance intrinsic motivation, and build confidence to change." (Kraybill and Morrison, 2007)

- Open-ended questions - These questions invite the interviewee to tell their life stories in their own words without leading them in any particular direction. A willingness to listen must be shown on the part of the clinician.
- Affirmations - Statements that recognize the client's strength; acknowledge behaviours that lead in the direction of positive change no matter how big/small. They aim to build confidence in one's ability to change. Affirmations must be genuine and relevant to be effective.
- Reflective Listening - Think reflectively, close the communication loop to make sure no breakdowns in communication occur. Basic techniques in reflective listening are to repeat/rephrase, paraphrase, reflect of the feeling.
- Summaries - Can be used throughout conversation but are especially helpful during transition points. Helps ensure clear communication between speaker and listener

Therapies

Task Centred Therapy

- Break down specific problems into tasks and address them one at a time.
- Set goals, identify patterns of engagement, create an intervention plan, review goals and progress and terminate engagement *(works with those in long-term care)*

Solution Focused Brief Therapy

- Foundation is in collaborative goal setting and relationship building

- Largely self-directed, therefore reinforcing The Banyan's value system and approach to care
- Can help improve quality of life for those with psychiatric disorders by focusing on micro aspects of functionality (preferences, clothes, nature of work, daily remuneration, nurturing friendships, religious visits)
- Goal setting, Specific-questioning, helping clients realise their own strength and virtues
- Focus on what individuals can do, rather than what they can't

Narrative therapy

- Views people as separate from their problems, allowing clients to gain some distance from their issues to see how it may be helping, protecting or harming them
- Events are viewed as stories, some which stand out as significant stories more than others
- Significant stories most of the time can shape a person's identity
- Largely self-directed, clinician helps client realise that they are experts of their own lives
- Working to uncover aspirations, dreams, values, goals and skills that are separate from problems

Open Dialogue

- Meetings involving client together with their family members
- Create shared understanding of the problem
- Focus on interpersonal relationships
- No decisions are made about the client outside of network meetings
- Social work practitioner uses transparency, empathy, unconditional positive regard

Expressive Arts

- Combination of psychology and the creative process to promote emotional growth and healing
- Creativity is the pathway to express feelings and initiate change (e.g. music, theatre, poetry, dance, etc.)
- Social work practitioner helps client communicate through art making
- Problems are highlighted and analysed through the creative process

Strengths model (Rapp, 1998)

- Focus is on individual strengths rather than pathology
- The community is viewed as an oasis of resources
- Interventions are based on client self-determination
- Case manager-client relationship is primary and essential
- Aggressive outreach is the preferred mode of intervention
- Model is implemented through a collaborative relationship an assessment of strengths, planning, resource acquisition, ongoing modification of the plan and gradual disengagement

Positive Psychology

- Positive Emotions
- Engagement
- Relationships

- Meaning
- Accomplishments

Cognitive Analytic Therapy (CAT)

Cognitive analytic therapy (CAT) was developed by Dr. Anthony Ryle in the early 1980s. He believed that it was important to take the best parts of different approaches in order to offer a time-limited therapy within the health service structure. They believed that the therapy would undergo further research, adjust and grow organically with the experience of the therapists and clients, and that is what happened.

This type of therapy combines ideas from psychoanalysis with those from cognitive therapy. The therapy aims to understand why a person feels, thinks and behaves in a certain way, prior to helping them address poor coping mechanisms and problem solve via new ways of coping. CAT empowers the client to be active in the process of their recovery by inviting them to view their life from an objective perspective and make the changes necessary.

Features:

- A combination of psychoanalysis and cognitive therapy
- Investigating learned behaviours or beliefs from an individual's past/their contribution to the current problem
- Illustrate to the client how they can alter these learned behaviours or beliefs
- Focus on empowerment, and individualised treatment

Part 1: Analytical Side

- Exploring significant life events and experiences that could link to current issues
- Attempting to understand how and why those experiences could be affecting the individual now
- Attempting understand how and why those experiences took place

Part 2: Cognitive Side

- After working with the client to help them understand the implications of their past, the therapists will assist the client in coming up with current coping mechanisms for the problem
- The therapist will also identify current coping mechanisms and their effectiveness or lack thereof
- Techniques of cognitive therapy will be used so that the client can develop new tools in coping and management of current and future psychological issues.

Due to the nature of CAT, it is extremely important that the therapist builds a strong and trusting relationship with their client, as they will be working together much like a team. CAT is often used to address issues such as substance addiction, anxiety, depression, disordered eating, obsessions and compulsions, phobias, relationship issues, self-harm and stress.

Type of Service User	Assessment	Social Interventions
Homeless person living with mental illness		
Phase 1: Critical Time Intervention, Harm Reduction, Safety Planning	Risk assessment - their clinical status, risks to self, behaviours that may put individual in conflict with law, resource and support network mapping (individual resources, presence/absence of social support in vicinity etc.), previous history of institutionalisation if known	Critical time intervention
		Outreach and supportive services
		Referral to Other Services
Phase 2: Welcoming the Client - focus on dignity, support networks and environment	Case History Intake, Immediate Needs and Preferences Assessment	Design and Environment - orientation, modifications and adaptations
		Information dissemination on mental health and treatment
		Rights - information dissemination and recourse to relief options
		Assets Transfer & Maintenance
		Care coordination and Referral services
		Support Groups & Group therapeutic community
Phase 3 : Engagement with the client - working towards recovery; addressing precipitating and perpetuating factors; focus on self awareness, grit and resilience training - self directed care	Social functioning instrument (SFI), Individual Care Plan (ICP)	Illness and recovery narrative formulations
		Counselling
		Care of Self interventions
		Personal Recovery Goal setting
		Information dissemination on mental health and treatment
		Skills for daily living training
		Social skills training
		Medication optimisation
		Activity scheduling
		Supportive Therapy
		Group therapeutic Community
		Rights - Information dissemination and recourse to relief options

Phase 4 : Focus on Social Role Valorisation - Pre-discharge stay in recovery Hubs	Social functioning instrument (SFI)	Activity scheduling
		Care of self and Home Management interventions
		Counselling
		Motivational Interviewing
		Collaborative Strengths Mapping
		Stressors and Signs of Symptom Resurgence Mapping
		Solution focussed therapy
		Continued care planning
		Personal Safety planning
		Money management
		Cognitive enhancement therapy
		Work readiness and preparation
		Personal Safety planning
		Sexuality counselling
		Home environment adaptations planning
		Information dissemination on mental health and treatment
		Medication optimisation
		Peer advocacy
Phase 5: Reintegration	Social functioning instrument (SFI), Household Assessment (HAF), Cantril's ladder, Five Domains Rating	Home Visits
		Family Conferences
		Networking
		Social entitlement facilitation
		Discharge planning
		Community Circles
		Service arrangements mapping and connections
		Continued services planning
		Institute Home environment modifications

Phase 6: Aftercare	Comprehensive Household Assessment (HAF), Cantril's ladder, Five Domains Rating	Care coordination and referral services
		Counselling
		Home Visits and phone follow-up
		Home-based care
		Medication optimisation
		Motivational interviewing
		Problem solving
		Disability allowance
		Individual and household strengths mapping
		Housing support
		Assets transfer & maintenance
		Modified behaviour activation for clients and carers
		Illness and recovery narrative formulations
		Personal recovery goal setting
		Work readiness and preparation
		Employment
		Community circles
		Networking
		Social entitlement facilitation
		Information dissemination on mental health and treatment
		Support groups
		Modified cognitive enhancement therapy
		Self monitoring tools - cues/reminders for carers and individuals
		Collaborative behavioural prescriptions
		Respite care arrangements
		Referrals - matching care to address sources of individual and carer burden

People with mental illness living in poverty		
Phase 1: Identification and Help-seeking	Resource Mapping	Assertive community treatment
	Key informant survey	Participatory community appraisal
	Area Fact Sheet	Mobile crisis intervention
	Distress mapping	Lay counselling
Phase 2: Engagement		Home visits
		Illness and recovery narrative formulations
		Counselling
		Care of self interventions
		Personal recovery goal setting
		Information dissemination on mental health and treatment
		Skills for daily living training
		Social skills training
		Medication optimisation
		Activity scheduling
		Supportive Therapy
		Group therapeutic Community
		Rights - Information dissemination and recourse to relief options
Phase 3: Restoration		Supportive care arrangements
		Activity scheduling

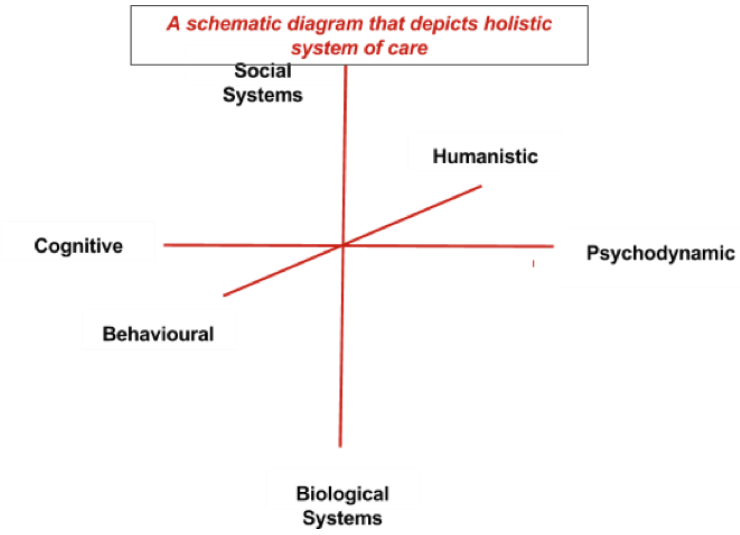
		Care of self and home management interventions
		Counselling
		Motivational interviewing
		Collaborative strengths mapping
		Stressors and signs of symptom resurgence mapping
		Solution focussed therapy
		Continued care planning
		Personal safety planning
		Money management
		Cognitive enhancement therapy
		Work readiness and preparation
		Personal safety planning
		Sexuality counselling
		Home environment adaptations planning
		Information dissemination on mental health and treatment
		Medication optimisation
Phase 4: Personal Recovery		Peer advocacy
People with mental illness with long term care needs		
Phase 1: Pre-engagement	Comprehensive Screening Form (includes File review, qualitative interview, preferences)	
Phase 2: Setting up the home: Adapting to new ecosystem and personalised care		
Phase 3: Personal recovery and sustaining well-being		

Psychological Services

As an integral part of The Banyan's comprehensive mental health services, the Department of Behavioural Sciences aims at facilitating recovery and psychological well-being with a focus on self-actualization.

The Department of Behavioural Sciences envisions to offer free psychological services for marginalised populations such as homeless persons, those living in abject poverty, individuals from traditionally oppressed communities such as tribal populations, scheduled castes, etc.

The Department of Behavioural Sciences within the Integrated Mental Health Program of The Banyan is staffed by qualified, licensed clinical and counselling psychologists. The Department's focus is on a holistic system of care that refers to the learning and developmental context of the individual, including early formative events, key relationships, traumas, triumphs, and important transitions. For an effective, holistic conception, it is useful to draw inference from major traditions.



The department offers specific psychological services in the hospital and the community, as a part of a large team providing inpatient and outpatient care. The department caters to both adults and children.

Current evidence from around the globe has provided a triangulated understanding about wellness through the emergence of positive psychology, a branch within psychology that enables individuals and communities through evidence--based interventions to thrive by building on strengths, and humanity's inherent need to lead fulfilling lives. This complements the results emerging from synthesising narratives about recovery from mental illness, which provides ecologically valid insights into the processes by which people experiencing mental illness can develop a purposeful and meaningful life. The implications for health professionals are also explored. While working with clients, more emphasis needs to be laid on the person's own goals and strengths, and integrated into routine clinical and non-clinical interventions aimed at promoting well-being.

The department is founded in a user-centric environment that encourages self-reliance during recovery, and aims to achieve this through the use of psychotherapeutic and

counseling sessions, psychometry and high caliber training sessions for students and prospective professionals. Furthermore, the department also works towards prevention and alleviation of mental illness by addressing mental health concerns such as dysfunctional coping mechanisms, stress, poor interpersonal relationships (with colleagues, friends or in a marriage) and dysfunctional emotional regulation strategies through workshops, counseling kiosks and training camps.

Multidisciplinary Approach

In any setting that provides care for those affected by mental health issues, a positive, co-ordinated approach by professionals is essential. The working relationship between agencies must result in a multidisciplinary approach that strives towards a common goal, particularly in procuring stability for persons are suffering with a mental health issue. The successful partnership between the mental health inreach team, primary care and the aftercare (follow up) team is crucial for an effective system.

Within the Department of Behavioural Sciences, psychologists draw upon a range of theoretical orientations, including psychodynamic, cognitive--behavioral, interpersonal, and integrative. Psychologists and interns conduct group therapy, crisis management, psychological assessment, individual psychotherapy, behavioral consultation, and other consultation with treatment teams.

Core components of the department

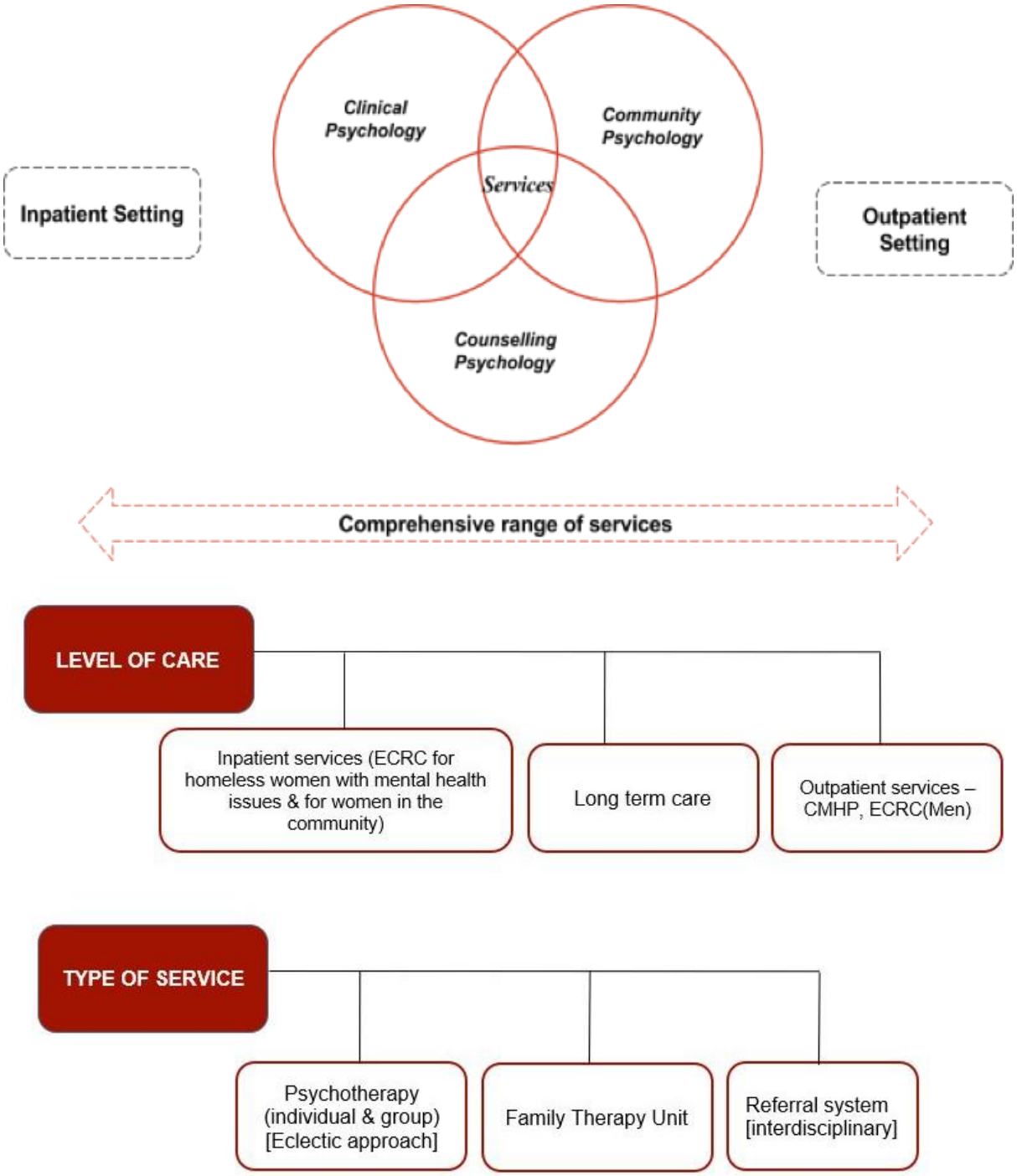
The Department offers a wide variety of inpatient (homeless and community) services, caregivers guidance programme, outpatient clinics and referrals for specific intervention and evaluation for children, adolescents and adults, emergency mental health services for men and women at The Banyan. **Clinical Psychology, Community Psychology and Counselling** are the three main specialities of the department at The Banyan. The department implements an eclectic approach to apply the above specialities based on the need and the suitability of the approach in a critical situation.

Clinical psychology is a specialised branch that provides continuing and comprehensive mental and behavioral health care for individuals and families. It is a specialty in breadth — one that is broadly inclusive of addressing concerns around psychopathology — and marked by comprehensiveness and integration of knowledge and skills from a broad array of disciplines within and outside the core domain of psychology.

Counseling psychology focuses on how people function both personally and in their relationships. Counseling psychology addresses the emotional, social, work, school and physical health concerns people may have at different stages in their lives, focusing on typical life stresses and other severe issues with which people may struggle as individuals and as a part of families, groups and organizations. Counseling psychologists help people

with physical, emotional and mental health issues improve their sense of well-being, alleviate feelings of distress and resolve crises.

Community psychology studies individuals' contexts within communities and the wider society, and the relationships of the individual to communities and society. Community psychology seeks to understand the quality of life of individuals, communities, and society.



Skills Department members are skilled practitioners and therapists	Knowledge	Knowledge of Major concepts, theoretical perspectives, empirical findings, and historical trends in psychology.
		Approaches demonstrate the use of scientific methods in practice
	Praxis	Dept activities will apply psychological principles to personal, social and organizational issues (staff member related counselling as well)
	Ethics	Dept will weigh evidence, manage ambiguity, act ethically, and reflect values of The Banyan
	Documentation, monitoring & evaluation to track the impact of interventions	Dept will be summarised every month into a monthly report after consolidating psychological data across programmes

Self- Awareness Understanding of self that enables all to lead happy, peaceful and purposeful lives characterized by healthy relationships with self and others.	Character	Facilitating one's own self -exploration and character development.
	Expression	Encouraging exploration and expression of ideas about oneself while practicing principles in psychology - self introspection
	Relationship	Demonstration of effective teamwork skills
Diversity and Dignity of all Department will recognize the diversity and dignity of all and understand their own role in the pursuit of social justice.	Pluralism	Understanding and respect of socio-cultural diversity
	Managing distress	Addressing social, economic and environmental issues

Referral System

The services offered by the department of Psychology within The Banyan is referral and need based. These services include mental health promotion, prevention, early identification of mental health concerns, and referrals for treatment of adults, children and families. The team of therapists and mental health professionals promote and design programmes and approaches that promote social and emotional development and effectively address challenging behaviors. Facilitating a referral for mental health services involves helping families understand the value of engaging in these services and matching them with the best available provider to ensure a good fit. Interdisciplinary referral process with a family can have lasting effects on the family's level of participation in the therapeutic process and consequent outcomes. The following array of services are offered:

Psychotherapy: The department facilitates insight into various concerns and problems through various schools of psychotherapy, such as cognitive-behavioural therapy (CBT), behaviour therapy, humanistic approach, psychodrama, psychodynamic approach, marital and family therapy, behavioural-marital therapy, Clinical Hypnosis and sex therapy. With a larger focus on adults, therapy is formulated for specifically adult disorders. Various disorder specific interventions are offered, such as CBT for depression, anxiety disorders, insight (in psychosis), substance use and dependence, eclectic approaches in marriage and family therapy, with children, and for interpersonal issues. Outlined below is a list of methods:

- **Clinical Interviews (case work up, diagnostic formulation and clarification, therapeutic formulation):** Mental ill health is a complex problem that often manifests in a variety of ways. In order for the mental health practitioner to understand the primary problem, they often use a technique known as clinical interviewing. This is a semi- structured process that helps in acquiring information which contributes to developing a diagnosis and then toward therapeutic formulation- What is the primary problem? What does the person need? How can it be offered? What is an appropriate psychological intervention that can be offered in order to achieve these needs? - these questions are often answered through clinical interviewing. Clinical interviews usually are completed in one session; in the event a follow-up session is required, it may be offered on a need basis.
- **Individual Care Plan**: Developing Individual care plans collaboratively with the Dept of Social Work, Nursing and Psychiatry In offering good mental health care to each individual, it becomes important to provide a care plan that is need based, holistic and personalized. In order to achieve this, 'individual care plan' are developed using a biopsychosocial framework, for each person accessing services at The Banyan. This will be developed with the individual seeking the service after a clinical interview is completed.
- **Behaviour Therapy:** Developed by the school of behaviourism, this form of therapy holds that undesirable behavior is learned and has a purpose to the individual. The therapy therefore focuses on interventions that are offered are carefully

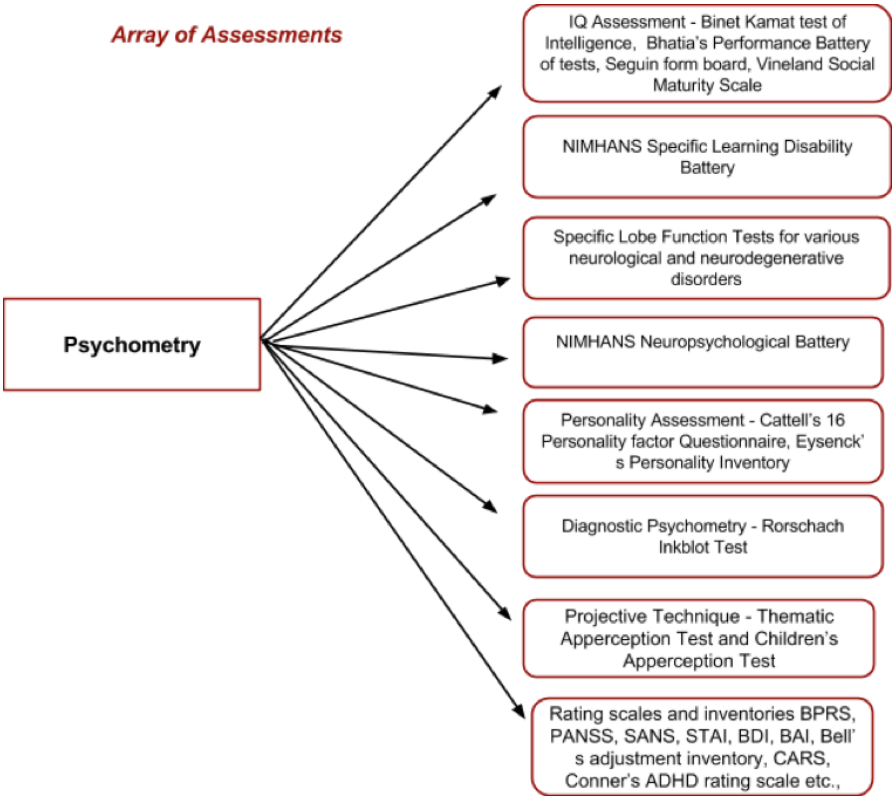
monitored to the detail and reinforced positively or negatively, depending on the therapeutic formulation.

- **Marital and Family Therapy:** Offered in contexts of couples and families respectively, this form of intervention is used to strengthen or improve upon existing interpersonal relationships that may be strained due to a variety of underlying problems such as sexual health, bereavement, financial problems and so on.
- **Cognitive-Behavioral Therapy (CBT)**: We all engage in patterns of thinking and behavior in our day-to-day living. CBT explores the dynamic relationships and patterns between our beliefs, thoughts, and emotions in relation to our behaviors and actions.
- **Cognitive remediation program:** The primary aim of cognitive remediation therapies is to reduce cognitive deficits. When considering the remediation tools that are currently in practice one could compare it to brain training. However, in contrast to cognitive remediation, brain training is aimed at healthy subjects wishing to prevent aging-related cognitive deficits before they occur. Brain training programs (in addition to possible medical indications) employ evidence-based techniques to prevent cognitive aging. Cognitive deficits can manifest as disorders of attention, memory, and executive function (ability to organize one's actions and speech). Certain mental illnesses are sometimes characterized by specific cognitive deficits, such as social cognition disorders (which prevent the patients from understanding other people's intentions, desires and emotions). These types of cognitive disorders highly compromise the social and professional integration of people going through such problems. Rehabilitation treatment offering exercises with an aim at improving attention, memory, language and/or executive functions can be used to address these disorders.
- **Client Centered Therapy:** This form of therapy holds the view that the client is most important, and they are capable of managing their lives given appropriate support and direction. It's non-directionist. Given that the individual is most important, unconditional positive regard - total acceptance and support of the person without judgement and evaluation - is the key principle in this form of therapy.
- **Dialectical Behavior Therapy (DBT)**: Dialectical Behavior Therapy is a Cognitive Behavioral approach that addresses psychosocial aspects of mental health. Some people's emotional arousal levels can increase far more quickly than others, achieve a higher level of emotional intensity, and involve a significant amount of time to return to normal arousal levels. As such, these individuals can experience extreme swings in their emotions. DBT focuses on teaching coping skills for managing intense emotions in our day-to-living.

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

Psychometric Assessments

These are used adjunct to therapies and counseling. Various assessments such as IQ assessments, performance testing, diagnostic psychometry, projective techniques, personality assessments and neuropsychological assessments are completed by clinical psychologists, on a referral basis from other mental health professionals such as social workers, psychiatrists, general practitioners.



The department members meet once in a fortnight along with the head of the department to debrief and offer peer supervision.

Counselling Services: These are offered for common mental health concerns such as stress, anger management, interpersonal issues and so on. They contribute substantially towards our aim to prevent mental illnesses. Techniques of psychodrama are also used for specific concerns such as time management, anger management, poor impulse control, strained relationships, etc.

Group therapies: Group therapy is a type of psychotherapy in which carefully selected patients are placed in a group led by a psychotherapist, who stimulates the participants to help each other and promote changes to their personality and behavior. Various techniques from different schools of psychotherapy are used to facilitate group therapy. Common groups include those that address negative symptoms of psychosis, depression, substance use, anxiety disorders, etc. The department at present conducts behavioural- training based intervention that aims to improve cognitive processes (attention, memory, executive function, social cognition, or metacognition) with the goal of durability and generalization. The objective to establish this group therapy was to see if it is possible to achieve any improvement in cognitive functions in schizophrenia using non--pharmacological methods.

Training, supervision and continuing education: The department is a training site for both professionals in the field of mental health, and students in the clinical/counselling branches of psychology. It also conducts short duration training sessions providing professional development opportunities.

It is essential to integrate theory into practice. Psychological interventions is applied in a variety of settings to serve our communities; we reflect on how to improve practice from one's experiences in these settings (homelessness and community) ; a practitioner needs to share with students the knowledge one has gained from his / her experiences. To accomplish these actions one must serve as both teacher and learner in both classroom and field.

Disorder-Specific Psychological Interventions

	Assessments and Psychometry			Psychotherapy	
Type of Disorder	**Screening**	**Periodic Assessments**	**Disorder Specific Tools**	**Option 1**	**Option 2**
Dementia	Initial Screening forms Physical assessment Mental status examination Diagnostic evaluation Mini Mental Status Examination	Clinical Dementia Rating Scale	Clinical Dementia Rating Scale NIMHANS Neuropsychological Battery Addenbrooke's Cognitive Examination	Didactic Information on illness and management	
Substance Use Disorders	Initial Screening forms Physical assessment Mental status examination Diagnostic evaluation CAGE Questionnaire Alcohol Use Disorders Inventory Test (AUDIT)	Brief Psychiatric Rating Scale (BPRS) Clinical Global Index (CGI) Extrapyramidal Symptom Rating Scale (EPSRS) Modified Global Assessment of functioning (m-GAF) WHO Quality of Life (QOL) Presumptive Life Event Scale(PSLES) (OP)	CAGE AUDIT	Individual/Group Therapy Motivational Interviewing Transtheoretical Model of Change Cue Exposure Therapy Aversion Therapy Relapse Prevention Strategies Contingency Management Family Therapy Didactic Information on illness and management	Self Help Approach - Alcoholic Anonymous (AA Groups) Religious Approach to deal with moral reduction / strengthening Therapeutic Community Re-emphasising option 1 is necessary

Psychosis	Initial Screening forms Physical assessment Mental status examination Diagnostic evaluation	Brief Psychiatric Rating Scale (BPRS) Clinical Global Index(CGI) Extrapyramidal Symptom Rating Scale (EPSRS) Modified Global Assessemnt of functioning (m-GAF) WHO Quality of Life (QOL) Presumptive Life Event Scale(PSLES) (OP) The Indian Disability Evaluation and Assessment Scale (IDEAS)	BPRS The Positive and Negative Syndrome Scale (PANSS)	Individual/Group Therapy Social Skills Training Cognitive Behavioural Therapy to deal with hallucinations and delusions Distress management techniques and positive symptons diary Cognitive Retraining Didactic Information on illness and management	
Bipolar Affective Disorder	Initial Screening forms Physical assessment Mental status examination Mood Chart Diagnostic evaluation	Bried Psychiatric Rating Scale (BPRS) Clinical Global Index(CGI) Extrapyramidal Symptom Rating Scale (EPSRS) Modified Global Assessemnt of functioning (m-GAF) WHO Quality of Life (QOL) Presumptive Life Event Scale(PSLES) (OP) The Indian Disability Evaluation and Assessment Scale (IDEAS)	Montgomery-Åsberg Depression Rating Scale (MADRS) Young Mania Rating Scale (YMRS) Hamilton Rating Scale for Anxiety (HAM-A)	Individual/Group Therapy Didactic Information on illness and management Interpersonal and social rhythm therapy (IPSRT) Family Therapy Stress Management	

Depression	Initial Screening forms Physical assessment Mental status examination Diagnostic evaluation	The Beck Depression Inventory	The Beck Depression Inventory Zung Self-Rating Depression Scale	Individual/Group Therapy Didatic Information on illness and management Guided Self Help strategies Interpersonal Therapy Behaviour therapy Mindfulness-based cognitive therapy (MBCT)	
Anxiety Disorders	Initial Screening forms Physical assessment Mental status examination Diagnostic evaluation	Hamilton Anxiety Rating Scale State-Trait Anxiety Inventory (STAI) Liebowitz social anxiety scale Yale brown obsessive compulsive scale (Y-BOCS)	Hamilton Anxiety Rating Scale State-Trait Anxiety Inventory (STAI) Liebowitz social anxiety scale Yale brown obsessive compulsive scale (Y-BOCS)	Individual/Group Therapy	

Trauma & Homelessness

Traditionally, trauma is often related to its counterpart, post traumatic stress disorder (PTSD), a clinically relevant and often disabling condition that requires psychiatric consultation. This has resulted in trauma interventions being applied to people who fit a predetermined criteria of diagnosis and this is often dictated by a mental health professional. Others, who do not fit this criteria but do experience subclinical levels of "trauma" and distress as a result, remain in the periphery of clinical practice, receiving little or no intervention for their traumatic experiences. However, in recent times, the definition of trauma in the research arena is taking a turn toward integrating inclusive and broader perspectives.

Homelessness and mental illness is a complex phenomena; the pathways remain somewhat unclear, but a general understanding exists on its gravity and detrimentality. Lack of opportunities, psychological deficits in coping, and other distressing experiences resulting from structural barriers are often traumatic. Similarly, those with mental illnesses are also often pushed toward the periphery of society, resulting in the experience of fewer opportunities, stigma, discrimination, cognitive decline, and other persistent problems that often leads to re-traumatisation. The Banyan understands that while PTSD is observable and detectable in clinical interviews, often, trauma as a

result of negative life experiences are not, unless a deeper understanding of the case is obtained. The Banyan therefore makes efforts to recognise this, and offers support to those who feel poorly resourced in addressing social or psychological challenges. Grounded in stress-vulnerability theories, this notion allows for trauma-informed interventions and research to centre daily work.

This methodology of trauma-informed research and practice feeds into policy and advocacy discussions, impacting putative global ideologies of trauma as being more related to PTSD and less to negative life experiences.

Psychiatric Services

Psychiatrists have an important role to play in the treatment of people with mental disorders, particularly with those with severe mental disorders.

Intake

Psychiatrists get involved in care soon after a person gets admitted into the hospital. They evaluate the person, and in the case of an involuntary inpatient admission, send a report to the magistrate for issual of a reception order. Often, this process is not very simple because the assessment may be inconclusive about the presence of any identifiable mental health problems because of chronic exhaustion, under nourishment, dehydration, and associated physical health problems.

Assessment

- The assessment of the person who is suspected to be mentally ill should take place at least two times in a day in the first 72 hours so that a comprehensive report can be submitted (including a person's behaviour, abnormalities detected in speech, thinking process, perceptual disturbances, cognitive problems and insight).

- Based on this report, a reception order can be obtained after the jurisdictional metropolitan magistrate has met the person. Treatment can begin after obtaining the reception order.

  All patients admitted to psychiatric care will be evaluated physically within the first 24 hours of admission, and all the relevant investigations will be completed in the next 2-3 days. These include:

- complete hemogram
- fasting
- post-prandial blood sugar
- lipid profile
- renal function test
- thyroid function test
- HIV testing for both men and women
- pregnancy test for women
- VDRL
- routine examination of the urine

Based on the findings of the above evaluation, appropriate interventions will begin. All patients admitted to an acute care facility are reviewed twice a day and appropriate medication will be initiated.

It is also important to ensure in the first week of treatment, that the person is well **hydrated, adequately nourished, ensure that they are eating well, and at the same time monitor side effects.**

Other Activities

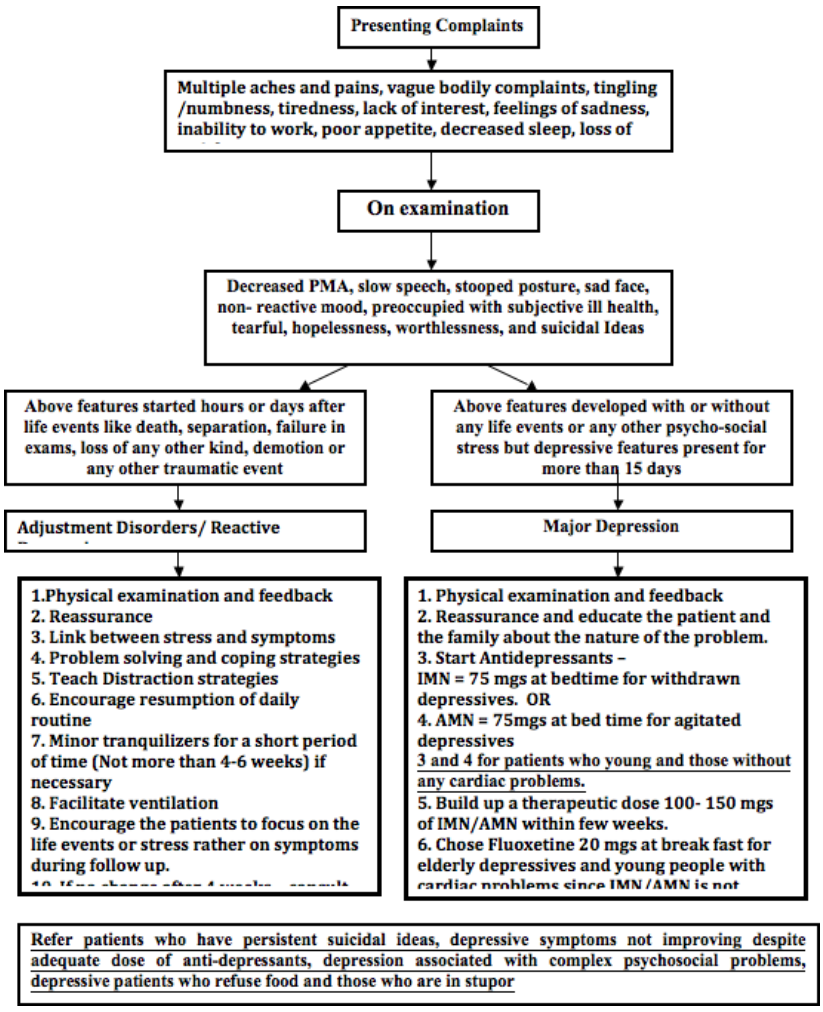
- Depending on the clinical recovery of the person, they may be able to participate in group activities like work, community therapy meetings, physical activity, recreational activity. These options should be explored.
- It is advisable to start the person on attention enhancing tasks (e.g. paper cover making, beading, block printing) to facilitate a move to the second stage of vocational training.
- It is important to identify an area that the person is interested in (e.g. gardening, pet care) so that they sustain their interest in that area of work. Forcing an area that is of no interest to the patient is not advisable.
- Once the person becomes amenable to vocational activity, he or she should be exposed to regular work avenues. The benefits of work participation are mentioned in the skills section.

Monitoring progress

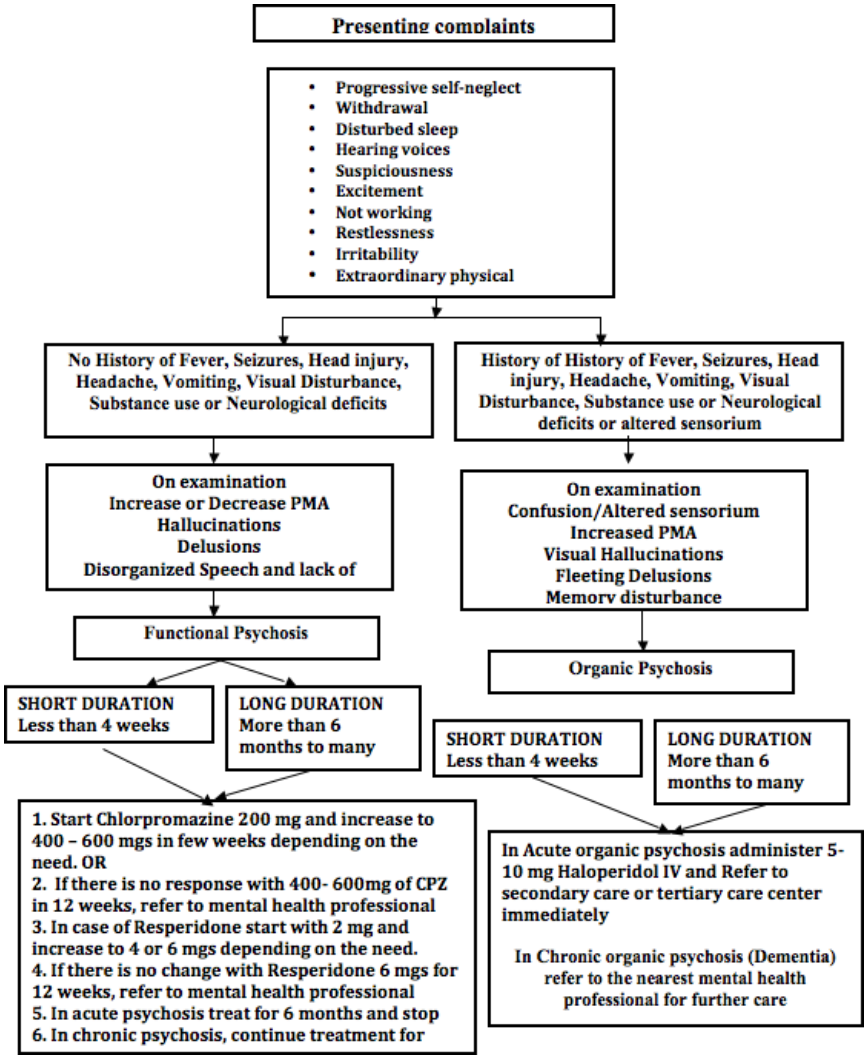
As the person is progressing, the psychiatrist interacts with the multidisciplinary team to track progress which includes reduction in symptoms, monitoring side effects, interest shown in work/a particular skill, interest shown in group/recreational activities and also information about the family.

Critical experience suggests that patients are able to give information about the family in anything between 2 weeks and three months. That information has to be validated by establishing consistency. Based on this information, efforts are made to locate the family either by telephone call, a home visit (if access is possible), or through a law enforcing agency like the police. The National Bureau of Crime Records has information in its database about missing persons. Making use of this database can also be helpful.

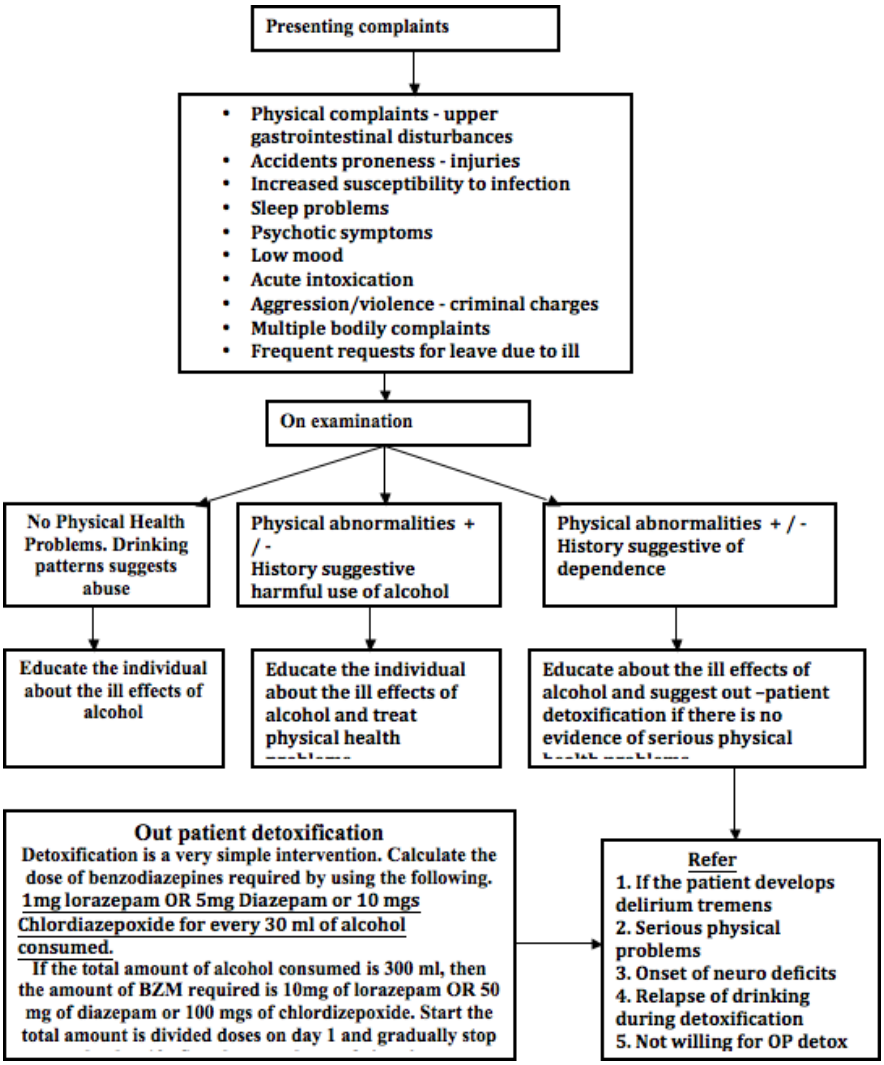
Depressive Disorders



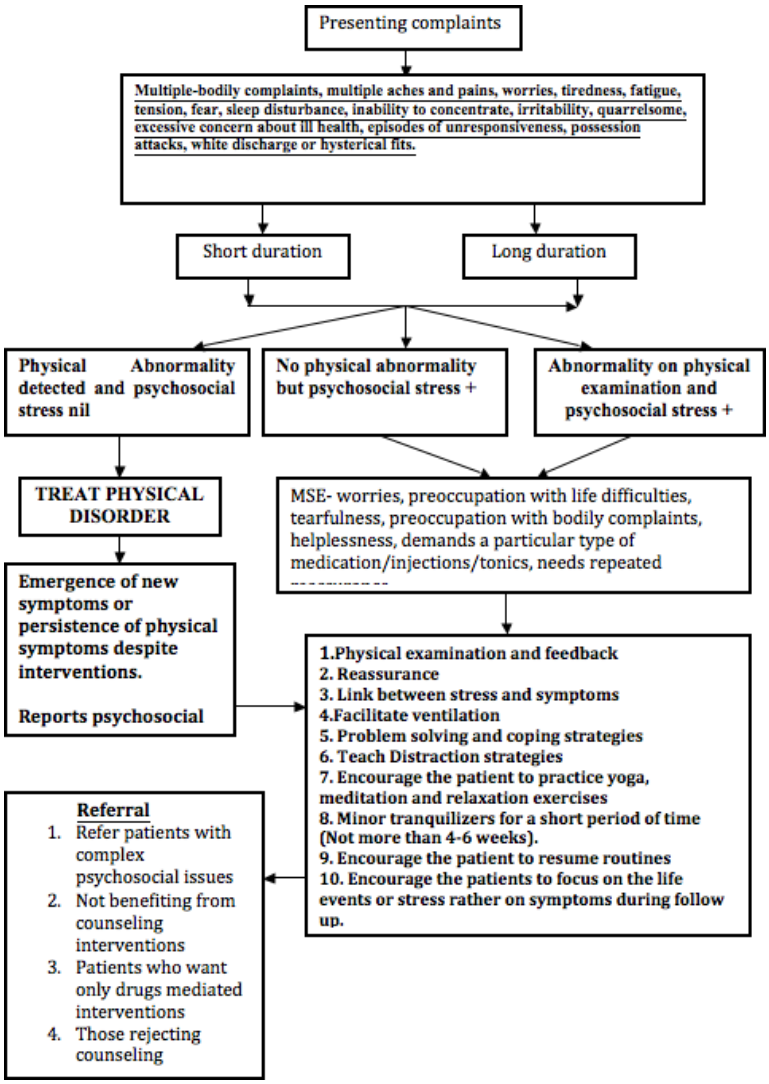
Psychotic Disorders



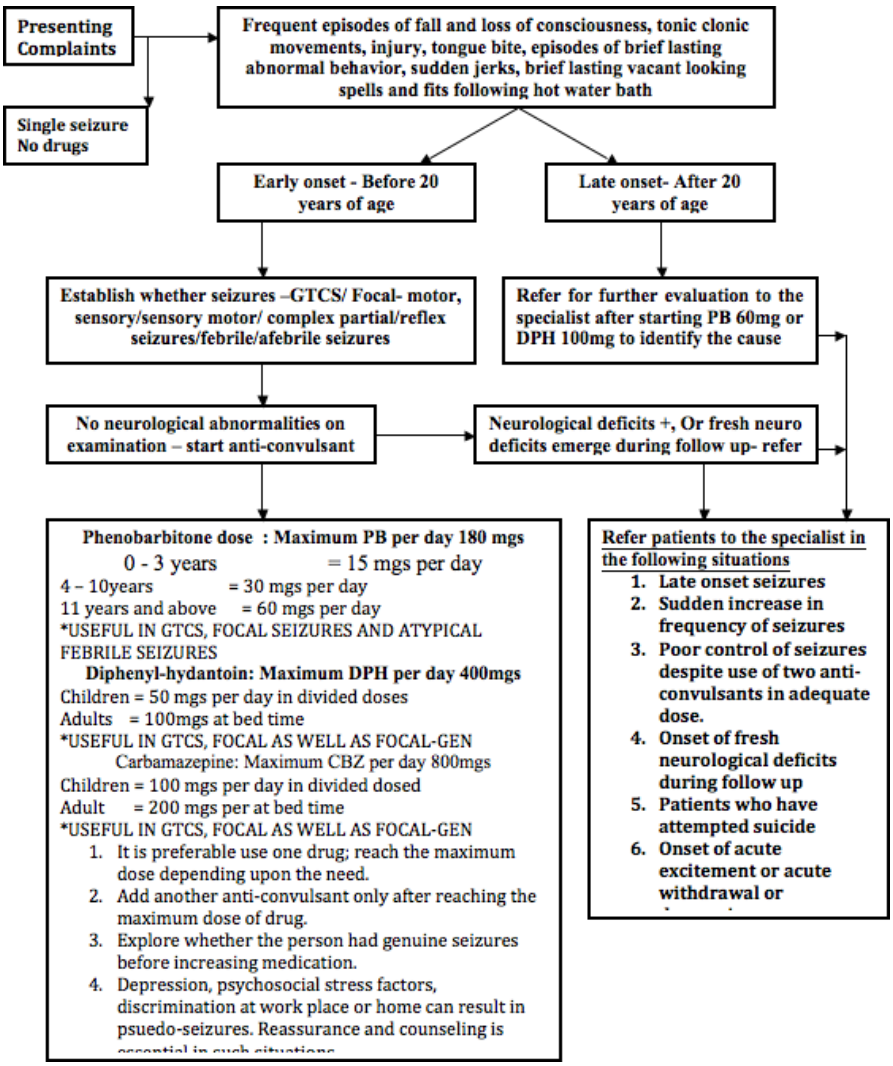
Substance Use Disorders



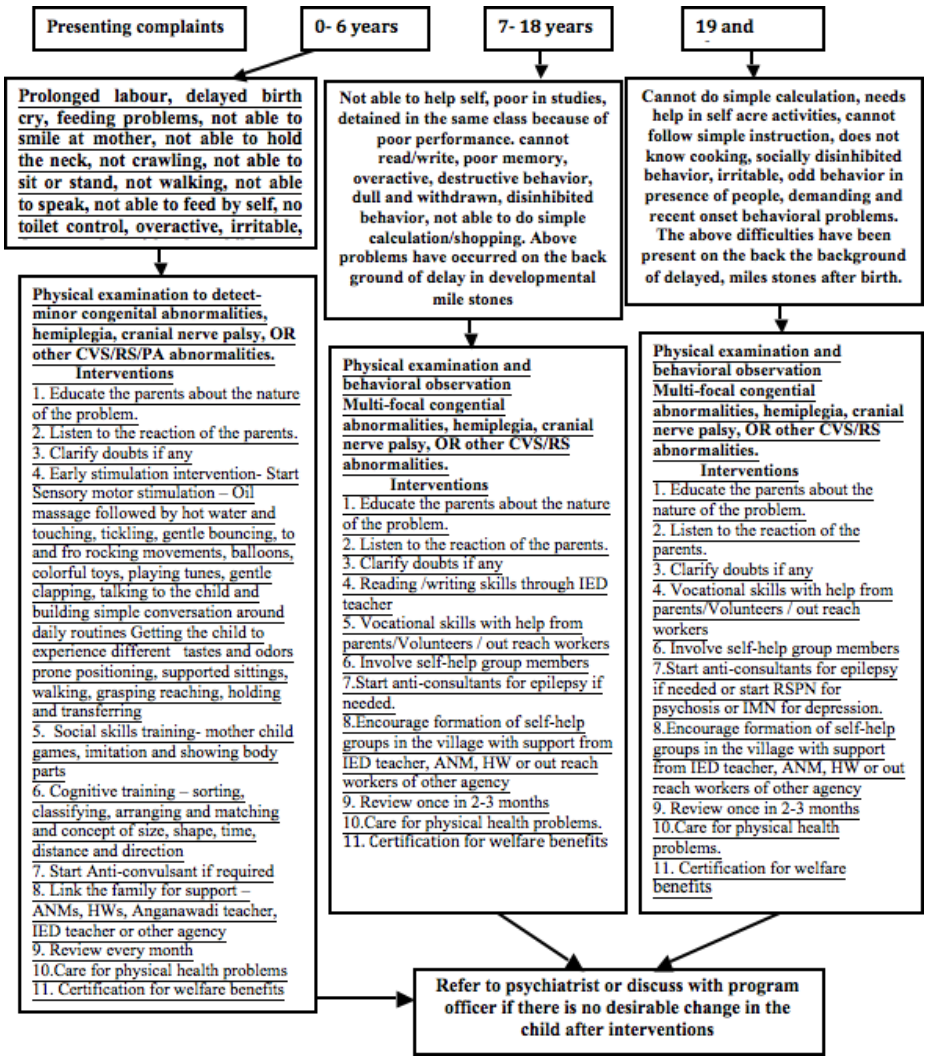
Stress Related Disorders



Epilepsy


Presenting Complaints
Frequent episodes of fall and loss of consciousness, tonic clonic movements, injury, tongue bite, episodes of brief lasting abnormal behavior, sudden jerks, brief lasting vacant looking spells and fits following hot water bath
Single seizure No drugs
Early onset - Before 20 years of age
Late onset- After 20 years of age
Establish whether seizures –GTCS/ Focal- motor, sensory/sensory motor/ complex partial/reflex seizures/febrile/afebrile seizures
Refer for further evaluation to the specialist after starting PB 60mg or DPH 100mg to identify the cause
No neurological abnormalities on examination – start anti-convulsant
Neurological deficits +, Or fresh neuro deficits emerge during follow up- refer
Phenobarbitone dose : Maximum PB per day 180 mgs
0 - 3 years = 15 mgs per day
4 – 10years = 30 mgs per day
11 years and above = 60 mgs per day
*USEFUL IN GTCS, FOCAL SEIZURES AND ATYPICAL FEBRILE SEIZURES
Diphenyl-hydantoin: Maximum DPH per day 400mgs
Children = 50 mgs per day in divided doses
Adults = 100mgs at bed time
*USEFUL IN GTCS, FOCAL AS WELL AS FOCAL-GEN
Carbamazepine: Maximum CBZ per day 800mgs
Children = 100 mgs per day in divided dosed
Adult = 200 mgs per at bed time
*USEFUL IN GTCS, FOCAL AS WELL AS FOCAL-GEN
1. It is preferable use one drug; reach the maximum dose depending upon the need.
2. Add another anti-convulsant only after reaching the maximum dose of drug.
3. Explore whether the person had genuine seizures before increasing medication.
4. Depression, psychosocial stress factors, discrimination at work place or home can result in psuedo-seizures. Reassurance and counseling is
Refer patients to the specialist in the following situations
1. Late onset seizures
2. Sudden increase in frequency of seizures
3. Poor control of seizures despite use of two anti-convulsants in adequate dose.
4. Onset of fresh neurological deficits during follow up
5. Patients who have attempted suicide
6. Onset of acute excitement or acute withdrawal or

Intellectual Disability



Medications & Side Effects

The choice of medication is based on the clinical symptoms. It is a good practice to administer medication in adequate doses for an adequate period of time, before arriving at a conclusion that the said medicine is ineffective for the person.

Once the person has made significant improvement, it is important to educate the individual about the nature of their illness, treatment prescribed, duration of treatment, and profile of side effects for that particular drug. It is important to help the individual understand that they have a treatable disorder and that medication is important to facilitate clinical recovery.

Medication does play an important role, but there are several challenges that the clinician may run into. A person may not adhere to the regime prescribed or may not comply with medication because of side effects or due to negative attitudes about treatment. Continuous ongoing education is an important step that needs to be taken so that the individual understands their treatment. Educating patients in groups has great value. In a group context each of them may share there own experiences, which can often be very positive, therefore can have a beneficial effect on the group. In such a situation, peer support and peer pressure can also be of importance to motivate the person to take treatment.

There are some side effects which can be very distressing (e.g. weight gain, excessive sleep, change in menstrual cycles, decreased libido, secretion of breast milk etc.). These side effects need careful, sensitive exploration, as well as strong reassurance and an enumeration of the reasons why these side effects may manifest. Early identification and initiation in remedies to reduce distress is important.

Initial Treatment

Haloperidol → If the patient is excited, over active or irritable, this is administered to achieve desirable clinical effects or symptom remission.

Chlorpromazine → If the patient has prominent sleep disturbances associated with identifiable psychotic illness.

Risperidone → If a person has withdrawal, dullness or asocial behaviour, this stimulating antipsychotic can be helpful.

Benzodiazepine (4-6mg) → If the person has catatonic symptoms like echolalia, echopraxia, posturing, psychic pillow. This will be followed by evaluation and a decision on which antipsychotic is most suitable.

Once medication is initiated, one has to keep track of acute dystonic reactions (that may occur within 24 hours – 48 hours), or emergence of extrapyramidal symptoms, drooling, postural hypotension (drop in blood pressure with change of posture) which needs close monitoring. From

then onwards, monitoring of symptoms that were initially documented is completed to ensure whether there is reduction in any of the symptoms.

Antipsychotics can produce the following side effects in this order:

- Acute muscle contraction (within 48 hours)
- Extrapyramidal side effects (e.g. rigidity, tremors, slow motor movements which are seen few week/months after)
- Akathisia (seen several months after initiation)
- Tardive dyskinesia
- Neuroleptic malignant syndrome (NMS → very rare)

The mentioned side effects described is seen in 10-30% of patients taking medication.

The psychiatrist is responsible for monitoring these side effects and minimizing the occurrence of side effects by tailoring the dosage appropriately.

Non-caucasian patients are slow metabolizers of antipsychotic drugs and therefore, it is important to arrive at the lowest dosage effective enough to control symptoms, while at the same time result in minimal or low side effects. This is a very important as well as a great clinical challenge. It should not be understood that all antipsychotics produce severe side effects.

Factors that may contribute to occurrence of side effects include chewing tobacco, head injury, anemia, and lack of use of antidotes to counter side effects.

The most commonly used drugs fall into three major categories**:**

1) Anti-anxiety drugs – anxiolytics or minor tranquilizers
2) Antidepressants
3) Antipsychotics – major tranquilizers

Anxiolytics (Minor Tranquilizers)

Anxiolytics are effective for symptomatic relief wherever symptoms of anxiety are present (e.g. sweating, tremors, palpitations, trouble sleeping). Their effectiveness as sole curative agents is, however, very restricted to those conditions where the anxiety symptoms are of, a) very recent origin; b) the patient has in the past shown ability to cope adequately with stress; and c) there are no severe and prolonged interpersonal/familial problems. In all other cases, the role of anxiolytics is limited, and the management must necessarily also include counseling and family education. In such cases if symptoms of anxiety are severe, anxiolytics can be used only as adjuncts to other modes of managements.

Commonly used anxiolytics

Name of the Drug	**Tablet strength**	**Daily dose per day**
Diazepam*	5mgs	5-15 mgs
Nitrazepam	5mgs	5-15 mgs
Lorazepam	5mgs	1-3mgs
Chlordiazepoxide	10mgs	10-30 mgs
Alprozalam	0.25, 0.5 and 1 mgs	0.25-3 mgs
Propranolol	40mg	40-80 mgs

*Diazepam should not be given more than 15 mg per day as it can cause drowsiness, lethargy and ataxia. (**Intravenous diazepam** is very effective in cases of status epilepticus. The injection must give **slowly, 10 mg of diazepam over 3 minutes.**)

Hypnotics should be used **sparingly.** They facilitate sleep in conjunction with antidepressants in cases of severe insomnia. The word 'sparingly' is deliberately emphasised because, firstly, prescription merely of a hypnotic to an insomniac person will do nothing to his problems which are causing insomnia, and there is danger of the individual developing **addiction**. If this happens doctors will be contributing to the individual's escape from healthy and legitimate responsibilities. Secondly, in majority of instances, insomnia will automatically set itself right either when the underlying problem is adequately dealt with, or when anxiety or depression is treated.

Pharmacological name of a useful hypnotic is **Nitrazepam. Concomitant use of alcohol and hypnotics will cause excessive drowsiness and should be avoided.**

Antipsychotics (Major Tranquilizers)

Antipsychotics are effective in the treatment of psychotic symptoms that may occur in a variety of psychological/neurological disorders (schizophrenia, bipolar disorder, depression, alcoholism, epilepsy)

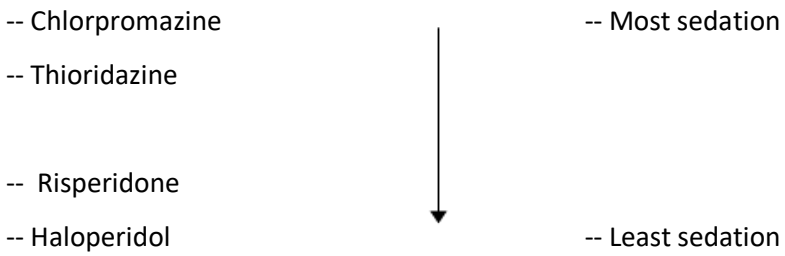
Commonly used antipsychotics

Name of the drug	**Strength**	**Dose per day**
Chlorpromazine	25, 50, 100 and 200 mgs	200-400 mgs
Risperidone	1,2,3 and 4 mgs	4-6 mgs
Haloperidol	1.5, 5 and 10 mgs	5-15 mgs
Fluphenazine Decanoate	25mgs per ML	25 mgs every 15 days

Note: The maximum therapeutic dose mentioned above should not be given in the outpatient setting. In case of Depot Phenothiazine: (a) it is used generally as a maintenance medication for **schizophrenic psychoses-chronic type,** (b) the dose is adjusted by altering the interval, and between 0.5 ml and 1 ml.

All antipsychotic available are equally effective when used in equivalent dosages. It is best to become familiar with one antipsychotic (Chlorpromazine or Risperidone) and use it as first level drug.

These antipsychotic drugs have differing degrees of **sedative effects,** and this can be made use of to meet special clinical requirements like (a) when severe insomnia is a predominant problem, and (b) the patient has to attend work during day time. The sedative effect of the drugs is mentioned in decreasing order.



The differences are related to sedation and the variation in the incidence of side-effects. Some patients whose symptoms fail to respond to one of the drugs will respond to another. The reasons for this is related to blockade action on various types of dopamine receptors.

Side Effects

The following are the side effects of the antipsychotic drugs:

(i) **Minor and transient:** They usually disappear spontaneously after 2-3 days of treatment. These are dryness of mouth, blurring of vision and drowsiness.

(ii) **Extrapyramidal side effects**

Acute dystonic reaction: Sudden muscular contraction, most often in neck, tongue and pharynx, presenting as occulogyric crisis, laryngeal spasm or as protrusion of tongue against clenched teeth. One of the commonly used drugs in general practice. **Dystonic reactions occur in about 10% of patients and manifest with 72 hours of starting medication**. Acute dystonic reactions can be quickly relieved by 50 mg of intramuscularly promethazine or I.V. diazepam given slowly.

Drug induced Parkinsonism: The features are excessive salivation, tremors, rigidity and mask-like face. **EPS occurs in 15-20% of patients and manifest after one week of treatment.**
Akathisia: It is a condition of motor restlessness that is often accompanied by mental restlessness, namely, the patient cannot sit or stand at one place quietly for more than a few seconds and is distressed. It is rare side effect seen several months after starting medication.

Acute dystonia and extrapyramidal symptoms can be treated with antiparkinsonian drugs. If the patient is on any antiparkinsonian drugs already, the dose will have to be increased. Antiparkinsonian drugs should be continued till the extrapyramidal symptoms disappear.

(b) **Tardive dyskinesia (TD):** The clinical feature is one of Bucco-oro-facio-lingual movements, almost continuously seen in a wakeful state. There can be classical 'fly-catching' movements of the tongue and grinding of the teeth. This usually occurs 6 months after treatment. TD is seen about 10% of patients. This distressing side effect is difficult to treat, if it is not identified early. The dose of medication should be reduced, and THP stopped, soon after identification of TD. Diazepam 5-10 mgs per day should be added, in addition to antipsychotic medication. The occurrence of TD can be decreased by careful and limited use of antipsychotic and anticholinergic drugs. It is preferable to stop THP after three months of treatment. Anemia, brain damage, tobacco and other substance use can increase risk of developing TD. Refer the patient for evaluation if TD persists after the above mentioned treatment.

(c) **Jaundice:** A very rare side effect seen with chlorpromazine. Drugs must be stopped immediately, and the patient must be referred to a psychiatrist.

(d) **Postural hypotension:** A very common side effect seen with chlorpromazine in the first 4 weeks of treatment. This is a self limiting side effect which disappears gradually. The patient must be educated to gradually assume erect posture from sleeping or sitting position. If the postural hypotension continues to bother the patient, try to reduce the dose or change the drug to Risperidone.

(e) **Skin sensitivity:** This is common in fair people and they must be educated to avoid sunlight or take the necessary precautions (sunscreen).

Anti-parkinson Agents

This group of drugs is effective for treatment of major tranquilizer induced extrapyramidal side effects. They should not be routinely used.

Anticholinergic drugs

Name of the drug	**Strength**	**Dose per day**
Trihexyphenidyl	2 mg	2 to 6 mg
Procyclidine HCL	5 mg	5 to 15 mg

Antidepressant drugs (tricyclic compounds)

Name of the drug	**Strength**	**Daily dose per day**
Imipramine	25, 50 and 75 mgs	75-150 mgs
Amitriptyline	25, 50 and 75 mgs	75-150 mgs
Clomipramine	25, 50 and 75 mgs	75-150 mgs

These drugs are effective against depression of any cause.

Newer antidepressants

Name of the drug	**Strength**	**Daily dose per day**
Fluoxetine	20 and 60 mgs	20-60 mgs
Sertraline	50 and 100 mgs	100-150 mgs

Newer drugs: Same potency but side effect are less compared to older drugs. Drugs should always be taken in the day time.

Note: A higher or single night dose is preferable and equally effective when the patient can tolerate without side effects.

On an average, the therapeutic benefits become obvious after 14-21 days of starting the treatment. Therefore, it is essential to advise the patient to take the drug for a minimum period of at least 3 weeks before considering any change.

Imipramine causes least sedation. The following are the common side effects – dryness of mouth, blurring of vision, constipation. Rarely, **imipramine** can cause retention of urine and paralytic ileus when drugs have to be stopped immediately.

It is essential to advise the patients about these possible transient side effects so that they are prepared if they experience them, and do not stop the medication. Antidepressants can cause nausea or vomiting when stopped abruptly.

Antidepressants are to be used with extreme **caution** and in consultation with the psychiatrist in patients with **glaucoma, recent myocardial ischaemia and enlarged prostate. The powerpoint slides in the appendix can be referred to for further information.**

Prophylactic Lithium and Carbamazepine

Lithium carbonate is effective in treating cases of mania, and it is widely used in preventing recurrent manic depressive psychosis. **The initiation of prophylactic use of the drug is best left to the decision of a psychiatrist because of the need to do baseline investigation like thyroid and renal function tests in addition to an ECG**. The primary care doctor can effectively provide the maintenance care. The commonly used dose in 900-1200 mg per day in three divided doses. Because the therapeutic and toxic levels are close to each other, the lithium levels are monitored by periodic **serum lithium estimations.** The therapeutically effective serum lithium level is 0.6 to 1.2 mEq/L (or milli mols\1). Beyond 1.5 mEq\L toxic effects manifest in the form of abdominal discomfort, nausea, vomiting, diarrhea, tremors of hand, drowsiness. If they occur, the drugs must be immediately stopped and the patient referred to a psychiatrist. Lithium toxicity is an emergency situation. Carbamazepine (Tegretol) in the dose range of 400 to 800 mg is also useful as a preventive drug in M.D.P.

Drug Interaction

Patient with psychiatric problems may need to take other drugs for other health problems. The following are some of the guidelines about drug interactions. However, if there is difficulty in regard to management of associated physical problem, it is appropriate to take the help of a psychiatrist.

Psychotropic drug	Other drugs	Interaction
1. Anti-depressants		
Imipramine	Cimetidine	Toxicity due to high levels
	Ranitidine	No change
	Dextropropoxyphene	Toxicity due to high levels of IMN
	Oral contraceptives	Toxicity due to high levels of IMN
Amitryptaline	Furazolidine	Toxic psychosis
	Disulfuram	Acute confusion and alcohol disulfuram reaction
Fluoxetine	Erythromycin	Acute confusion
	Diazepam	Excessive drowsiness
	Alprozolam	Excessive drowsiness
	Phenobarbitone	Toxicity
	Nifedipine	Increase in side effects of nifedepine
	Carbamazepine	Toxicity of carbamazepine
	Lithium	Toxicity due high levels of lithium
	Diphenylhydantion	Toxicity of Diphenyhydantion
	Cyproheptidine	Reverses antidepressants action
	Haloperidol	Severe extra pyramidal symptoms
2.Anti-psychotics		
Resperidone	Carbamazepine	Decrease in blood levels of RSPN
	Chlorpromazine	Increase effect of RSPN
	Haloperidol	Increase effects of RSPN
	Propronolol	Increase effects of RSPN
	Imipramine	Increase effects of RSPN
	Lithium	Lithium toxicity
3.Anti-epileptics		
Phenobarbitone	Furesimide	Phenobarbitone toxicity
	Paractamol	Decrease analgesic effect
	Anti-diabetics	Rapidly metabolised

Diphenyl Hydantion	Co-trimoxozole	DPH toxicity
	Cimetidine	DPH toxicity
	Dextropropoxyphene	DPH toxicity
	Diltiazem	DPH toxicity
	Disulfuram	DPH toxicity
	Ibuprofen	DPH toxicity
	Isoniazid	DPH toxicity
	Metronidazole	DPH toxicity
	Omerperazole	DPH toxicity
	Antacids	DPH is not absorbed
	Combination of ATT	DPH toxicity
	Phenobarbitone	DPH levels decrease
	Rifampicin	DPH levels decrease

In addition, antacids when taken together delay absorption of the phenothiazines. Both antidepressants and chlorpromazine are liable to precipitate epilepsy in known epileptics, because they reduce the seizure threshold. Oral contraceptives are known to cause depressive symptomatology in some women. Alcohol when taken with most drugs described in this chapter enhances the depressant effect on CNS. In view of this, **a person on psychiatric drugs should be advised to avoid taking alcohol.**

Health issue	**Early signs**	**Management**
Depressive episode	Depression can be described as a disease of losses, characterised by morbid sadness, psychomotor retardation, withdrawal and disinterest in most things that one previously appreciated. ***Early signs*** Loss of sleep, subjective sadness, and decreased or increased appetite. This is followed by decreased interest in pleasurable activities, decreased energy, crying spells, lack of confidence, a sense of hopelessness and worthlessness, and suicidal ideation. Some persons may express guilt of having committed unpardonable sins, feel persecuted, or feel that other people are talking about them. Some patients may report that internal organs are not functioning properly. They may claim that their intenstines are rotting, or sometimes think that they are dead. Most depressed patients have insight into their illness. Many depressed patients may lose weight or complain of constipation and wake up two	A person who is withdrawn, dull or depressed could be reacting to a specific situation or may be clinically depressed. If that is the case, do the following: Talk to them and try to understand the difficulties that they perceive or is reacting to. Ensure that they eat well and drink sufficient amounts of water. If they have a poor appetite, ensure that they eat in smaller quantities of food, frequently. In case they are constipated, encourage them to eat a plenty of greens and vegetables. If they have persistent depressive symptoms which are pervasive and present for more than two weeks, consult a doctor since they will require medication. In case they are suicidal, talk to them about their distress or suicidal plans, if any. Ensure that harmful objects such as knives, blades, screwdrivers, iron rods, ropes, medicines, cleaning detergents, pesticides and plastic wires are kept away and in safe custody. Ensure that someone is with the individual at all times. If required, ensure that bolts and latches are removed from the doors. Administer medication regularly as prescribed by the doctor. Ensure that they adhere to the treatment plan. It is important to supervise intake of medication. Medication can result in benefits only after 3-4 weeks, from

	hours before their normal waking time.	there on the person will have to take medication regularly and also consult the doctor frequently. Once depressive symptoms have improved the person should take medication for a period of 1 year, discontinuation of medication may not result in relapse of symptoms immediately, depressive symptoms may emerge after a few months.

Manic/hypomanic episodes	A manic episode is characterised by elation, overactivity and increased ideomotor pressure *(fast speech).* ***Early signs**:* Decreased need for sleep, constant engagement in multiple activities without completing any tasks, interfering in others' lives, exhibiting and displaying a sense of exaggerated self esteem are some early signs of mania. Often a person is boastful about themselves. People who develop full-blown manic symptoms may experience increased psychomotor activity, pressure of speech, flight of ideas, circumstantial speech etc. In addition, they may talk about their grandiose identity or grandiose abilities. They may deny being ill. In case of hypomania, there is no evidence of delusions or hallucinations but overactivity, excessive happiness, pressure of speech, interfering behaviour will be present.	People with hypomania or mania may need medical intervention as soon as initial symptoms are identified. In the initial phase these patients require medication to symptomatically reduce overactivity and excessive happiness. Generally, it takes 4-6 weeks to achieve this. Mood stabilizers such as Lithium, Carbamazepine, or Sodium Valproate are typically used. These medications must be monitored closely since toxicity (in the cases of Lithium and Carbamazepine) can develop if an increased dose is administered, or due to concomitant use of other drugs. In general, mood stabilisers are safe. In case the individual is taking these medications during pregnancy, investigations should be carried out to look for fetal abnormalities in early pregnancy. The case manager must be able to keep track of the therapeutic drug levels and work closely with the treating doctor for continued management. Ensure adequate sleep by titrating the medicines efficiently until an adequate dosage is arrived at. During the acute phase, try not to confront or disagree with the manic patient in the midst of an episode. Writing, painting, collage-making, organising things, household chores, creative arts, yoga, mindfulness practice can be helpful activities in addition to medication.
Manic switch	Depressive patients treated with antidepressant medications like imipramine, fluoxetine, sertraline can develop a manic switch. In other words, they develop manic or hypomanic symptoms as described above. If the person on treatment for mania develops sudden unexplained withdrawal or crying spells, consider depression as a strong possibility.	Consult a doctor immediately. Administration of an injection of 2cc of Lorazepam IM or IV is helpful. Once the medication is changed, manic or hypomanic symptoms will reduce in a couple of weeks. That is, stopping of antidepressants and initiation of antipsychotic drugs and mood stabilisers like Sodium Valproate, Lithium, or Carbamazepine. Carbamazepine is most helpful in people who suffer from frequent episodes in one calendar year (rapid cycling mood disorder). Consult the doctor immediately as medication may need to be changed. Talk to the person to understand if she is reacting to any psychological, social or environmental factors.

Schizophrenia	Schizophrenia is a very severe mental disorder, seen frequently in homeless population. It is a somewhat disabling condition and psychotropic drugs, like antipsychotics, are very effective in symptom reduction and reduction in dysfunction. It is important to note that early identification of schizophrenia can result in better recovery for people affected by this condition. ***Early signs*** include unexplained withdrawal, progressive disinterest, scholastic difficulties, progressive reduction in self-care, difficulties in communication, unpredictable behaviour, poor socialisation, persistent sleep problems, and change in eating habits. Gradually the progression results in emergence of positive symptoms like hallucinations, delusions, disorganised speech and lack of insight.	Schizophrenia is a treatable condition. Effective, economical and safe interventions are available at the present time in the form of antipsychotics drugs. They are haloperidol, risperidone, and clozapine, depo injections like haloperidol, fluphenazine, and flupenthixol are also available. Psychosocial therapies are as important as medication - a combination of antipsychotic drugs and psychosocial therapies are found to be effective in facilitating recovery. Antipsychotic drugs act by causing blockade of dopamine transmission. Antipsychotic medication can produce side effects this is characterised by tremors of outstretched hands, slow motor movements, and rigidity. This can be reversed by adding anticholinergic drugs such as Trihexyphenidyl (pacitane). The above described side effects (extrapyramidal symptoms) can be seen in about 30-40% patients on antipsychotic drugs. Most frequently with haloperidol. An important side effect referred to as acute dystonia can be seen within 24 hours to 72 hours after initiation of treatment. It is characterised by acute muscle spasms of a muscle or group of muscles, or muscles on one side of the body. This can be reversed by administration of inj. Phenergan 50mg IM. Acute muscle spasms will disappear in 30-40 minutes.

Self-harm indicative behaviour	Persons undergoing treatment for mental health problems can deliberately harm themselves by hurting any part of their body through violent acts like slashing their wrists, jumping from heights, consuming liquid detergents, self-immolation using inflammable substances like kerosene or petrol. They may even attempt to hang or drown themselves.	Any act of self-harm should be taken seriously and psychological and social help must be sought immediately. In case of consumption of substances like kerosene or petrol, do NOT make the patient drink water but rush the person immediately to a hospital. In case they have consumed tablets, encourage them to drink water. Induce vomiting by stimulating the back of the mouth so as to empty the stomach contents. This patient should also be rushed to the hospital. If toilet cleaning substances such as acid have been consumed, rush the person to hospital immediately without making an attempt to give them water. In case, the person has inflicted a deep cut on their body, they may require suturing. Apply a pressure bandage to stop bleeding and rush them to hospital. In case the injuries are superficial, clean the wound. Talk to the person about their distress and consult the doctor subsequently.

Substance Misuse	Substances like alcohol, cannabis or prescription drugs like minor tranquilisers can be abused by people undergoing psychiatric treatment. The most common substance used is nicotine. The most common method of consumption is inhalation (smoking) and through the oral route (chewing).	People using substances should be educated on the harmful effects of these substances (use posters). Emphasise that drug interactions between the substance and medication can reduce effective blood levels of antipsychotic drugs, or increase the effect of one of the drugs, which can be dangerous. Persons who are addicted to substances should practise protective shield rituals, such as meditation or yoga and be encouraged to share their distress with others, as well as participate in household activities and recreational and physical activities. Ensure that advising persons to get off substances such as tobacco are more for health reasons than talking about moral values.
Picking up signs of relapse	A person on maintenance medication can develop a relapse psychosis, depression or manic symptoms. Features of early relapse includes loss of sleep, decreased appetite, unexplained withdrawal, decreased socialization, desire to be alone, frequent emotional outbursts.	A relapse is an acute medical emergency. Consult the doctor immediately. Identify psychological, social, environmental or other stress factors bothering the individual. These factors may either precipitate or perpetuate distress in the individual. Interpersonal conflicts, breakdowns in relationships or the presence of high **Expressed Emotion [EE] 5** in the family could result in frequent relapse, and therefore should be identified and appropriate interventions should be initiated. That will include teaching communication skills, coping skills and education about the nature of the problem. An acute relapse can manifest as suicidal behaviour, or restlessness or agitation. An injection of Lorazepam 2mg IM may be helpful. This medication will take about 30 minutes to calm the person down.

5 ***Expressed emotion*** *is the critical, hostile, and emotionally over-involved attitude that relatives have toward a family member with a disorder. The* ***expressed emotion*** *can be high or low, which is decided by a taped interview known as the Camberwell Family Interview. Theoretically, a high level of EE in the home can worsen the prognosis in patients with mental illness, or act as a potential risk factor for the development of psychiatric disease.*

Dementia	Often such persons forget what they ate, where are they are, who they are talking to, what they did a few minutes or hours ago, and demand food without realising that they have consumed food just a short time ago. Demented individuals usually have memory disturbances in immediate and recent memories while remote memory remains intact. It is possible that such persons may experience confusion and thus exhibit agitation whenever they are, unable to find answers to some of the questions asked. It is also common for them to fill in false information as answers to questions asked (confabulation). Disorientation to place, person and time could result in them losing their way.	Dementia is a progressive degenerative brain disorder. There is no effective drug available to reverse memory loss at this point in time. Reality oriented therapy is an important intervention that is possible either by a personal assistant, or a relative or a key caregiver. Reality oriented therapy includes updating the individual about where they are, who they are talking to, etc. It is important not to ask them questions that they are unable to answer or to discuss things that they have no recollection of. Instead of asking them too many questions, update them on an everyday basis about all the events that are happening around them; this may comfort them a great deal. If they have problems in mobility, ensure that a walking stick is used regularly.
Challenging behaviors	Challenging behaviours such as assaultiveness, aggression, irritability, disruptiveness, confrontation, active negativism and rebellious behaviour are often seen in people with severe mental disorders with comorbid personality difficulties, people with intellectual disabilities, people with mental illness with comorbid substance use or people with brain damage (due to intractable or uncontrolled seizures, etc.)	While challenging behaviours may seem very intimidating and difficult to handle. They can be handled it is important to listen to the person, accept whatever they say in a matter of fact manner, verbally reassure them that distress will be addressed. Calm them down and talk to them about the most pressing problem they are facing at present. Identify provoking or antecedent factors that contribute to their state of mind and attempt to minimise them. Understand the nature of the behaviour and its consequences using Antecedents Behaviour and Consequence analysis.

Epileptic seizures	Epilepsy is a very common diagnosis amongst homeless individuals. Epileptic seizures are commonly seen in people diagnosed with intellectual disability, people with history of brain damage or in people taking antipsychotic drugs or antidepressants in high doses, since these drugs reduce seizure threshold. Epileptic seizures could be of **two** types: 1. Generalized tonic clonic seizures 2. Focal seizures or focal seizures becoming secondarily generalized.	A person who has had a seizure should be made to lie on a cot or on the floor, turned to one side so that froth/blood can drain. The clothes of the person needs to be loosened and sharp objects removed from the immediate vicinity. Since the seizure may last only for 10-15 seconds, there is no need to do anything more than what is described above. If the person has more than 2 attacks of seizure in a day or is having continuous seizures lasting for minutes, they should be referred to an emergency room immediately.

	Some focal seizures can manifest purely as behaviour disturbances which manifest as non-purposive motor movements (automatisms), these are referred to as complex-partial seizures.	
Physical health problems	Patients can develop medical problems such as acute infections, fever, body ache, vomiting, diarrhoeal diseases, upper respiratory tract infections. Some of these symptoms may be indicative acute viral or bacterial infections. Suspect febrile illness if the person is not socializing, or remains dull and withdrawn for long periods of time, refuses to eat food or complains of tiredness, etc.	For patients with febrile illnesses, temperature, pulse, and respiratory rate must be recorded every four hours. Administer paracetamol tablets (500 mg) as and when necessary. But ensure that a dose of 2000 mg is not exceeded in a day. Ensure that the patient is well hydrated. Consult a doctor as soon as possible.
	Remember, people with psychotic illness, depressive disorders, dementia and other psychotic conditions may not talk about their discomfort due to fever spontaneously. Unusual withdrawal and dullness should make us suspect Look pyrexia or any infection proactively.	The moment you come across a person with injury, examine the wound and clean it with safe water. Apply gauze and bandages to stop the bleeding. If the wound is contaminated with mud, Inj. Tetvac (tetanus toxoid) should be given. In case the person has a deep wound, refer them to the nearest emergency room for suturing and further needful.
	Injuries due to fall are common in households. In locations such as mental health centres and facilities, patients could have a fall due to side effects of medication, gait difficulty, vision problems or due to ill lit rooms or slippery floors. this could be related to medication or poor safety features such as uneven or wet/slippery floors, ill-lit rooms, etc.	If bites are due to insects or reptiles (e.g. snakes), such people should be referred for immediate medical help. Clean the wound with soap and water. Dress it with antiseptics. If the wound is extensive with lacerations, urgent medical attention may be necessary. There is no need for Inj. TT or an anti-rabic vaccine. If the person is vomiting persistently, injection Perinorm 10 mg or tablet inj. Emeset 4 mg is very useful as an IM injection or tablet Emeset 4mg is very useful, injection can be given intramuscularly.. Ensure that the person drinks enough water orally and in small sips, frequently or drinks liquids in small sips frequently. Similarly, if a person has loose stools associated with painful abdomen cramps or reports of bloody stools or mucus in the stools, it is best to consult the doctor immediately.
	Bites: Insect bites, reptile bites or due to interpersonal violence in the form of human bites, or aggression resulting in bites can be encountered in psychiatric patients rarely.	Dry skin and itching is not a disease condition. These can only be avoided by good levels of personal hygiene. Frequent anti-lice treatment is very critical to prevent folliculitis. In case the folliculitis is severe with pus formation, an antibiotic is indicated. In case of increased severity or if anti-lice treatment cannot be initiated, tonsuring may be considered if its causing the person distress, itching, ill health. Ensure that the person also agrees with the course of treatment wholeheartedly. Always explain why a particular method of treatment is initiated. Information sharing is the most essential part of human rights promotion.
	Diarrhoea and vomiting: Diarrhoea and vomiting are common in cases of febrile illness or gastrointestinal infection.	

	Skin: The most common skin infections encountered in patients with mental health problems are fungal infections, bacterial infections, allergic reactions or contact dermatitis. Folliculitis scalp (boils on the scalp) is very common in people with mental health problems due to poor personal hygiene.	The patient's temperature, must be recorded every four hours. Collect midstream urine samples to check for albumin, sugar, microscopy. In addition, culture and sensitivity is indicated so that we can reduce time to initiate appropriate treatment. Ensure that the patient drinks 6-8 litres of water in a day (to flush out infections). Administer TB. bactrim DS after the urine sample has been sent for culture and sensitivity. In case the patient develops an allergic reaction after ingestion of tablets, take her to the doctor immediately. Hypothyroid patients should be given thyroid supplements on an empty stomach. Ensure that they do not take anything orally for half hour after the thyroid supplements was ingested. Monitor the patient's weight and menstrual cycles regularly. Note: blood samples for T3, T4 and TSH should be drawn after 12 hours of fasting.
	Urinary tract infections: UTI is very common in women. It is often accompanied by fever, chills and rigors. **Hypothyroidism**: This is a very common endocrinal disorder amongst people with mental health concerns. Such patients are obese and they may have hoarse voice, coarse skin, menstrual irregularities, dullness and slow motor activity. Hypothyroidism is also known to affect moods and result in depressive behaviour patterns. **Diabetes** is a very common condition seen in people treated for mental health problems. Nearly 15-20% of residents may be diagnosed as diabetic. Patients with diabetes are treated with oral antidiabetic drugs or insulin injections depending upon control of blood sugar.	Diet, exercise and medication are three important pillars in the management of diabetes. Please ensure that patients with diabetes avoid sweets, chocolates, ice creams etc. as much as possible. Do not add sugar in their coffee or tea. Patients who develop hypoglycaemic episodes, characterised by sweating, tremors, weakness, shivering and sinking feelings should immediately be fed with some chocolate, or a teaspoon of sugar. The case should be reported to the doctor. Please ensure that the correct dose of insulin is administered. Errors in administering insulin can be dangerous.

Department of Nursing

Nursing Responsibilities

- Physical Assessment will be done by a nursing supervisor [head to foot assessment, vital signs, Body Mass Index, height and weight].
- **Routine investigations**
    - These include: complete blood count, blood grouping, urine analysis, urine gravindex (below 45 yrs), liver function, renal function, calcium, thyroid profile, lipid profile, HIV, VDRL, HBsAg, chest x-ray, ECG, random blood sugar (below 40 yrs) or fasting and postprandial blood sugar (above 40yrs).
        - Bio-medical waste management will be followed up by all levels of medical team and healthcare workers; specialized investigations like hemoglobin/CBC, blood sugar thyroid profile are done on frequent intervals or as per the physician's advice which are recorded in a diary on specified dates.
        - Drug levels (Valproic acid, Carbamazepine, Phenytoin Sodium, Phenobarbitone, Lithium) are checked whenever a client shows the symptom of drowsiness to rule out toxicity, or when the psychiatrist recommends to check whether the prescribed dose is adequate or not.
    - The lab reports will be reviewed by the head of the department and will be referred to the general physician, and then will be filed in the respective client's file with the physician's initial.
- **Reviews**
    - Psychiatric review will be conducted:
        - once during admission,
        - Followed by once a week (for 2 weeks),
        - Then once in fortnight (for a month)
        - Then once monthly, or as needed.
    - General Physician review will be conducted:
        - Once during admission
        - Then once monthly, or as needed
    - After each review conducted by either a physician or psychiatrist → individual responsible for data entry will update the prescribed medicines in the master

medicine list in the system. The medicine list will be distributed to the supervisor on daily basis for dispensing medicines.

- **Medication**
    - The master medicine list comprises of different categories that include B-breakfast, L-lunch, D-dinner (given by the senior health care worker); ointments, syrups & injections comes under others list (given by the nursing supervisor).
    - This list indicates the name of the drug with dosage, frequency, quantity, doctors' name, date of last review, and the next review date. Injections are recorded in the dairy on the specified dates for each client by the nursing supervisor to administer right drug on right time.
    - The nursing supervisors cross checks the medicine list with the client's file immediately after the doctor's review to confirm whether they are getting the right drug or not.
    - The nursing supervisors indent monthly medicine requirement list from the pharmacy with the approval of the project manager.

Serious Illness

- When a client is very sick or serious, she will be shifted to another hospital for further assistance and management. All the hospital visits are recorded in their respective registers (hospital emergencies, hospital admissions and hospital appointments).
- When a client has been identified to have tuberculosis (pulmonary or extrapulmonary), the nursing supervisor links with an organization called REACH (Resource group for Education and Advocacy for Community Health) and starts on Anti-tuberculosis treatment (ATT) as a dot provider.
- Multi-specialty health issues are followed through with the concerned doctor's advice with medications, special diet and physical exercises.
- Clients who have open wounds or closed wounds are treated with with an in-house sterile dressing.

Dental Hygiene

- All the clients are reviewed with the in-house dentist, on a rotation or on a need based which functions weekly twice [Tuesday & Friday between 4.00-6.00pm].
- To improvise the oral hygiene of each client, special brushing process happens post lunch, and mouth wash post dinner on daily basis.

Other Tasks

- Inter-departmental referrals are also be followed through on the need base through the nursing department.
- Assign tasks to nursing students in the different wards and monitor their care plan and implementation.
- Medical camps [Gynaecology/Eye/ENT/ Dental, etc.] will be conducted once in 6 months.
- Death Audit will be conducted post demise of the client.

Lay Health Workers

There is a severe human resource crunch in mental health and social sectors worldwide. This problem requires constant innovation to ensure effective and quality care. Non-specialist health workers, otherwise known as lay health workers or community workers, are increasingly becoming the most invaluable resource especially with regard to mental health services. Studies show that lay health workers trained in collaborative, integrated mental health care can reduce the prevalence of common mental disorders, suicidal behaviour, psychological morbidity and disability burden.

The Banyan's health care workers and community workers are undeniably the backbone of the organisation, and account for **60%** of staff strength. They are from local communities, and are trained to identify mental health issues within communities, ease referral pathways, facilitate socio-economic entitlements, and most importantly, engage with clients to help them navigate the challenges of managing their illness and achieving their own subjective notions of wellness. Additionally, this model enables livelihoods and aids in poverty reduction by creating jobs amongst poorly resourced individuals.

Health Care Worker Responsibilities

- On daily basis, the healthcare workers will record the physical and psychiatric problems of their respective ward clients and refer them to either to the in-house doctors or to the external medical facilities like Sundaram Medical Foundation, Sri Ramachandra Medical University, Hindu Mission Hospital or even to government facility at times for the multi-specialty health issues.
- Health care workers facilitate vocational training and occupational therapy sessions along with the vocational trainers and occupational therapists.
- For each client, the periodic physical and psychiatric assessment [MRD – Medical Record Department] will be done by the junior and senior healthcare worker which is supervised by the nursing supervisor and the healthcare supervisor fortnightly.
- Healthcare workers are trained on basic first aid that includes wound dressing, arrest bleeding, fever, vomiting, diarrhea, seizure disorder, drawing blood samples, instillation of eye/ear/nasal drops, administration of injections and infusion of intravenous fluids; also they are been trained on mental health issues and its management.

Appendix

Quality Audit (Example)

Dear all,

It was as usual a great visit to Home Again Rural . I did send the pics to our group, but here are a few detailed observations. This is a consolidated report of the past three visits.

1. **Most significant observation - social mixing** : Neighbours seem keen on more people coming in. Could be rents, altruism, or a mix of both. But a good trend, over all, I guess, as long as economic gains don't transcend into exploitation. Doesn't seem like it now. Social Mixing will help change attitudes for sure.

2. **Life much more relaxed and organic - 'normalisation'**. : Each resident seems so much more at home, less confused, more mobile, more in control of her environment : I sense a feeling of stability and safety as she leads me to the kitchen, chats, shares a cup of tea, or complains. ' Come see what we have cooked today', ' come see our kitchen garden' etc, ' come see the toilet' etc.

3. **Gossip sessions, free flowing conversation, opinions and a lot more** : While Viji said' I want to get married, I'm fed up of staying here. I want a family that is real, and a husband so I don't have to work at all', Ramani said, ' I don't want that at all, its such a problem. Dowry (varadakshinai) and so many other issues will emerge'. Umalaughed and said' she wants to get married ', and then spoke to herself, somewhat unhappy about her own marriage and her husband's exploitative behaviour. To which Vijisomewhat matter of factly said' why, 'I'm not too old'.

Maami who is a part of this family, has been discussing prospects of her son getting married to Viji or to a prospective , eligible girl. She has gently explored this idea with Saga, Gayathri(same community, so brownie points for that) and with Viji. ' I will stop eating meat, if he is willing to marry me', Viji adds, to which someone else responds ' it will all be OK now and maybe for some time but don't change yourself for anything, you will regret later'. They go on to discuss what makes a family and talk about how they feel a sense of belonging to the people in this home, so this is ' their family'.

Ramani makes the tea, sits down hugging renuka (the PA) and then after chatting for a while, at an appropriate time, leaves to clean the dishes. Vijaya helps her. They share some delicious egg and veggie dish with me that Vijaya had made. Maami, the matriarch looks indulgently at us as we all chat. I get a nice head massage for a fee. And Rowdy, Vijaya's and the home dog also pats me to sleep.

Meanwhile, in another house, Girija Maami blesses Saga, ' to not get married and remain happy and single', and says that' it is simply not worth it, unless the guy is really good'. Daisy and Shahina listen in rapt attention, while Vanishree walks in and out and xx and xx sit down with us in their stylish hall and participate in the conversation, smiling sometimes, patting my back other times. The house owner walks in and joins in on the conversation, very respectful of the members of the house and concerned about all that goes on there. They seem to like them and engage closely with him as well.

Loss of weight : Vani Shree and Mallika have lost weight , but are doing much better over all.

Work : Mallika seems so happy and content and Saga tells me that the employer observed that Mallika ' was so much more engaged ' and ' so well dressed and coordinated ' these days. Dr LRK said she would teach Onion pickle - MR please note. Can market it well.

Appearance and Aesthetics : Each house was unique and homelike with many contributing to the running of the house. In one of the houses , xxx mentioned ' We can only turn on the motor once, maybe we should check if we can twice '. She also asked me ' Who are you, what's your name '. She's moved in recently. When I said' Vandana', she said' Oh, Madam, I didn't recognise you. (some call me madam, some call me amma, some akka, some by name - have to change it to name or one of the other options). You have lost so much weight'.

All looked good, some had dental issues - Saga is looking into it . PLEASE BUY AND USE LISTRINE FOR ALL, WHEN NEEDED.

No one looked different. They had their styles, their colour pref, but looked like any of us and we looked like them- while individuality is important, sometimes looking hugely different because of poor self care isolates people, often at the initial stages of a conversation.

TOILETS : All bathrooms were clean and well maintained. Anyone could use them.

New House : In Bindu Aunty's house , many were upset that Aruna , the PA, wasn't eating her breakfast. ' She is sad I think and doesn't eat well at all. We are worried for her'. Kelan, when Aruna cried because of the stress of moving into a new home ,walked towards her and with her and wiped her tears lovingly with her pallu, and looked very concerned. All like the new house more, or so they said. Its bigger for sure. Bindu, I thought somewhat missed the old house though. Maybe because she said ' the bathroom is on top' and climbing two flights of stairs may affect her ?

We can observe and take a call.

PA's : I feel their training has been excellent. They are in the background and gentle facilitators. This is just brilliant. They have become confident, and are family (daughter, sister or granddaughter to some and friend and mother to a few).Its lovely!

Sense of family : I see this feeling increase (fictive kinship) thanks to, consistency in input , the same group staying together, stability in housing , Saga's and Pa's presence and in ' rituals' we have followed have enabled them. Rituals include cooking and outings together, hosting festivals, chatting together, watching TV together, singing, dancing etc : they have learnt to look out for one another : ' She fell down, when will she come back from the hospital, should I go along ', Amudha's friend in her house asked me concerned when I transported her from HA to SMF . One brought her slippers, another packed her bags etc . There is also a lot of personal sharing between residents about their past, lows and highs, which I will not reflect here , since it was not directly with me.

Saga, very, very well done. I'm so glad people are able to live the lives they do. They would have been dead, sad, in institutions or uncared for otherwise. Keep it up.

IDEA : Can we move all HA homes except for those working to this neighbourhood and Anith can also move , or one other person if she can't. Makes logistical and cost level sense.

Preference List

Individual Preferences List

What do you need to Decorate your House	God Pictures
	Calender
	Clock
	Flower Vase
	Curios
	Any other
Sanitary	Tissue Box
	Soap
	Pads
	Shampoo
	Detol
	Washing soaps/ surf
	Mouth Wash
	Hand wash
Kitchen	Vessels
	Glasses/Plates
	Kadai
	Gas stove/ Cylinder
	Trays
	Cooker
	Ammi Kal/ Mixi/ Grinder
Clothes	Saree/ salwar/ Nighties/ Modern dress/ Pavadai Thavani/ Skirt- Colors
	Underwears- Color

Cosmetics	Powder
	Bindi
	Deodorants/ Perfumes
	Nail polish
	Lipstick
	Face Cream
	Mahendi
	Kajal
Jewellery	Bangles
	Earings
	Chain
	Anklet
Sleep area	Mat/ cot
	Pillow
	Bed spreads/ sheets
Drawing Room	Chairs
	Mats/ Gadis
	Telephone
	Table
Stationary	Books / Novel/ Story Book
	News Papers- Tamil/ English
	Letters
Prayer & Recreation	Gossip with Friends
	Visit to nieghbor house
	Temple/ Church/ Mosque
	TV/ Radio
	Theatre
	Park
	Walk

	Market
	Old Games- Pallanguzhi/ Thayam/ Parama patham etc.

Repeated Scales

Modified Colorado Symptom Index.

Primary Respondent (s):

		Not at all	Once during the month	Several times during the month	Several times a week	At least everyday
1	In the past month, how often have you felt nervous, tense, worried, frustrated, or afraid?	0	1	2	3	4
2	In the past month, how often have you felt depressed?	0	1	2	3	4
3	In the past month, how often have you felt lonely?	0	1	2	3	4
4	In the past month, how often have others told you that you acted “paranoid” or “suspicious”?	0	1	2	3	4
5	In the past month, how often did you hear voices, or hear or see things that other people didn’t think were there?	0	1	2	3	4
6	(Read slowly) In the past month,how often did you have trouble making up your mind about something, like deciding where you wanted to go or what you wanted to do, or how to solve a problem?	0	1	2	3	4

7	(Read slowly) In the past month,how often did you have trouble thinking straight, or concentrating on something you needed to do like worrying so much, or thinking about problems so much that you can't remember or focus on other things?	0	1	2	3	4
8	In the past month, how often did you feel that your behavior or actions were strange or different from that of other people?	0	1	2	3	4
9	In the past month, how often did you feel out of place or like you did not fit in?	0	1	2	3	4
10	In the past month, how often did you forget important things?	0	1	2	3	4
11	In the past month, how often did you have problems with thinking too fast (thoughts racing)?	0	1	2	3	4
12	In the past month, how often did you feel suspicious or paranoid?	0	1	2	3	4
13	In the past month, how often did you feel like hurting or killing yourself?	0	1	2	3	4
14	In the past month, how often have you felt like seriously hurting someone else?	0	1	2	3	4

Cantril Ladder (modified)

Primary respondent(s):

Here is a picture of a ladder. Assume the ladder is a way of picturing your life. The top of the ladder represents the best possible life for you. The bottom rung of the ladder represents the worst possible life for you.

Indicate where on the ladder you feel you personally stand at the present time? Step number _____

Indicate where on the ladder you feel you personally stood before accessing treatment? Step number _____

Indicate where on the ladder you feel you will personally stand in the future? Step number _____

Community Integration Questionnaire (CIQ)

Primary respondent(s):

Home Integration	Answer (circle one)
Who usually does shopping for groceries or other necessities in your household?	Yourself alone (2) Yourself and someone else (1) Someone else (0)
Who usually prepares meals in your household?	Yourself alone (2) Yourself and someone else (1) Someone else (0)
In your home who usually does normal everyday housework?	Yourself alone (2) Yourself and someone else (1) Someone else (0)

Who usually cares for the children in your home?	Yourself alone (2) Yourself and someone else (1) Someone else (0) Not applicable (score is the average of 1,2,3 and 5
Who usually plans social arrangements such as get-togethers with family and friends?	Yourself alone (2) Yourself and someone else (1) Someone else (0)
Social Integration	
Who usually looks after your personal finances such as banking or paying bills?	Yourself alone (2) Yourself and someone else (1) Someone else (0) Not applicable (score is the average of 1,2,3 and 5)
Can you tell me approximately how many times a month you now usually participate in the following activities outside your home?	
Shopping	5 or more (2) 1 – 4 times (1) Never (0)
Leisure activities such as movies, sports, restaurants	5 or more (2) 1 – 4 times (1) Never (0)
Visiting friends or relatives	5 or more (2) 1 – 4 times (1) Never (0)

When you participate in leisure activities do you usually do this alone or with other?	mostly alone (0) mostly with friends who have mental illness (1) mostly with family members (2) mostly with friends who do not have mental illness (3) with a combination of family and friends (4)
Do you have a best friend with whom you confide?	Yes (2) No (0)
Integration into productive activities	
How often do you travel outside the home?	almost every day (2) almost every week (1) seldom/never (less than once per week) (0)
Please choose the answer below that best corresponds to your current (during the past month) work situation:	Full-time employment (>20 hours/week) (5) Part Time Employment (< 20 hours/week) (4) Not working, but actively looking for work (3) Not working, not looking for work (2) Not applicable, retired due to age (1) Volunteer job in the community (0)
Please choose the answer below that best corresponds to your current (during the past month) school or training program situation	Full-time (2) Part-time (1) Not attending school or training program (0)

In the past month, how often did you engage in volunteer activities?	5 or more (2) 1 – 4 times (1) Never (0)

Disability Assessment Scale (WHO DAS)

Primary respondent(s):

	In the past 30 days, how much difficulty did you have in:	None	Mild	Moderate	Severe	Extreme or cannot do
S1	Standing for long periods such as 30 minutes?	1	2	3	4	5
S2	Taking care of your household responsibilities?	1	2	3	4	5
S3	Learning a new task, for example, learning how to get to a new place?	1	2	3	4	5
S4	How much of a problem did you have in joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can	1	2	3	4	5
S5	How much have you been emotionally affected by your health problems?	1	2	3	4	5
S6	Concentrating on doing something for 10 minutes?	1	2	3	4	5
S7	Walking a long distance such as a kilometre?	1	2	3	4	5
S8	Washing your whole body?	1	2	3	4	5
S9	Getting dressed?	1	2	3	4	5
S10	Dealing with people you do not know?	1	2	3	4	5

S11	Maintaining a friendship?	1	2	3	4	5
S12	Your day-to-day work/school?	1	2	3	4	5
H1	Overall, in the past 30 days, how many days were these difficulties present?	Record number of days: _____				
H2	In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?	Record number of days: _____				
H3	In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?	Record number of days: _____				

Significant Events

S.No	Critical life events & Associated Factors	In your lifetime	Remarks
1.	Personal serious illness, injury, or assault		
2	Serious illness, injury, or assault happened to a close relative		
3	Death of a partner, parent, or child		
4	Death of close friend or relative		
5	Separation due to marital difficulties		
6	Breaking off a steady relationship		

7	A serious problem with a close friend, neighbor, or relative		
8	Unemployed or seeking work unsuccessfully for more than 1 month		
9	Fired from job		
10	Major financial crisis		
11	Problem with the police and a court appearance		
12	Something valuable was lost or stolen		
	Additional items (suggested by experts)		
13	Lack of access to care		
14	Treatment adherence/ Drug Compliance		
15	Abandoned		
16	Serious mental illness		
17	Abuse (emotional, sexual, physical)		
18	Lack of Proper housing		
19	Increased hostility/Critical comments		
20	Social Isolation		
21	Substance abuse (alcohol, drugs, tobacco)		

Social Functioning Instrument - Staff Rated

This instrument measures the level of independent social functioning among persons with mental illness through ratings on 109 items. Read each item and rate based on your observation, functioning on a scale of 0-3 as follows:

- 3 - Able to do independently with no support and consistently (daily/as often as needed)
- 2 - Able to do with low support (encouragement and/or reminders) or independently but sometimes or inadequately
- 1 - Able to do with moderate support (demonstrations and/or parts of task completed) or independently but rarely
- 0 - Able to do with high support

Date:	Client Identifier:
Rater relationship with client: 0 Psychiatrist 1 Case Manager 2 Health Care Worker 3 Personal Assistant 4 Community Worker 5 Primary Carer in Family	Service Location: 0 Hospital (Adaikalam - ADK, Health Center - HC, Community Care Ward - CCW) 1 Shelter (Shelter for Homeless men with psychosocial needs - SLT) 2 Community Outpatient Clinic (Kovalam - KOV, Sembakkam - SMB, Maanamathy - MNY, Mogappair - MOG, Teynampet - TNP, Choolaimedu- CLM, Santhome - SAN, KK Nagar - KKN) 3 Supported Housing in Community (Clustered Group Homes - CGH, Home Again - Chennai - HAC, Home Again - Malappuram - HAM, Home Again - Trichy - HATR, Home Again - Thiruporur - HATP)

Item	**Rating**
1 Care of Self	
1.1 Waking up	
1.2 Making bed (folding mat/sheets, laundering the bedding on a regular basis)	
1.3 Caring for teeth (brushing, pressing gums, cleaning tongue)	
1.4 Taking a bath (preparing bathwater, using soap, scrubbing, use of towel, towel hygiene, using appropriate attire post bath)	

1.5 Managing menstruation (identifying onset of monthly period, using preferred menstrual product, changing the product routinely during cycle/as needed, being aware of staining of garments, disposing menstrual product appropriately)	
1.6 Caring for hair (washing hair, removing nits and lice,, managing dandruff, styling as per preference)	
1.7 Caring for skin (using preferred creams and lotions, carrying out necessary skin care routines example for eczema)	
1.8 Using the toilet (identifying need for toilet, regular and appropriate use of area,cleaning anal and genital regions, flushing)	
1.9 Changing clothes (choosing preferred clothes, focus on aesthetics and cultural resonance,, wearing clothes, changing when clothes get soiled or dirty, identifying issues such as missing buttons/wear and tear/inappropriate sizing and repairing or discarding)	
1.10 Completing laundry (washing clothes, drying clothes appropriately, folding, organising in cupboard)	
1.11 Washing hands before and after meals, and after using washroom	
1.12 Consuming meals (identifying hunger and satiety, following regular mealtimes, consuming food appropriately at designated place, following necessary diet plans)	
1.13 Cleaning up after meals (removing food debris, wiping place of consumption, washing plates, tumbler and other cutlery, drying utensils, putting them back in place)	
1.14 Managing menstruation (identifying onset of monthly period, using preferred menstrual product, changing the product routinely during cycle/as needed, being aware of staining of garments, disposing menstrual product appropriately)	
1.15 Removing facial and body hair according to personal preferences (shaving and trimming, safe and appropriate use of razors and hair removal products)	
2 Home Management	
2.1 Sweeping and mopping the floor (Using broom, wet mop, dusting, gathering debris, discarding)	
2.2 Cleaning the washroom (Scrubbing bathroom floor, washbasins, pot, unclogging drains, cleaning mirrors and fittings)	
2.3 Recognising repairs and maintenance and calling for appropriate help (Repairs in general lighting/plumbing/wood work, knowing and appropriately contacting local plumber/electrician/carpenter/sanitation worker)	
2.4 Shopping for Groceries and Vegetables (Identifying required items, estimating quantity based on number of people to be served and making purchases)	

2.5 Preparing meals (Understanding recipes, preparing ingredients, cooking, using stove safely)	
2.6 Serving and cleaning up after meals (Appropriate serving of meals, washing utensils after meals)	
2.7 Cleaning kitchen (Scrubbing kitchen grime, cleaning stove and countertop)	
2.8 Disposing garbage (Throwing trash in appropriate bins, removing trash to designated community collection points, changing trash bags, washing dustbins)	
2.9 Managing necessary utilities (Switching motor on and off for water, aware of electrical mains to switch off, organising water during shortage)	
2.10 Paying bills (Pay electricity and water bills, maintenance if any)	
2.11 Carrying out minor repairs (Changing a basic lighting fixture, sealing/joining small cracked surfaces, oiling hinges, unclogging a sink or a bathroom outlet)	
2.12 Taking interest in home decor and aesthetics	
2.13 Planning and buying preferred and as needed furnishings for home	
2.14 Organising wardrobe and personal assets	
2.15 Using kitchen tools and home appliances (Safe use of knife, mixer, grinder, operating television, washing machine and so on as may be applicable)	
3 Social Life, Relationships and Skills	
3.1 Initiating or joining a conversation (Greeting, Tone, Eye contact, Joining a conversation based on interest, Joining a conversation at the appropriate time, Understanding when others want to leave the conversation)	
3.2 Recognising non-verbal cues (facial expressions, body language, hand gestures)	
3.3 Speaking coherently (Staying on topic, listening, asking and clarifying questions)	
3.4 Welcoming others into a conversation in progress (Giving equal chances for others to speak, Being affirmative, Able to avoid conversation if she doesn't want to participate, Shift topics based on the flow of conversation)	
3.5 Communicating with fellow residents in the home	
3.6 Communicating with people outside the home (Need based conversation, routine gossip or discussions)	
3.7 Recognising and connecting with personal role in the home	
3.8 Understanding various kinds of relationships	

(Differentiates relationship between family, friends and neighbours, Roles in different relationship, Differentiates good and bad touch based on relationship)	
3.9 Pursuing friendships, companionships and/or intimate relationships (Acknowledging a new companion / friendship, Maintaining relationship, uses discretion and judgement in accept intimate relationships)	
3.10 Offering help to and receiving help from others (Aware of when to offer and receive help)	
3.11 Recognising others feelings and undertaking appropriate behaviour in social situations (Identifying when others are upset / frustrated, Responds to others feeling appropriately, Remaining calm when others are upset)	
3.12 Recognising one's own feelings and undertaking appropriate behaviour in social situations (Aware of one's feeling, Deals appropriately with unfavourable situations like - Cancellation, postponement etc, Expresses her feelings appropriately in a various situations)	
3.13 Being aware of appropriate/inappropriate times and relationships for disclosure of information (Disclosing personal information or sensitive information about others only within confines of limited and supportive social circle)	
3.14 Planning and undertaking engagements with friends (Participating in various festivals, leisure activities, Working in team, Organising an event)	
3.15 Using modern communication aids (Use of Mobile phones)	
3.16 Using public transport and transit (Appropriate use of public transport, Navigating routes, Paying fare)	
3.17 Recognising and attempting to resolve interpersonal conflicts (Take necessary action to resolve conflict, Listening to others opinion, Moving the conflict to the private space, Apologising when appropriate)	
3.18 Understanding date and time and using to schedule (Understanding Morning-Afternoon -Evening, Using calendars to remember the appointments, being able to tell time, Connecting dates with events, Create and follow series of task - jotting down when to do it, when to complete it)	
3.19 Participating in leisure activities of choice (Engaging in leisure activities based on interest, Providing others the same choice)	
3.20 Participating in social activities of the community (Aware of various groups-clubs functioning in the community, Becoming a member in that groups, Aware of various organisation, Participating in events)	
3.21 Discussing with and/or seeking help from trusted circle in social networks for difficult personal issues (Communicates feelings of being unhappy, frustration and anger, Aware of appropriate people to approach for various situations, Clarifying their doubts pertaining to relationships)	
3.22 Identifying personal emotions and feelings and conveying in a healthy manner (Identifies emotions such as unhappy, frustration and anger, Displaying emotions in the right time and right place, Seeks help from health personnel)	
3.23 Identifying and engaging in appropriate means of sexual expression	

(Aware of appropriate and inappropriate sexual behaviours, Awareness of sexuality and potential risk, Aware of the level of sexual intimacy she would be comfortable with, Appropriate place to exhibit sexuality, Inappropriate touching / grabbing)	
3.24 Visiting family, friends or relatives (Planning visit - time period of stay, Capable of taking care of finances, Mode of transport)	
3.25 Hosting visitors or guests at home (Inviting guest to the home, Offering lunch, Inviting guests to participate in festivals or events)	
4 Health Management	
4.1 Recognising and communicating when unwell or injured (Pointing to body parts, Communicating symptoms at the right time, Reaching people for help)	
4.2 Administering basic first aid (Appropriate use of first aid kit - cotton, bandage, generic medicines, Responding to emergency situations, Assessment of scenes of illness/injury)	
4.3 Identifying personal medication (Name of the medicine, Dosage, Aware of medicines that are changed, Appropriate use of medicine, Treatment adherence)	
4.4 Taking personal medication as per advice (Taking only prescribed medicines, When to take medicines - before food/after food, Morning/night, empty stomach, How many days advised to take, Refill the box with medicines if it is over and if it is necessary)	
4.6 Remembering and attending doctors' and therapists appointments (Follow up on appointments, Finding doctors/therapist availability, Check in the prescription for next date of appointment)	
4.7 Being aware of common, safe, non-prescription over the counter remedies and using appropriately (Band aid, balms and lozenges only - Checking the manufacture & expiry date while getting generic medicine from the pharmacy)	
4.8 Being aware of and able to commit to lifestyle choices related to personal health conditions (Diet, Exercise, Canned foods / Junk foods)	
4.9 Being aware of stressors and triggers for mental and physical ill health (Being aware of stressors and triggers, Aware of appropriate handling of such situation, Aware of therapeutic approaches)	
4.10 Being aware of self regulation strategies to support physical and mental health (Knowing about your body-what is good and bad for health, Evaluating one's self, Seeking information/assistance, Differentiating various emotions, Identifying healthy and unhealthy emotions, Seeking assistance for mental health)	
5 Work, Engagement and Employment	
5.1 Identifying and articulating interests and aptitude (Identifying own interest, Setting goals, Finding resources, Planning and application of your skill)	
5.2 Being able to set and follow a daily routine (Scheduling task, Follow a sequence of task, Understanding daily routine, Executing task, Determining how much time it takes for a particular task to complete)	

5.3 Identifying and pursuing activities of interest (Identifying interest, Involving in activity based on interest, Exploring activities in community, Planning and discovering resources)	
5.4 Identifying opportunities and applying for desired jobs (Aware of jobs of interest, Finding opportunities through local and staff contacts, Evaluating self to fit into the job criteria, Verifying jobs, awareness of potential scams, enhancing skill if necessary, verifying benefits and compensation)	
5.5 Managing work relationships (Communicating effectively, Good teamwork and team management, Knowing workplace boundaries, Resolving interpersonal conflict, Informing the leave of absence to the reporting staff, Aware of the right person / department to approach for queries in your workplace)	
5.6 Traveling to place of employment (Aware of appropropriate use of transport to workplace - knowing route and landmarks,, Workplace contact numbers, safely traveling to work and going back home)	
5.7 Reporting for or engaging in work consistently	
5.8 Understanding role at work (Understanding the nature of work and its requirement, Aware of accepted behaviours at workplace, Completing task, Working with responsibility)	
5.9 Being able to sequence tasks towards a goal (Formulate and following a sequence of tasks, Prioritising task, Estimating time to complete task)	
5.10 Using adaptive coping mechanisms to deal with work related stress (Aware of situations at workplace that triggers stress, Planning and scheduling everyday tasks, Remembering important appointments and follow ups, Seeking important information and resources, Relaxing when required)	
5.11 Managing demands of both employment and caring for self and home (Aware of work life balance, Time management, Delineating stresses at work from home)	
6 Personal Safety	
6.1 Being aware of personal address, emergency telephone numbers and safe spaces (Knows the right person to contact during emergency or when needed, Aware of one's address and landmarks, Able to identify which places are safe, Being alert while traveling to unknown places)	
6.2 Being aware of safety processes in case of emergencies (Knowing the safety exit at all places, Emergency response mode - Alarms, signals, fire extinguisher, Not using lift, Not to panic and get gathered in the assembly place)	
6.3 Identifying appropriate touch based on relationship and escalating for help (Aware of good and bad touch pertaining to different relationship - Family - friends-workplace, Knows whom to communicate when experiencing bad touch, Self defence (prompt action when required), Learn to avoid such situation)	
6.4 Identifying abusive and exploitative situations or relationships and escalating for help (Accessing appropriate help resources when: ● ridiculed or discriminated by peers, staff, members of community ● oppressed, marginalised within home or in community ● restricted access to resources at home or community ● physical or emotional exploitation by carers, co-residents or members of community such as use of free labour, unfair wages, constant abuse, coercion, non-consensual sexual	

encounters and so on)	
6.5 Being aware of potential risks in daily life situations Dealing with strangers, Transporting, Right way of exercising)	
6.5 Being able to navigate roads and community spaces safely (Knowing road signals, Crossroads and pedestrian crossing, Uinge sidewalks)	
6.6 Being able to assert personal boundaries and space (Physical boundary - define one's comfort zone, pertain to your personal space, privacy, and body, Vocalise against boundary violations, Emotional boundaries distinguish separating your emotions and responsibility for them from someone else's)	
6.7 Understanding and following safety precautions for home (Right usage of kitchen appliances-Pressure cookers,Cylinders,Electrical hazards, Working in height)	
6.8 Using appropriate facilities to secure safety of precious personal belongings (Money Locker, Cupboards, Segregated usage of possessions)	
7 Economic Transactions	
7.1 Understanding currency and recognising denominations (Count money, Knowing different currency forms, Identifying fake currency, Identifying denominations)	
7.2 Understanding and performing simple calculations (add, subtract, multiply and divide)	
7.3 Understanding concept of trade (Understanding concept of buying and selling goods, awareness of local markets)	
7.4 Undertaking personal shopping (assessing personal needs, choosing appropriate avenues for the same within a time-money framework)	
7.5 Undertaking shopping for home (Carrying bags from home, taking necessary money, and list of items required, knowing appropriate shops to purchase different commodities)	
7.6 Being aware of personal income (Understanding one's cash inflow - Personal income - Assets-family/friends, Able to manage expenses within the income)	
7.7 Saving money (Differentiating necessary and unnecessary expenses, Exploring various options of saving money, Everyday savings versus savings in bank)	
7.8 Being aware of money on hand (Self aware of the place where money is kept, Noting down the cash inflow / outflow)	
7.9 Planning and budgeting for expenses (Understanding budgeting, Self assigned periodic budgeting, budgeting based on prioritising commodities and personal cash flow, Limit self to one's budget)	
7.10 Operating a bank account (Deciding the bank, Deciding the type of account - savings, personal, RD, FD, Account opening procedure, request for cheque, Withdraw money from bank & ATM, Deposit procedure, Availing locker facility, Passbook maintenance)	

7.11 Understanding loans, repayments and dues (Assessing the capacity to repay loan, understanding interest rate across banks, Schemes available, Ability to defer loan payment if necessary)	
8 Cultural and Spiritual Pursuits	
8. 1 Celebrating festivals and events of personal significance	
8.2 Participating in cultural events of choice such as a temple festival, music concert etc in the local community	
8.3 Identifying cultural affiliations and pursuing relevant choices in daily life such as manner of dressing, food and so on	
8.4 Identifying spiritual inclinations and pursuing engagement and expression in preferred ways	
9 Citizenship	
9.1 Being aware of essential public offices and services in the local community and accessing as may be necessary	
9.2 Being aware of current affairs in the local	
9.3 Being aware of local governance and political events (such as grama sabha, elections)and participating as per one's preference	
9.4 Participating in discussions or taking action on civic issue in the local community	
9.5 Participating in discussions on politics and governance concerning country of affiliation	
9.6 Developing critical awareness in relation to shared experience and marginalisation as a person with mental illness	
9.7 Engaging as a peer advocate	
10 Interdependence	
10.1 Understanding mutual reliance and reciprocity in relationships	
10.2 Demonstrating empathy for co-residents/ friends and offering help or support	
10.3 Demonstrating empathy for staff/ carers and offering help or support	

Domain	**Score**
Care of Self	
Home Management	
Social Life, Relationship and Skills	
Health Management	
Work, Engagement and Employment	
Personal Safety	

Economic Transactions	
Cultural and Spiritual Pursuits	
Citizenship	
Interdependence	
Total	

Pre- Discharge Home Visit Report

Interviewed by:
Date:

File No:	
Name:	
Type of contact:	1 - Phone Contact 2 - Pre Discharge Home Visit
Date:	
Home Visit Completed by (Names and Designation)	
Interviewees (Names and Relationship with Client)	

Family Readiness –
Make a note on the ***living AND care arrangements*** of the client post discharge:

Possible risks identified during the home visit:

Level of support required to be offered by/to family to facilitate smooth transition into community through reintegration with family:

New information on critical incidents/history of client:

Highlight Issues and Challenges Identified and possible solutions or next steps:

Discharge Summary

File Number:	
Participant Code:	
Name:	
Date of Admission:	
Date of Discharge:	
Discharged from:	
Gender:	0 – Male 1 – Female 2 - Other
Age (in years):	
Diagnosis:	1 - Schizophrenia, 2 - Acute psychosis, 3 - Bipolar Disorder (history of mania) 4 - Bipolar Disorder (no history of mania) 5 - Paranoid State 6 - Senile or presenile Dementia 7 - Other organic psychosis (eg. brain damage, Korsakoff's syndrome, other organic disorders) 8 - Depression, 9 - Obsessive Compulsive Disorder 10 - Chronic Mixed Anxiety 11 - Substance Misuse 12 - Personality disorder 13 - Mental Retardation 14 - Mental Retardation with Psychosis 15 - Other Diagnosis (Mention) _____ 16 - No Diagnosis 17 - No current psychiatric illness

Concurrent Disabilities:	1 - Blindness 2 - Low-vision 3 - Leprosy cured person 4 - Hearing Impairment (deaf and hard of hearing) 5 - Locomotor disability 6 - Dwarfism 7 - Autism Spectrum Disorder 8 - Intellectual disability 9 - Cerebral Palsy 10 - Muscular Dystrophy 11 - Chronic Neurological Conditions 12 - Specific Learning Disabilities 13 - Multiple Sclerosis 14 - Speech and Language Disability 15 - Thalassemia 16 - Hemophilia 18. Sickle Cell Disease 19 - Acid Attack Victim 20 - Parkinson's Disease
Aids used to help with disability:	
Comorbid physical health concerns and medication for comorbid health conditions (include dosage and frequency): Diabetes, Metformin dosage frequency	
Primary Carer *(Please write full name)*:	

Primary Carer - Relationship with client:	
Primary Carer Address: House No. Street Locality City/Village: Taluk: Post Office: District: Pin code: State:	
Primary Carer Contact Number:	
Secondary Caregiver *(Please write full name)*:	
Secondary Caregiver Relationship with client:	

Secondary Caregiver Address: House No. Street Locality City/Village: Taluk: Post Office: District: Pin code: State:	
Secondary Caregiver Contact Number:	
Other contacts - They maybe other relatives, friend, school teacher, neighbour, employer, Panchayat Head, any SHG head, VHN , DMHP doctor, Police station contact , local NGO/ CBO , legal aid services functionary, PHC doctor, Nurse : (Please write name, relationship to client, address, phone number)	

History of client (*duration of illness, type of onset, onset, homelessness, critical incidents, progression and level of disability at admission*):

Treatment during stay at hospital:

Psychiatric -

Psychological -

Social -

Current Status:

Symptoms:

Functioning:

Relationship with medication (degree of support required, any side effects):

Specific needs and conditions to maintain recovery:

Signs of resurgence of symptoms and significant stressors:

Criteria for Discharge and Aftercare

(If the criteria has changed since time of reintegration, please note in the third column the reason as to why it changed)

Clinical Stability	/10	
Safety Planning	/10	
Ethical Code	/10	
Social Capital	/15	
Organizational Capability and Resource	/5	

Description of family:

Proposed living and care arrangements:

Aftercare Plan

Name (person or facility), Address and Contacts Info:

Aftercare Level (Tick the one that applies):

__ Aftercare Level 1
__ Aftercare Level 2
__ Aftercare Level 3
__ Aftercare Level 4
__ Aftercare Level 5

Treatment Plan upon discharge (mention if outpatient care, postal medicine, aftercare network):

Current medication**:**

Type of medication (psychiatric or general)	**Name**	**Dosage**	**Morning**	**Afternoon**	**Night**

Medication on hand up to date: _____

Level of support required to be offered by/to family:

Description of follow up:
Main themes/issues/domains to be focussed on for follow up:

Phone Follow up (frequency):

Local network partner home visit (frequency):

Home Visit by The Banyan (frequency):

Social care facilitation:
(mark all applicable and describe in detail intervention to be offered)
1 Financial
2 Employment

3 Respite care
4 Day care
5 Housing
6 Support networks

Case Manager:
Signature:
Date:

Treating Psychiatrist:
Signature:
Date:

Reintegration Report

File number:	
Participant Code:	
Date of Admission:	
Date of Discharge:	
Date of Reintegration:	
Diagnosis:	1 - Schizophrenia, 2 - Acute psychosis, 3 - Bipolar Disorder (history of mania) 4 - Bipolar Disorder (no history of mania) 5 - Paranoid State 6 - Senile or presenile Dementia 7 - Other organic psychosis (eg. brain damage, Korsakoff's syndrome, other organic disorders) 8 - Depression, 9 - Obsessive Compulsive Disorder 10 - Chronic Mixed Anxiety 11 - Substance Misuse 12 - Personality disorder 13 - Mental Retardation 14 - Mental Retardation with Psychosis 15 - Other Diagnosis (Mention) _____ 16 - No Diagnosis 17 - No current psychiatric illness
Address: House No Street Locality City/Village Taluk District Pin Code State	

Alternate Addresses: Similarly, PLEASE INCLUDE – House No., Street, Locality, City/Village, Taluk, District, Pin Code, STATE	
Primary Caregiver:	
Relationship with client:	
Contact Numbers: Primary Carer: Secondary Carer: Support Networks: (Relatives, friend, school teacher, neighbour, employer, Panchayat Head, any SHG head, VHN , DMHP doctor, Police station contact , local NGO/ CBO , legal aid services functionary, PHC doctor, Nurse)	
Interviewee(s)	1. Client 2. Carer(s) 3. Client and Carer(s)

Socio Demographic Characteristics

Primary respondent(s):

1	Name of the client (note aliases, **underline name to use for postal medication**):	
2	Age (in years):	
3	Gender:	0 – Male 1 – Female 2 - Other
4	Marital Status:	0 – Single 1 – Married 2 – Widowed 3 – Divorced 4 – Separated
5	Age at marriage (in years):	
6	Number of children (client's children) Note gender and current age (F, 8/M, 1) and their care arrangements:	
7	Religion:	0 - No religion 1 – Hindu 2 – Muslim 3 – Christian 4 - Others (specify) _____
8	Caste:	0 - No caste 1 - ST 2 – SC 3 – OBC 4 – MBC 5 – BC 6 – FC

9a	Years of education:	
9b	Reason for discontinuing education (if not attained up to graduation)	
10a	Occupational Status:	0 – Unemployed 1- Employed 2 - Student 3 – Homemaker 4 – Retired 5 - Business 6 - Others (specify): _____
10b	Occupation:	
10c	Personal Income (per month)	
11a	Number of household members	
11b	Number of children in the household (< 18 years)	
11c	Number of elderly in the household (> 60 years)	
12a	Number of earning members in the household	
12b	Household Income per month (verify for inclusion of sources other than salary)	

13	Number of household members with disability (including mental illness, excluding the respondent)	a. Blindness b. Low vision c. Leprosy d. Hearing Impairment e. Locomotor disability f. Dwarfism g. ID h. Mental illness i. Autism spectrum disorder j. Cerebral palsy k. Muscular Dystrophy l. Chronic neurological conditions m. Specific learning disabilities n. Multiple sclerosis o. Speech & language disability p. Thalassemia q. Haemophilia r. Sickle cell disease s. Multiple disability t. Acid attack victim u. Parkinson's disease
14	Gender of Household head	0 Male 1 Female 2 Other
15	Location of stay	0 Urban 1 Rural
16a	Type of house	1 Pucca (Concrete) 2 Semi pucca (Not all walls are made up of bricks, stones) 3 Kutcha (Wood, mud)
16b	Is this dwelling your own or rented?	1 Owned 2 Rented 3 Leased 4 Homeless
16c	Number of rooms in the house (except kitchen and bathroom)	

17	Which of the following social entitlements do you possess currently/have accessed in last 12 months?	0 - Voter's ID, 1-Disability Card, 2-Aadhar card, 3-State Health Insurance, 4-Ration Card, 5-Old Age Pension, 6-Widow Pension, 7-Interest free state loans, 8-State housing scheme, 9 - Disability Allowance, 10 - MNREGA Job Card, 11 - Psychiatric Medication from local PHC, 12 - Others (Describe:	
	Entitlements	*Was it facilitated at the point of discharge?* *1 – Yes, 0 – No*	*Who is the provider? (State, The Banyan, Another NGO)*
a)	Voter's ID		
b)	Disability Card		
c)	Aadhar Card		
d)	State Health Insurance		
e)	Ration Card		
f)	Old Age Pension		
g)	Widow Pension		
h)	Interest free state loans		
i)	State housing scheme		
j)	Disability Allowance		

k)	MGNREGA Job card		
l)	Psychiatric medication at local PHC:		
m)	Other (Specify - _____)		

(B) Course of Homelessness
Primary respondent(s):

1	Did you have a mental illness prior to becoming homeless?	1 - Yes 0 - No
2	Approximately, how old were you when you first became homeless? (in years)	
3	Approximately, how many days were you homeless? (Note the number and actual unit of days, months or years that the client answers in, as is)	
4	Who were you living with prior to becoming homeless?	0 – Alone 1 – Parents 2 – Spouse 3 – Children 4 - Others (specify) _____
5	In your opinion, what are the critical reasons that led to you becoming homeless? (qualify critical as something that made a significant contribution in their perception to their homelessness)	

6	Do you think you may be at risk of becoming homeless again?	1 – Yes 0 - No
7	If yes to Q6, why do you think you may be at risk of becoming homeless again?	

(C) Course of Illness and Service use
Primary respondent(s):

1	At what age did you develop mental illness? (in year)	
2	What kind of treatment or help was taken at onset of mental illness, if any?	0 - Traditional medicine (Ayurveda & Siddha) 1 - Modern medicine (Allopathy) 2 - Homeopathy 3 - Faith Healing 4 - Counselling 5 - Others (specify:) Notes:

(D) Perspectives on Illness and Recovery
Primary respondent(s):

1. What do you call your problem? When did it start?

2. What do you think caused your problem?

3. What does your illness do to you? How does it happen?

4. How severe is your illness? Do you think it is an acute or chronic condition?

5. What do you fear most about your illness?

6. What are the chief problems caused for you due to your illness?

7. What treatment and care services are you receiving for your illness? Are you satisfied with the results? Why or why not?

8. Do you agree with and adhere to the care plan? Are there any specific difficulties you experience due to treatment and care services?

9. What kind of services do you think you should receive? What are the important results you hope to achieve from it?

10. Do you think recovery is possible? Why or why not?

11. How and when would you describe yourself being in recovery? What are the main changes you hope to see?

In addition complete: **Modified Colorado Symptom Index, Cantrill's Lader (modified), Community Integration Questionnaire (CIQ), Disability Assessment Scale (WHO DAS), Significant Events.**

Post Discharge Follow Up Form

File No:	
Name:	
Type of contact:	1 - Phone Follow Up 2 – Post Reintegration Home Visit ✓
Date of Follow Up:	
Home Visit or Phone Follow Up Completed by (Names and Designation)	
Interviewees (Names and Relationship with Client)	
Services Offered:	___ mobility related ___ medication ___ addressing risk factors ___ related to work participation ___ caregiver level
Follow up Recommended:	
Current Aftercare Level	
Mention if change in aftercare level	
Next Review	

Clinical status

New information on critical incidents/history:

What are the current care and living arrangements:

Illness and Recovery Perspectives:

General living and community integration:

Issues and Challenges and solutions recommended:

*Repeated Measures (from Reintegration Report) to be filed at 6th month and 12th month from discharge.

To add: quality audit example

www.thebanyan.org | www.balm.in | www.azimpremjifoundation.org

TATA TRUSTS