OPERATIONS MANUAL

SHELTER FOR HOMELESS MEN WITH PSYCHO SOCIAL NEEDS

The Banyan

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Shelter for Homeless Men with Psychosocial Needs

PROGRAM MANUAL

ACKNOWLEDGEMENTS

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Table of Contents

Client Care

Human Resources

Administration and Maintenance

Financial Management

Introduction to the Banyan and Shelter for Homeless Men with Psychosocial Needs

The Shelter for Homeless Men with Psychosocial Needs in Dooming Kuppam, Chennai, is one arm of The Banyan's prevention to promotion service spectrum that fosters safety, social inclusion and skills development in a 30-bed therapeutic environment. Since acquiring the shelter in 2012, the Banyan has provided care tailored to the needs of each resident with underpinnings of *unconditional positive regard* and *radical acceptance* that drive all facets of the organisation. Through an *integrated care pathway*, residents and their multidisciplinary teams collaborate to enhance their overall functioning, self-agency and aftercare support systems. The shelter also works in partnership with the Corporation of Chennai under the National Urban Livelihoods Mission (NULM).

The following manual is aligned with the Banyan's commitment to disrupt the cycle of systemic poverty and homelessness that disproportionately deprives persons with mental illness, as well as other subgroups described in this document. Born in 1993 as a registered non-governmental organisation, the Banyan responded to an unmet need to provide holistic care to persons experiencing homelessness, many without resources to manage mental health issues. The Banyan endorses interventions founded on decades of field experience, research, multidisciplinary expertise and, most importantly, empathy through the engagement of clients who are at the heart of the work.

The Operations Manual for the Shelter for Homeless Men with Psychosocial Needs is designed to provide guidance to administrators and shelter personnel currently operating shelters. Whether you are a seasoned expert working to improve policy or organisational frameworks, or a new professional refining tools and techniques with your clients, the Banyan welcomes you to review the following pages for guidance and integration into your avenue of social change.

This manual is dedicated to our Teacher and Patron, Dr Joyce Siromoni (1932-2019)

Vision

An inclusive and humane world that promotes capabilities, equity and justice.

Mission

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.*

Background of the Problem

Homelessness in India. Homelessness embodies one of the most intricate, yet pervasive sets of social problems in India. The 2011 Census of India[1] found that there were approximately 1.73 million homeless individuals in the country, many of whom were sleeping in exposed, unsafe conditions such as hume pipes, mandaps and on roadside platforms. Issues of undercounting as a result of invisibility, frequent movement and the scope of who is considered "homeless," creates ambiguity in determining the breadth of the issue (*Shelters for the Urban Homeless,* 2014). Causes of displacement include political discord, lack of employment opportunities, mental health or other social stigmas, natural disasters, lack of financial resources for medical care, and domestic violence (Gopikumar & Ravi, n.d.).

Mental health in India. Persons with mental health issues require service providers who understand the complexity of their intersecting medical and mental health conditions, as well as the interconnectedness of their potential to function in society and the readiness of their environment to support their success. In 2016, the National Health Survey[2] reported that an astounding 150 million Indians met the criteria for a mental health condition. Due to a lack of quality mental health resources, mental health stigma, and low self-perceptions of service need, 80% of Indians with mental illness do not access mental health treatment (Demyttenaere, Bruffaerts, Posada-Villa, Gasquet, Kovess & Lepine, 2004). The pervasiveness of certain mental health conditions such as depression are most rampant in socially marginalized groups related to environmental stressors based on gender, socioeconomic status and caste.

Homeless shelters in India. Professionals working in homelessness should be familiar with central government operative regulations and daily shelter management. Shelter staff need to educate and collaborate with community stakeholders to grow their understanding of the client population and improve service delivery. They should identify or create specialized resources for care that falls outside of the shelter's scope of services. Safety of clients should be prioritized first, as well as accommodations necessary to help make self-care decisions that support their well-being and autonomy.

Legislation. In 2010, the Supreme Court of India issued legislation mandating the creation of shelters with basic facilities and amenities across India (GO. Section PIL No. 1 Court No.5; Dated 05.05.2010). Implementation in major cities has been differential based on a number of factors including urbanization, resources and the limitation of properly trained providers (*Shelters,* 2014). Providers working in homelessness should be familiar with the rights of their clients guaranteed by their local, state and central governments, as well as the social entitlements that clients can access.

Shelter providers should also understand the relationship between homeless persons and the criminal justice system. Some legislation adversely perpetuates homelessness by criminalizing homelessness, including beggary laws that police may use at their discretion (*Shelters,* 2014). As an alternative to engaging in prosocial training and treatment, as needed, homeless persons are arrested and removed from their communities per the Prevention of Beggary Act of 1945.

[1] Census of India 2011

[2] National Mental Health Survey

Shelter Population and Conceptual Framework

Shelter population. Shelters and homelessness prevention programs must be prepared to address the complex needs of their diverse client population presenting with issues including, but not limited to, local language, disability, financial distress, strained family relationships and systems of social isolation. Residents of the Shelter for Homeless Men with Psychosocial Needs span from different parts of India and may experience additional maltreatment in Chennai as a result of language barriers. Many have informally participated in the labour sector as farmers, fishers or construction workers, and predominantly originate from low-income households.

Critical to maintaining stability and continuity of care is reengagement of the residents' natural support systems, including their communities and families experiencing hardships that inhibit their ability to maintain residents at home without additional guidance. Residents present with cognitive impairments and behavioral issues stemming from severe mental illness, intellectual and developmental disabilities, dementia and other conditions. The health and social care needs that accompany such diagnoses swiftly destabilize persons without access to proper local resources. Given familial limitations due to financial instability, housing issues, elderly caregiving and chronic health conditions, residents are provided little recourse to realize their potential without an integrated approach that addresses the systemic deficits preventing their participation in society.

Conceptual framework. Repeated traumas experienced by homeless persons with mental health issues by individuals, family members and society, may have significant impact on their view of self, the future and the outside world. In the most recent case of homeless maltreatment, at least 16 rapes and death of young girls occurred under the care of a government shelter in Muzaffarpur, Bihar.[3] Public cases such as these highlight the significance of practicing transparency as a shelter program. Shelters are encouraged to prioritize safety and welcome outside visitors for random audits to deter preventable atrocities.

Prolonged **social exclusion** also prevents opportunities to develop the social and life skills that the general population gains through **social inclusion** such as maintaining healthy relationships, managing money or problem-solving. As opposed to a one-size-fits-all approach to care, the shelter uses a *person-centered approach* (Cooper & McLeod, 2012) to empower residents by modeling principles of empathy, radical acceptance and unconditional positive regard that help restore a personal sense of safety and agency. Overtime, residents internalize and integrate this treatment into their self-perceptions.

Direct service providers should welcome residents into this new way of thinking and being by honoring their dignity from the very first moment they interface with the organisation. Providers can help mitigate fears or resistance by regularly and repeatedly explaining the nature of services being offered so that residents are no longer made to feel powerless as they have in the past. Multidisciplinary teams should include residents in decision-making to the greatest extent possible with safety and their well-being as top priorities.

[3] In Bihar Shelter Where Girls Were Raped, Cops Dig For 'Buried Body'

Program Model and Services

Shelter residents are introduced to services upon rescue by a team comprised of a nurse, health care worker and a driver, as well as a user trained in outreach and counselling. Teams are advised to practice sensitivity to the traumatized mental states of homeless persons by introducing themselves and explaining the services being offered prior to transport. Teams also travel with a rescue kit containing: Banyan program information, clothes, first aid, food, water, gloves and face mask.

During admission, shelter staff should ensure that the resident's care needs do not exceed the scope of services available at the shelter as determined by the needs assessment, obtain a police memo and attempt to locate family members, if possible. Shelter staff should also address primary care needs, orient the resident to services, obtain informed consent, provide a welcome kit of necessities and refer the client for immediate medical or mental health attention for urgent matters.

Residents use an integrated care pathway with a multidisciplinary team (MDT) to oversee their mental, medical and social well-being as they participate in skills and employment training suited to their skills and interests. They are also provided a familial environment that promotes peer support and community engagement. As residents acclimate to a new structure and environment, shelter staff work collaboratively to teach adaptive skills that replace former coping strategies that aided their survival on the streets such as running away or hoarding. Self-advocacy among residents is encouraged through a formal grievance redressal process as well as other forums to practice the interpersonal skill of boundary-setting and improve their quality of care at the shelter.

During reintegration, residents and their multidisciplinary teams plan and implement interventions to prepare for a positive return to the community. Based on reintegrative needs, shelter staff may need to research specialized care resources or provide education to external providers on how to best support the resident in the community. Aftercare service plans include reengagement of their natural support systems and referrals to local resources to ensure their continuity of care and prevent homelessness relapse. The shelter staff coordinates with community stakeholders to monitor the safety of former residents and ensure they remain in the least restrictive level of care possible. Auxiliary services at the shelter includes: soup kitchen, clothing bank, night shelter, street engagement, and outpatient clinics.

Description of Client Population

Although the Shelter for Men exclusively attends to the needs of men, they carry similar demographical information and experiences as clients participating in other Banyan programs. Residents arrive at the shelter from different regions such as Rajasthan, Madhya Pradesh, Jharkhand, Bihar, Andhra Pradesh, Telengana, Karnataka and Kerala. They speak languages less common to locals which impacts how they are received and treated by the community. Most clients are usually of low socioeconomic backgrounds. Their families of origin are exposed to similar traumas of displacement, financial distress, health issues and maltreatment. With few exceptions, a majority of clients present with moderate to severe mental illness, intellectual disability or behavioral issues. It is not uncommon to see a combination of conditions. It is important for all providers of the homeless to have, at minimum, a basic understanding of the social and health conditions impacting their client population.

Person-centered Approach to Care

Homelessness depends on the preservation of structural barriers that arrest the ability for homeless persons to access information, autonomy or personal growth. At the Banyan, interventions are used to honor the humanity of persons who are homeless and restore the internal resources lost after prolonged subjugation.

From executive leadership to direct care providers, Banyan practices **a person-centered approach** that embraces the inherent worth of each client by including them in every step. Information regarding treatment and care is accessible and clients participate in informed decision-making to the greatest extent. Skills development and wellness initiatives are *promotive* and tailored to meet individual needs. All staff engage in *critically reflective practice* through supervision and training to develop effectiveness.

At the shelter, person-centered care is observable in daily residential interactions. For example, residents **may voluntarily leave** the shelter upon their request. They participate in **interest-based** skills and **training on-site** with the choice to opt-out. For **long-term** concerns not dangerous to self or others, the Banyan will take a ***harm-reduction approach***[4] such as asking residents to smoke in designated areas as opposed to enforcing punitive measures counterproductive to progress.

Such as with persons who are able to participate in mainstream society, **residents** use their voices to **practice self-advocacy** by **sharing feedback on their care in human rights committee meetings**, annual **non-partisan service audits** with external stakeholders or with Banyan-affiliated students who collect anonymous data for the organisation. The shelter will also offer **"suggestion boxes"** with senior staff phone numbers to be reached directly.

Modeling and practicing person-centered care in each phase of service reminds residents of their self-worth and **instills many of the skills necessary to face systems of discrimination upon reintegration.**

[4] Harm Reduction International defines "harm reduction" as: "policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption. Harm reduction benefits people who use drugs, their families and the community."

Overview of Programs

The Banyan approaches homelessness prevention and client support using a preventive to promotive continuum of care. Clients participate in programs and services designed to address a diversity of needs within an evidence-based, adaptive mental health systems framework. Facilitators of their mental health and social care include: psychiatrists, psychologists, social workers, occupational therapists, health care workers, community mobilizers and personal assistants, medical officers, vocational trainers and development practitioners.

Emergency Care and Recovery Services. Hospitals and shelter-based services serve as the first point of contact for homeless persons experiencing mental health distress, and stand as a model for humane and holistic care to homeless persons with mental illness.

NALAM. Rural and urban mental health primary care programs serve communities across three states. Community mobilizers and multi-disciplinary teams reach mental health consumers at service access points or mental health care units (MHCU).

Inclusive Living Options. Long-term care homes support social inclusion of persons with moderate to severe mental health issues in rural and urban communities. The homes located across Tamil Nadu and Kerala range from cottage style assisted-living to natural home environments.

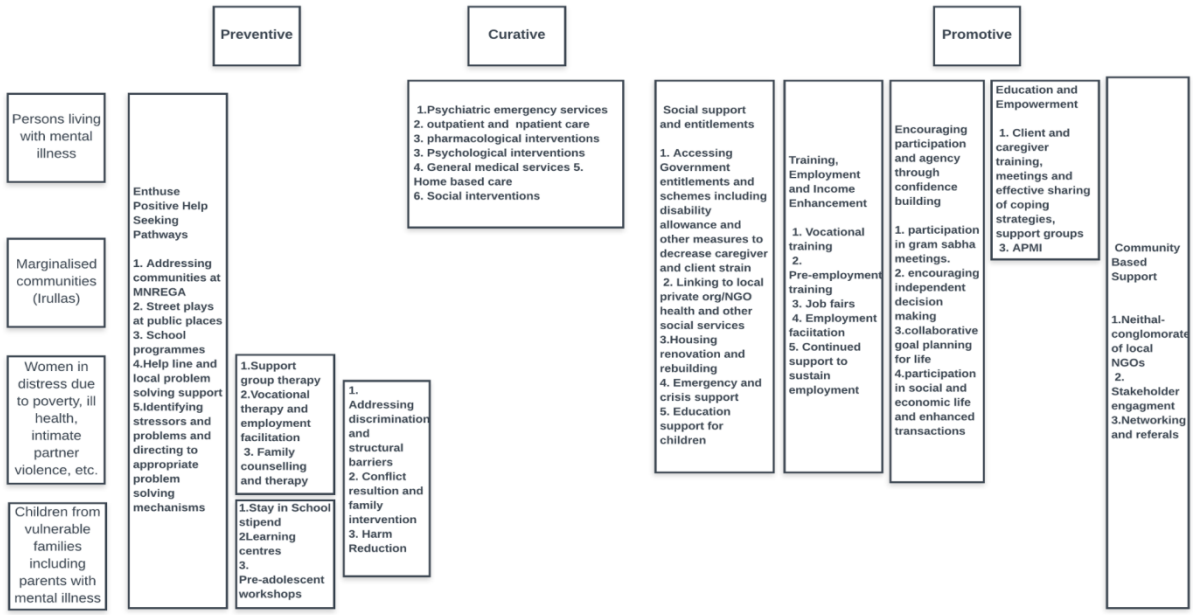
Skills Development & Social Enterprise. Aspiring entrepreneurs, intrapreneurs, users and caregivers form social coops and engage in collaborative work based on their interests and access to vocational training and employment options. Small and medium scale grants are viewed as investments into the financial security, inclusion and agency of clients.

The Banyan Academy of Leadership in Mental Health – Tata Institute of Social Sciences Collaborative. Budding mental health professionals engage in capacity building through constructivist pedagogy in graduate and diploma programs.

BALM – Sundram Fasteners Center for Research and Social Action in Mental Health. Research based in practice-based evidence contributes to positive social change and accessibility to dignified living standards.[5]

[5] Adapted from "Overview" section of *Structures & Processes Manual*.

Continuum of Care



*NALAM – The Banyan's Mental Health Primary Care: Services (*Structures & Processes* 2018)

Mr. MAK's Story

Dr. Joyce Siromoney is one of the most energetic and inspiring humans The Banyan has had the good fortune of coming across. She was engaged in the shelter's activities before The Banyan took over, and she continued to work with us from 2012 onwards. She used to work closely with some English and Malayalam-speaking clients at the shelter.

One of her clients, Mr. MAK was referred to The Banyan by Koshish, an NGO working in the homelessness space in Delhi and Mumbai. MAK is a 55-year old man, who dropped out of medical school after an onset of schizophrenia. He was diagnosed early but wasn't always compliant with medication. He eventually became homeless after a battle with drugs, accompanied by his illness and family conflict.

Our first contact with him was at 'beggars' home' in Bangalore, which was back then run by The Banyan's current director. MAK then moved to a beggar's home Delhi, where he had relapsed and spiralling downward. MAK had difficulty moving forward, with grandiose ideas and plans from 20 years ago, such as returning to medical school, continuing with his research and residency programmes, inheriting a large sum of money from his adopted parents, etc.

Each of his plans were explored in detail by Dr. Joyce, who got in touch with MAK's dean from college, his friends, family and ex-colleagues to make sure all attempts are made to help him realise his dreams. As expected, he was unable to get back to college, and the property he was due to inherit had come under legal dispute. This caused a huge setback to MAK's life.

When everyone was ready to give up, Dr. Joyce infused new energy into the whole system, got in touch with MAK's best friend from college (who was working in Angola at the time), persuaded him to visit MAK and help him find a job and a new life. Her persistence and hard work finally bore fruit. MAK's friend found a new place and new job for him next to his family home in Kerala where MAK has started a new life with a large support system comprised of Dr. Joyce, his close friends from college, and the shelter and Koshish teams.

MAK's angel in disguise will always be Dr. Joyce, who never gave up hope, especially when MAK had none, never stopped trying, and was the best teacher and guide MAK could have hoped for. MAK's story was a happy ending, and a much needed one for the homelessness sector.

Homelessness: An Issue of Access

Prevalence of homelessness in India. The Census of India identifies persons who are homeless as: "those who live in the open or roadside, on pavements, in hume-pipes, under flyovers and staircases, or in places of worship, mandaps, railway platforms, etc."

The last census of 2011 estimated approximately 1.73 million homeless persons living in India. Those familiar with the nature of homelessness understand the challenges in capturing an accurate account of individuals who may have been missed in the study:

1.) **Invisibility.** For several reasons, including a history of distrust between homeless persons and the government, survival strategies and a lack of trackable data, persons who are homeless are made to be unseen.
2.) **Definition of homelessness.** Persons residing in public centers, institutions or facilities at the time of the census were not counted as homeless.
3.) **Transience.** Persons who are homeless and not present at the time a survey was conducted in their area were not included in the survey (*Shelters,* 2014).

Social exclusion. The factors that contribute to and perpetuate homelessness are a complex interplay of issues. Despite widespread misconceptions about homelessness, it only takes one impetus to enter homelessness rapidly and unexpectedly, but it can take more than a lifetime to overcome the structural barriers that block individuals from reintegrating into society.

In order to truly be effective, it is imperative for all professionals working in homelessness to create avenues to combat and mitigate such barriers. Shelters should:

- Coordinate with local police officers to deter arrests for laws such as the Prevention of Beggary Act of 1952 targeting homeless persons impeding their access to training or entitlements. Rejected bills such as the Persons in Destitution Model Bill of 2016 sought to provide comprehensive rehabilitation centers in lieu of beggar's homes[6].
- Combat invisibility by helping residents secure identification and bank cards.
- Accommodate displaced persons in anticipation of natural disasters or political turmoil.
- Enact proactive measures to protect individuals who have experienced domestic violence, bonded labour, or debt slavery. The government should assist with loans or grants to relieve bank debts and deter exploitation.
- Coordinate with local employers to prevent the exploitation of homeless persons in informal work environments due to their status (*Shelters*, 2014).
- Engage families and communities to understand needs of their loved ones who are homeless, reduce stigma of incarceration related to homelessness, and organize family conflict arbitration.
- Communicate with local government officials and service providers to create a network of support for persons who are homeless, and share provider expertise.

[6] Anti-trafficking Bill gets Cabinet nod; government's focus should now shift from punitive action to rehabilitation

Legislative Implications

Supreme Court of India Order on Night Shelters. The central mandate for dignified shelters was first introduced across all states in 2010 as guaranteed by the Right to Life Act under Article 21 of the Constitution of India. The legislation ordered that for every one lakh people, one night shelter be created with standard amenities. However, facility space, resource and training limitations present challenges to implementation on the state and local levels (*Shelters for Urban Homeless*, 2014)

National Urban Livelihoods Mission (NULM). Under a nationwide program for urban homelessness, Shelter for Urban Homeless, the central government issued regulatory guidelines for shelter operations through NULM.[7]

United Nations Convention on the Rights of Persons with Disabilities of 2006. This international human rights accord outlined "the rights and dignity" of persons with disabilities. The treaty called for nations to promote non-discriminatory practices and inclusion across all sectors of society, as well as recognize the contributions of persons with disabilities.[8]

Rights of Persons with Disabilities Act of 2016. In response to the United Nations Convention on the Rights of Persons with Disabilities, India ratified the treaty in 2007 and passed new legislation affording persons with disabilities the same rights and protections, including "reasonable accommodation for persons with disabilities" and "access to a range of in-house, residential and other community support services."[9]

National Trust Act of 1999. The National Trust for the Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act created a governing body called "The National Trust" that oversees initiatives to provide educational, vocational, health and social services to persons with intellectual and developmental disabilities, and their family caregivers.[10]

Mental Healthcare Act of 2017. This legislation expanded rights to persons with mental illness by granting access to mental health care by government-affiliated centers regardless of socioeconomic status, a right to a dignified life, confidentiality, individual consent for media release and freedom from discrimination. The bill also decriminalized suicidal behavior.[11]

Prevention of Beggary Act of 1952. This law to detain persons believed to be begging in beggars' homes has been adopted by 21 states and 2 union territories. Their dependents,

[7] National Urban Livelihoods Mission Document

[8] Conventions on the Rights of Persons with Disabilities and Optional Protocol

[9] Rights of Persons with Disabilities Act of 2016

[10] The National Trust Act of 1999

[11] Mental Healthcare Act of 2017

excluding children, are incarcerated for the same period (Rebbapragada, 2018). Upon release, persons may be denied access to ration cards, healthcare insurance, employment prospects and social entitlements.

Division of Labour Between Government and NGOs

The table below distinguishes operative shelter oversight between the NGO which oversees direct care and daily facility management, and the government which manages budget and building maintenance.

Domain	**Corporation**	**NGO**
Client Care	Monthly government hospital visits, clinics, reviews, lab tests and reports, emergency management, group hospital	Health, mental health, social care, case management, reintegration, aftercare
Social Interventions	Attestation of Aadhar Cards, ID cards, Voter's ID Cards etc.	Camps and drives to obtain ID cards for residents and neighbourhood homeless persons, bank accounts, jobs, housing, legal aid, family arbitration, marital skills training, disability certifications, disability/old age pensions, bank loans for self-employment
Food and Water	Quarterly payments	Quality and nutrition
Medicine	General and psychiatric medication	Quarterly/half-yearly requisition of medicines, as needed
Reintegration	Attestation of ID cards for client and caregiver travel reimbursements	Coordinate travel reimbursements in collaboration with corporation and central government
Human Resources	Staff salaries	Appoint and train Nurses, ANMs, Health Workers, Security Guards and Co-ordinator
Administration	Repairs and building maintenance	Daily maintenance and housekeeping
Maintenance	Installation and periodic services for electricity, water, plumbing , pest control	Daily maintenance
Finance	Quarterly payments	Cash vouchers and bills attested by the NGO; advance letters, where applicable

Homeless Shelters in India

As described in the *Legislative Implications* section of this document, the right to life with dignity for homeless persons has garnered legislative attention in recent years leading to the central government mandate requiring one shelter per 100,000 people in all major cities across India. Such as with other states nationwide, Tamil Nadu responded to the order by converting dozens of governmental buildings into shelters. As of 2017, there were 43 homeless shelters in Chennai. Shelters are expected to meet operational guidelines outlined in the National Urban Livelihoods Mission (NULM) per the Shelters for Urban Homeless (SUH) scheme and are subject to state and local government oversight.

According to the SUH Handbook for Administrators and Policymakers (2016), shelters should be established with the following in mind:

- **Accessibility.** Establish shelters in locations with the highest concentration of homeless persons enhances engagement and ease of participating in services.
- **Autonomy.** Residents will engage in services if they believe their needs are being met. Shelters should not detain persons against their will.
- **Innovation.** Shelters should conduct outreach to community-based organisations to determine creative methods to reach and service homeless persons.

The Banyan also recommends the following:

- **Safety.** In congruence with specialized care, shelter providers should prioritize each resident's personal safety and capacity for decision-making based on presenting cognitive functioning and skills sets. Factors to consider include: history of treatment, behavioral health, lucidity, demonstrating an understanding of their rights, insight into their illness, etc.
- **Documentation.** Shelter staff should note entry and departure information for all residents to refer to if and when there is a concern regarding their whereabouts.
- **Scope.** Shelter staff should know the scope of their services and the nearest resources to accommodate and support residents that are outside of their scope. Specialized care may be needed for issues such as age, medical conditions or addiction.
- **Stakeholder communication.** Shelter staff should maintain contact with the police and local community to assist with monitoring residents' whereabouts and status, as needed.

Information on The Banyan's operative recommendations may be found in the *Lessons Learned* section of the Operations Manual.

Shelter Facilities and Amenities

Operators and administrators of shelter programs are encouraged to act with innovation when creating and designing shelters of accessibility, privacy and dignity. By government mandate, shelters are required to provide the following:

1. At least 50 square feet per person
2. Bed and laundered bedding
3. Personal locker for storage
4. Potable drinking water, sanitation and running water supply
5. Adequate toilet facilities with at least one toilet and bathing space for 12 persons
6. Bathing and washing area with running water
7. Adequate bathing facilities with running water, water storage cans, buckets and mugs
8. Cooling, ventilation and heating based on climate
9. Standard lighting, including emergency lights
10. Adequate fire protection measures adherent to guidelines for enclosed public places, clear and functional fire exits.
11. Common recreational area with television and reading space
12. First aid supplies to meet individual shelter capacity
13. Pest and mosquito control with fumigation
14. Regular cleaning of blankets, mattresses and sheets, and maintenance of other services
15. Suitable waste management arrangements
16. Open space on ground or terrace with additional spaces based on resident livelihood and storage needs, such as parking rickshaws and carts, or collected waste sacks
17. Kitchen/cooking space and necessary equipment such as cooking gas connections
18. Adequate utensils for cooking and serving
19. Childcare facilities for dependent minor children linked to the urban Integrated Child Development Services (ICDS) centre
20. Psychosocial counselling, treatment linkages and health services including deaddiction services
21. Referral services and transport facilities for health emergencies
22. Facilitation for convergence with other services such as postal address and banking to serve as transaction address, livelihood and vocational skills and other programmes.
23. Linkages with entitlements of social security, food, education and healthcare schemes of government[12]

[12] Refer to *Shelters for Urban Homelessness* "Facilities/amenities at Shelters" pp. 40-42 for detailed listing.

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

The 110-bed emergency care unit/psychiatric nursing home located at Mogappair, the 75-bed inpatient service in Kovalam, Kanchipuram District, and the homeless shelter run collaboratively with the Corporation of Chennai in Santhome, are often the first points of contact with an adaptive mental health care system for homeless individuals experiencing their first psychotic break or episode of distress. These mental health and crisis care teams are sensitive to multi-faceted vulnerabilities such as physical and sexual assault, starvation, severe maggot-ridden wounds, lacerations and injuries, including broken limbs, experienced prior to care. Compounding traumas of neglect, ostracism and chronic ontological insecurity lead to dysregulated emotional and physical health, fear and an inability for individuals to engage others and systems of care. Consequently, individuals are viewed through a public lens of absence: a lack of citizenship, personhood, engagement or potential for good.

It is critical that individuals, especially upon invitation to services, be treated with the upmost concern and respect. Care teams should demonstrate safeness in their body language and patience in order to build trust with clients. Genuineness and empathy are the foundation of positive rapport.

These centers offer a range of services to meet a diversity of client needs including:

1. Street-based outreach services
2. Critical Time Intervention (CTI) and admission to The Banyan's In-patient (IP) services
3. Referral for specialized care that exceeds mental health services (e.g. care for elderly people)
4. Healthcare and nursing services for cooccurring disorders or comorbidities (e.g. skin issues, diabetes, TB and other communicable and non-communicable diseases)
5. Services of a Personal assistant, health coach or an institutional caregiver
6. Psychiatric and pharmacological interventions
7. Psychological and therapeutic services
8. Social care and problem-solving services
9. Case management services to ensure continuity of care
10. Skills development (e.g. social, economic) and vocational training options
11. Employment and job placement services
12. Facilitation of social cooperatives and entrepreneurial opportunities
13. Grievance redressal mechanisms and Legal Aid services
14. Reintegration and Aftercare services
15. Family support and Family therapy services / Recovery Hubs and Family Therapy units
16. Inclusive Living Options for long-term needs (i.e. independent, quasi-institutional and supported)
17. Support group services or peer support facilitation[13]

[13] Adapted from "Emergency Care and Recovery Centres (ECRC) and Homeless Shelter Based Services (HSBS)" of *Structures & Processes Manual,* 2018.

Phases of ECRC and HSBS

Phase 1 - Critical Time Intervention, Harm Reduction, Safety Planning

Stage 1	Rescue call from concerned person/volunteer, NGO or 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 compliance

Phase 2: Welcoming the Client - focus on dignity, support networks and environment

Stage 1	Customized welcome based on time of day and client disposition
Stage 2	Welcome drink, food and other articles 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 and services - information sharing is critical regardless of the mental health status
Stage 4	Overnight kit, grooming services
Stage 5	Daytime walkabout of premises
Stage 6	Icebreaker events per client desire to introduce them to other facility members
Stage 7	Medical care

*Adapted from *Structures & Processes Manual, 2018*

Phase 3: Client engagement towards recovery: self-awareness, grit and resilience training for self-directed care

Stage 1	Personal care education, cultural considerations for service orientation, medical and psychiatric health reviews
Stage 2	Social ecology of mental disorders, biopsychosocial assessments
Stage 3	Self-awareness development - understanding self, family, community, society, support and referral networks
Stage 4	Understanding hierarchy of needs, aspirations and beliefs
Stage 5	Individual care plan formulation - customized mental health solutions with focus on triggers, conflicts, strengths and recovery goals developed collaboratively with client and multidisciplinary team
Stage 6	Psychological and social interventions, and case management
Stage 7	Socioeconomic profile, and aptitude and interest matrix for self-reliance
Stage 8	Vocational and social skills training to improve economic outcomes and increase self-esteem
Stage 9	Assessment of reintegration and aftercare options

*Adapted from *Structures & Processes Manual, 2018*

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

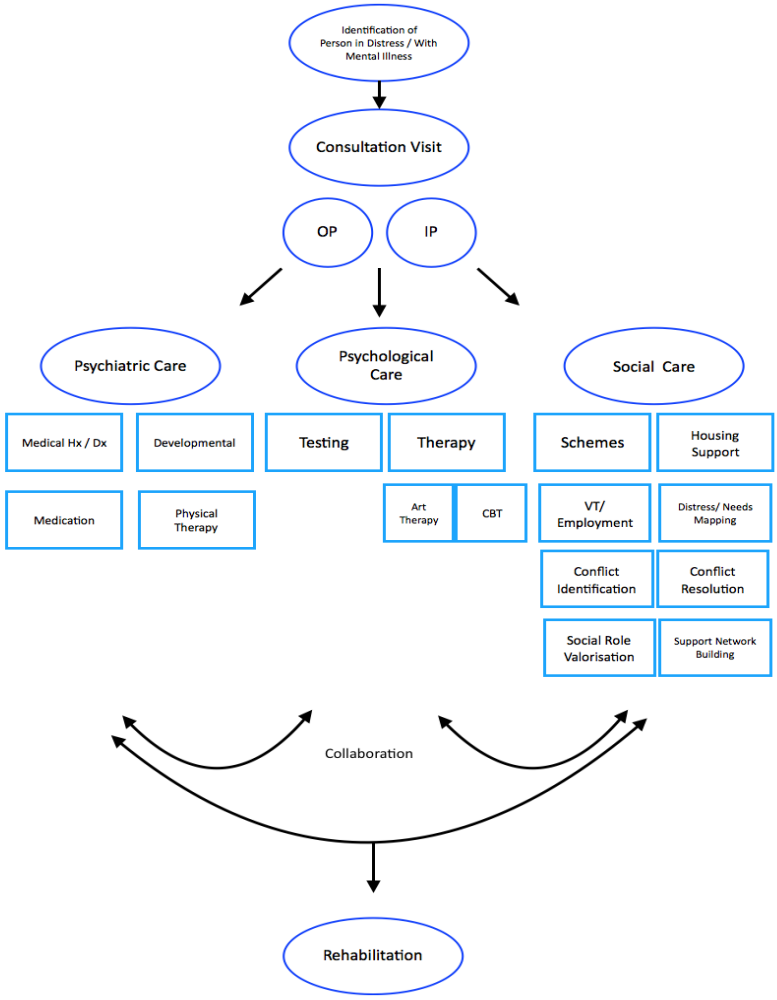
Stage 1	Joint narration of journey thus far
Stage 2	Check boxes in care
Stage 3	Understand preparedness and readiness in all functional domains using Social Functioning scale
Stage 4	Understand and address apprehensions for pre-discharge planning, assessment and understanding
Stage 5	Revisit domains of independence and self-awareness including health management, conflict identification and resolution or management
Stage 6	Build resilience, grit and stress management techniques
Stage 7	Simulate real world environment and challenges in the recovery hubs
Stage 8	Fulfill goals, aspirations, meaning and purpose towards a full life

*Adapted from *Structures & Processes Manual, 2018*

Integrated Care Pathway

Individuals exist at the center of ecological systems and as facilitators of client reintegration (or often, "integration,") into society, shelters are responsible for providing rigorous resilience-building services in conjunction with care that meets their fundamental rights to housing, food, water, safety and protection of health.

In order to eliminate resource barriers that allow clients to thrive, the Banyan endorses an adaptive care tool, the Integrated Care Pathway (ICP), that consolidates and structures facets of holistic health care into a framework that both clients and providers can navigate and understand. The pathway includes: medical, mental health and social health care.



*Integrated Care Pathway (*Structures & Processes* 2018)

Referral and Rescue Procedures

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

Stage -1	**Outcome**	**Process**	**Tracking Progress**	**Human Resources**
Rescue Call	Assess caller information to determine appropriate response	Helpline team prepared with response tools or referral services. Crisis team and intervention kit mobilized, containing necessities such as: 1. Clothes 2. Food articles and fluids (e.g. warm tea or water) 3. First aid kit 4. Blanket/Shawl 5. Information on organisation	Rescue call register	Banyan representative/ team member trained in effective and information sharing
Stage -2	**Outcome**	**Process**	**Tracking Progress**	**Human Resources**
Outreach and crisis support	→ If client found to be experiencing mental distress, offer MH first aid and refer to psychiatric nursing home/mental health facility → If client does not have severe MHI, offer food, clothing and temporary shelter and counselling services	Harm reduction, safety and care planning by assessing nature of 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	Healthcare worker trained in first aid Driver trained in MH work and first aid MH service User trained in outreach work and counselling

*Adapted from *Structures & Processes Manual, 2018*

Stage - 3	Outcome	Process	Tracking Progress	Human Resources
Confidence and Trust-building for effective health seeking pathways Suggested Script: Introduce yourself and ask for their 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 they say “yes,” then ask what form of support they prefer. Based on their response, introduce available services/support: access to safe space and food, brief care with goals of self-reliance, or opportunity to return home if lost or missing from family. 3. If they say “no,” but are not appropriately clothed, in danger of harm or unable to access necessary medication attention, the CM can say the following: “We have a home where you’ll have a place to stay, food to eat, earn money and if you want, seek treatment. Most importantly, 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	Promoting client’s rights to care, dignity and safety. Harm reduction	Establish contact by starting conversation on status of individual well-being and avoid gathering crowds or attention. Offer support and humility from body posture to dialogue of support. Peer user to share personal experience of accessing services and be involved at every point.	Client’s feedback on rescue processes during case management session, grievance cell meeting after week 4 and the user service audit.	MHP MH service user trained in outreach work and counselling General community Tea shops and supporters of homeless persons such as nearby family, auto driver, police, etc.

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, relevant positive outcomes, and their personal narrative and persuasive architecture to encourage the individual to seek treatment. Apply gentle pressure but never resort to physical coercion.				

*Adapted from *Structures & Processes Manual, 2018*

Stage - 4	**Outcome**	**Process**	**Tracking Progress**	**Human Resources**
Community education and interface	Building public trust in the organisation's capability and expertise, and motivating public response to the needs of others experiencing distress or mental illness on the streets by offering water, food, occasional shelter, problem solving and 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 membership	Driver trained in MH work and first aid M Healthcare worker trained in first aid and community relations

Stage -5	Process	Tracking Progress	Human Resources
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 per Mental Health Act of 2017: the individual needs to be assessed by a psychiatrist and a MHP (SW/Psychologist) within the first 72 hours after 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, representation has to be submitted/made to the MHRC, after which an extension will be permitted up to 180 days or more if required.	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

*Adapted from *Structures & Processes Manual, 2018*

Referral Management

Referrals from community stakeholders such as police, NGOs, health facilities or members of the community are one of the primary access points persons with homelessness have to services. It is imperative that staff receive and accept referrals at any time, day or night, and be prepared to obtain the appropriate information and initiate rescue team services in a timely manner. Callers should be advised to remain in the same location as the referred individual until a rescue team arrives in order to support the referred person's psychological safety and access to care.

Details gathered from referral calls are documented in the *Rescue Register.* Helpline responders should obtain the following information:

1. Caller name, contact and address
2. Time of rescue call
3. Location/landmark of client
4. Action taken and time
5. Admission reason
6. Name and contact of police station that issued memo

It is not uncommon for referrals to originate from families requesting assistance to have a family member removed from their care and serviced by the program. Helpline responders and staff should be alert to recurring calls from the same sources, as well as the nature of the calls to determine how to respond or refer the concern based on situational context and the scope of internal program services available.

Identification of Persons with Psychosocial Disabilities

Crisis responders that comprise the rescue team should be trained and skilled in: interpersonal skills to emotionally deescalate persons who are homeless and may be distressed, assessing and prioritizing needs, understanding the scope of services offered by their organisation, and how to link persons who are homeless to an appropriate care provider. Training specifically in mental health first aid is highly recommended to enhance response skills to mental illness and substance use crisis.

It is essential that the immediate needs of persons who are homeless be addressed in a timely manner. Individuals who are experiencing severe physical or psychological distress should be referred for emergency care prior to shelter admission. Persons who may have severe mental illness but not presenting with extreme distress should be considered for shelter services based on the resident profile of a shelter.

Rescue Team and Kit

Rescue team. Rescue teams usually consist of the following staff members: a nurse, healthcare worker and a driver. In addition, the presence of a user trained in outreach and counselling may assist in sharing social and practical support to the referred individual as a credible messenger of information with greater ability to build rapport with persons may be in need of services. Attention should be made to visual cues that will help persons who are homeless feel safe such as size and appearance of the rescue team vehicle, as well as members of the rescue team. Larger vehicles such as ambulances may draw unnecessary attention and adversely intimidate the referred person.

Rescue kit. Individuals who are referred to homeless shelters from the community usually require prompt attention to their physical needs, as well as their sense of safety. Rescue teams travel to crisis calls with kits comprised of the following items:

- Set of clothes
- Organisational information
- First aid kit
- Food such as biscuits or fruits to serve as immediate energy boosters
- Water
- Gloves
- Face mask

Rescue approach. Rescue teams should be sensitive to the compromised emotional, physical and psychological states of persons who are homeless and in anguish. Inappropriate physical contact or communication can have serious consequences leading to further trauma, systemic distrust and deterrence from seeking services. Rescue protocol should be adhered to for positive client engagement.

Police memo. Rescue teams are required to obtain a memo from two police stations – station where client was rescued and the other from a jurisdictional police station. Police memos indicate that the person who is homeless has a mental health issues, resides at a specific location, and is transitioning to a homeless shelter to address their specific needs. The Banyan has found that ensuring the police has documented the rescue helps keep them informed of an individual's whereabouts, ensures that no rights violation has occurred and helps with family reunification if a lead is found through complaints or missing persons registries.

Phase 2 - Welcoming the client

Focus on dignity, enhancing support networks and social architecture

Customized reception based on personal inclination and time of day. 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. Avoid technical terms and use friendly language: "We offer a bed, with crisp, clean, new bedsheets so you can sleep well at least for tonight. When you wake up rested, we can together decide on next steps and 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 tonight. 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 your best interest."
4. Provide basic overnight kit: one set of clothes, soap, powder, earrings for women, bottle of water and a flask of tea or coffee, and bar of chocolate, biscuits or peanut candy, based on preference. Offer GOD's photo if they desire to be placed by their side.
5. Introduce observation room staff by name and vice versa.
6. Enroute to the observation room and after a drink, let the peer counsellor or the MHP point in the direction of the dining hall, gym, television lounge and the prayer space so the client recognizes that rest, care and safety typically are assured (closed spaces could denote nefarious activities and mention of a spiritual space may lend a sense of calm).
7. If the person arrives during the day, grooming can occur after an empathic and private chat with the MH service user, MHP and client in a counselling suite. Be particular about spaces you use. Typical questions 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?" Based on client's response, continue with conversation: "Would you like to have a meal? 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, not communicate and take time to build trust. Regardless, run through these conversations, because our experience indicates that every resident remembers the first few days of interactions which sets the tone for the interventions that follow. Remember that those who enter the premises is unaware of your intentions, is in a strange community of people from diverse backgrounds that can be intimidating to anybody.[14]

[14] Adapted from "Phase 2 – Welcoming the Client" of *Structures & Processes Manual,* 2018

Phase 2 - Welcoming the client

Stage of engagement and observation period (3 - 36 hours)	Outcome	Process	Tracking Progress	Human Resources
First day: 1. Self-care and hygiene: bathing and grooming	Preservation bodily integrity and right to privacy, choice and dignity	Use of private space, to help clean and dress wounds, discard old and soiled clothes, oral hygiene, clean body, private parts and hair with client consent. 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 hair styles to choose from. Have books handy with stars they will identify from various regions. If client explicitly states that he or she does not want a haircut, wait two to three days to ask again. Take them to clothes room to pick three sets of clothes they like, figure styles, culture, colours, etc. Alter clothes as needed.	Rescue register records, Client 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 institution and care team, reduced distress and fear of a strange place. Inclination to remain and seek treatment. Relationships built with roommates,	Joint meal with other clients, and ice breaker events such as self-introductions or intro of best friend (with description of likes/dislikes). Make the environment more welcoming - first in smaller groups in the lounge, common area or terrace. Take client on a walkabout of the center. If admitted at night and 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.	Rescue register records, client testimonials in files, grievance redressal and human rights committee meetings. Ensure feedback is documented in group meetings in case of file and in-service audits	Social worker, nurses, health worker, volunteers
3. Medical care	All physical health concerns addressed and monitored	Check for: lice, maggots, broken bones, skin lesions. Diagnostic blood work to be obtained following morning with indicated purpose of request	C1 form in case file	Nurse/ MH service user

*Adapted from *Structures & Processes Manual, 2018*

Phase 3: Engagement with the client

Client engagement towards recovery: self-awareness, grit and resilience training for self-directed care

Stage 2 Engagement (weeks 2-7)	**Outcome**	**Processes**	**Tracking Progress**	**Human Resources**
Assigning care team Case management Counselling	Creating a life story of distress, loss, meaning and hope - building an identity Understanding challenges and motivations; 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 and other psychiatric and psychological scales, ethnographic observation Preparation of collabourative 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, 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 midterm 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 midterm goals or move on to long term goals. Third month the social functioning scale is introduced to focus on micro aspects across	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	Case manager - Social worker, counselling or clinical psychologist Nurse PA Psychiatrist Psychologist VT Trainers Peer counsellors

Medical care Skills training		domains of self-care, ill health management, home care, socialisation, work and meaningful engagement. 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 - Training offered ranges from healthcare to hospitality, handicrafts production, or federating into social co-ops and initiating social businesses f Physical health rehabilitation - monthly BMI checkups, indicators for anemia, TB, diabetes, skin infections and lesions- so general health improve		

*Adapted from *Structures & Processes Manual, 2018*

Daily Schedule

Visitors to the Shelter for Homeless Men with Psychosocial Needs experience the vibrancy of the residents who can be observed assisting each other with day-to-day personal care, thoughtfully working with skills development trainers in designated areas or preparing to run errands in the community. Fellow community members, volunteers and children often appear at the shelter to engage with residents in social and recreational projects as well.

06:30 – 08:30 a.m.	Brushing and Bathing
08:30 – 09:30 a.m.	Prayer and Breakfast
09:30 a.m. – 01:00 p.m.	Day Care
01:00 – 02:00 p.m.	Lunch
02:00-04:00 p.m.	Day Care
04:00-04:30 p.m.	Housekeeping
05:30 – 06:30 p.m.	Outdoor Activities (i.e. games)
06:30- 07:30 p.m.	Television
08:00 -09:00 p.m.	Dinner
10:00 p.m.	Bedtime

The provision of structure and space to practice skills set development, meaningful relationship-building and autonomy helps residents stabilize, and rebuild a sense of community and purpose. In a supportive shelter environment, residents are seen attending to one another as modeled by shelter staff who are patient and engage all residents with respect in their tone and language. For many residents, the shelter staff and peers feel like family, and the shelter environment feels like home.

Health and Hygiene

Residents entering the shelter have likely been subjected to self-neglect due to a history of unpredictability and lack of resources while homeless. The inability to access routines, including hygiene regimens, can make engaging in regular activities of daily living challenging without assistance. As residents build towards ADL independence, they incrementally learn how to achieve each ADL through modeling and encouragement, and the support of peer residents and the healthcare worker.

Each morning, the healthcare worker assists residents by helping to select colour-coordinated outfits appropriate to the weather, and encouraging prompts for bathing and dressing. Most residents generally require some verbal guidance to complete morning ADLs. A few residents voluntarily assist other residents with their morning ADLs as well. All residents may find shelter-provided toiletries secured in their personal lockers.

Outings

Periodic outings with peers, staff and community members introduce an informal therapeutic experience to shelter residents. Residents are encouraged to visit local sites such as the beach, mosque, church, temple, amusement park and cinema. They celebrate festivals, and sing and dance as well. Group outings allow residents to feel safe and supported while building familiarity and public trust. Residents are also able to practice social skills consistent with reintegration such as greeting or expressing positive non-verbal communication to community members. Participation in outdoor games or physical activity such as walking contributes to many aspects of a resident's well-being by engaging their fine and gross motor skills, creativity and executive functioning.

Skills Development and Vocational Training

Interest-based day care and vocational training options are presented to residents at the beginning of treatment as part of their integrated care plan towards personal recovery. Residents are encouraged to explore each day care option prior to committing to a training of their choice.

Training Modality	**Schedule**
Arts & Crafts	Mondays through Saturdays 9:30am – 1:00pm; 2:00 – 4:00pm
Beads	
Carpentry	
Housekeeping	

Immediate benefits of day care and vocational training include: confidence-building, reduced anxiety through mindful activities, skills acquisition and relationship-building with peers and skills trainers.

Tangible and abstract rewards. Positive financial reinforcements are provided to residents as compensation for the value of their time and investment in skills development. Reinforcements, or rewards, are tailored to be the most valuable and impactful to each resident. Shelter staff are encouraged to use positive affirmation and pubic recognition to honor the achievements of residents and motivate the endeavors of peers.

Employment and Recovery. An array of interest-based vocational training opportunities is available to propel residents into potential employment opportunities and financial independence. Some of the plentiful intrinsic benefits of gainful employment include: **personal recovery**; **distraction from negative thoughts and voices**; **tools to battle feelings of inferiority and internal stigma; agency, security and participation in family and larger society**; **opportunity costs for clients and caregivers alike; social inclusion by shattering stigma and common stereotypes** of persons with mental health issues in the workplace.

There are several barriers to securing employment placements and a high rate of attrition. It is essential to structure training programs customised to client needs, interest-based placements, mutual understanding between client and employer, and consistent resensitisation and follow up with employers (*Structures & Processes,* 2018).

The following suggestions offered by clients, caregivers and case managers may also help meet these challenges:

1. Sufficient training prior to placement in both soft 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. Adequate caregiver orientation to importance of clients' gainful employment to provide additional support when challenges arise and discourage them from dropping out.
5. Options for home-based work and support for independent businesses.

Goals of employment. The Banyan strives to enrich the lives of clients and the community by meeting the following goals towards employment:

1. Make available a wide range of skills training modules for persons with mental health issues and their caregivers.
2. Provide training programmes that will be inclusive, enjoyable, and useful for promotion of individual capabilities.
3. Provide options for home-based work and entrepreneurship opportunities through social cooperatives for clients and caregivers.
4. Facilitate employment placement based on mutual comfort between employer and employee.

Skills and employment training. The following training modules are designed to meet employment goals upon completion: handicrafts such as tailoring, basketmaking, paper bag making, and carpentry; housekeeping, cooking, and laundry; and health and social care including primary care, home care management, case management, project management and peer advocacy.

Salary structure. Productivity-based outputs are categorized broadly into 6 levels with incentives for attending skills training. If a client performs at varying levels during different parts of the month, they will be paid to the level performed for the majority of that month. After 6 months of training, attending 80% of scheduled sessions and achieving Level 3 of work, clients are referred to internal or outside employment.

Calculating Salaries: Level + Attendance + Incentives for extra hours worked

Employment facilitation process.

Step 1: *Employment support kiosks* with placement coordinator and case manager/health care worker to ascertain employment interests and logistical planning

Step 2: *Employer coordination* between employer and team to sensitise employer and client to needs of work arrangement

Step 3: *Follow up* with employer and client to graded degrees by week and then months

Step 4: *Address challenges and attrition* during monthly follow up sessions with healthcare worker and case manger

Step 5: Hold quarterly *job fairs* to sensitise employers, create prospective placements and share success stories

Step 6: Support *social cooperatives* offering support to promote work retention[15]

[15] Adapted from "Skills Development and Vocational Training" of *Structures & Processes Manual*, 2018

Outpatient Clinics

Residents of the shelter access outpatient care at least once per week by a primary care physician and the Urban Primary Health Centre (UPHC) on a monthly basis. Former residents access outpatient primary care and physicians in the community. Physicians typically consult shelter coordinators in-person or by phone to obtain collateral information such as changes to resident behavior that helps evaluate health status. Healthcare workers assist residents in receiving integrated and preventive health care from UPHC as part of the restoration and health optimization of residents.

Street Engagement

Engagement of persons who are homeless with mental health or other disabilities are carried out daily by shelter staff, youth clubs and volunteers within a 3-km radius of the shelter to ensure community access to care. Trust-building requires recurring contact with and often provisions such as food can that serves as a means to inspire homeless persons to share their concerns or needs.

Basic necessities that relieve some physical discomfort such as footwear, clothes and tarpaulins are obtained by funds from the primary budget or supplemental resources from new donors. If individuals require urgent medical care, the team may transport them to a local government hospital with their permission. Persons with mental illness may benefit from information regarding shelter services but it is not uncommon for shelter care to initially be declined. Street engagement teams should continue to communicate and support all individuals found during outreach regardless of their receptivity to the shelter. On a monthly basis, one resident is admitted through street engagement.

Night Shelter

Amenities such as the restroom, shower and meals are normally accessed by informal individual and family shelter consumers. A small number of homeless persons access night shelter and psychiatric services, including former residents with employment who are without housing.

Soup Kitchen

Shelters serving homeless members of their communities require budgetary considerations in order to properly engage their client populations. Between shelter residents and homeless individuals engaged through street outreach, approximately 275 food packets are disseminated per month. The Corporation administers funds to meet bed capacity of the shelter. Meals for an additional 10 – 20 homeless persons are provided daily by other means. As each food packet priced Rs. 20, at least 30,000 rupees are needed to cover the cost of just dinners. Distributors such as Oriental Cuisines have donated to the shelter.

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

Stage of engagement - week 8

Stage of engagement - week 8	**Outcome - towards personal recovery**	**Processes**	**Tracking Progress**	**Human Resources**
Individual reference and support network: reorientation to dominant social ideology and family, cultural and societal ecosystems of return Understanding apprehensions, perceived challenges, expressed emotional needs for confidence building, conflict management, assertiveness skills, 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 fulfilment of purpose	**Social role valorisation -** Understanding details on premorbid life, challenging the client with kindness and cautious optimism. Are they returning home with better understanding of themselves, needs, strengths and insights into their 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 of stressors, ill health patterns and strengths Fostering hope and personal responsibility	Treat the recovery center as they would their home - responsibility to maintain surrounding spaces Timetable designed collaboratively for cooking cleaning, washing, purchasing groceries from nearby store, money management (domains of functionality) Interaction with neighbors, visit to HA, outings with friends, decorating HA biweekly per their preference, teaching a language to PA and other clients and grooming in salons. Sexual health, safe sex practices (real world issues and safety planning) Counselling, Therapies simulating potentially stressful situations, stress management techniques: meditation and collaborative strengths mapping Pre-employment training, money management through bank accounts, spending money on friends, family	Case files Case presentation sessions Grand rounds Chart meetings Scales: mGAF, QoL, BPRS, EPSRS. Employment register HA visit registers Cantril (from stage 2 to now)	The Department of Reintegration will anchor these activities in collabouration with the case manager. The team will also work with other Departments to enhance the ability to maximize client potential and participation. The care team and co- residents are cheerleaders and reinforcers.

*Adapted from *Structures & Processes Manual, 2018*

Reintegration and Aftercare Options

Residents and transitional teams conduct a series of small group meetings to prepare for ongoing care after the Banyan and plans of action to support a restored sense of self. Reintegration and aftercare concepts are delivered to residents and care staff across all personnel at the institutional facility.

Discharge Planning Screenings

1. **Complete file review of all collateral sources who will participate in aftercare. Individually interview collateral sources of residents involved prior to admission** including non-family and police referral sources. Gather information on history prior to hospitalization, feasibility of returning home, known relatives, significant relationships and whom they wish to reconnect with from the past.

2. **Determine prospects for community re-entry through reintegration with family:**
    a. *Clinical (physical and mental health) status:* Level of recovery achieved by the participant. Symptoms, functionality and disability are key components.

    b. *Expressed intent and ethical considerations (self-rated needs, personal preference for future):* Includes age, nature of family relationships, number of dependents, duration of stay at emergency care centre. Young-to-middle aged adults with 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):* Account for practical challenges within prevalent socio-political systems. Access to hospitals and employment, and engagement of caregivers, peer networks and support groups are considered resources along with capacity to manage personal health, plan her life and problem-solve as needed. Domain assesses community resources that promote recovery, and impede relapses or deterioration of mental health. A higher score is given to those who have higher social capital and those with lower social capital are offered greater support.

    d. *Safety planning*: Assesses vulnerability to exploitation in one or more ways. Endorsement of all criteria at discharge may indicate vulnerable in community and requires close engagement to ensure safety. Interviewers are encouraged to use discretion and not be risk averse in evaluating vulnerability. For example, past attempts to die by suicide may not influence current scores if most recent self-harm episodes were negligible.

    e. *Organisational capacity*: Assesses Banyan's capacity to locate family and/or facilitate aftercare post-discharge. Organisational resources can be created based on need.

3. **Open a file for resident once criteria fulfilled**. File in the screening form and additional sheets with sessions.[16]

Pre-discharge: Preparing for Community Reentry

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. **Residents retain skills, build on or acquire new skills for independent living** during the 4-week pre-discharge period. Residents identify anticipated challenges in home environment and prepare for risks.
3. **Week 1:**
    a. Self-care and Activities of Daily Living. Develop home routine(s), structured demonstrations and engagements, determine with client how routines will be fulfilled and sustained in home environment.
    b. Home Management. Cleaning and laundry.
    c. Health. Symptoms awareness and management, awareness of health conditions and impact on mental health, medication management.
4. **Week 2:**
    a. Continue focus, introduce complexity and more independence from week 1.
    b. Home Management. Cooking and shopping.
    c. Economic Transactions. Sessions on understanding denominations; trading, barter, and payments; economic transactions and savings.
    d. Reinforce health-related messages.
5. **Week 3:**
    a. Continue Self-care 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 independently facilitated purchases. Assess level of independence and need for assistance.
    d. Social functioning, sessions and activities. Reorientation and reconnection with family, social roles and norms, and role of self within family. Group activities: initiate and maintain conversation, sources of challenges, interpersonal issues, conflict resolution and boundaries of self and others.
6. **Week 4:**
    a. Sessions on social functioning, adapting to Home environment and coping strategies for anticipated challenges
    b. Revisit planned daily routine(s) and collaboratively plan how to fulfill basic needs and sustain functioning once home.
    c. Revisit important health messages and relationship with medication.

[16] Adapted from *Structures & Processes Manual,* 2018

d. Plan for continued work engagement. Potential employment possibilities to be explored once returned home.[17]
e. Personal safety planning. Recalling location, address, and telephone numbers; orientation to time of day; insight into mode of touch; and escalation in case of sexual harassment; emergency protocols
f. Complete social functioning instrument again at end of Week 4.

7. **Network with police station, local government office or NGO nearest** location indicated by client, and request assistance in identifying and contacting family.

8. **Prepare discharge summary** including:
    a. History of client
    b. Treatment during hospital stay
    c. Client current status
    d. Level of support required by family for community reentry during reintegration with family
    e. Proposed living arrangements and aftercare plan[18]

Reintegration

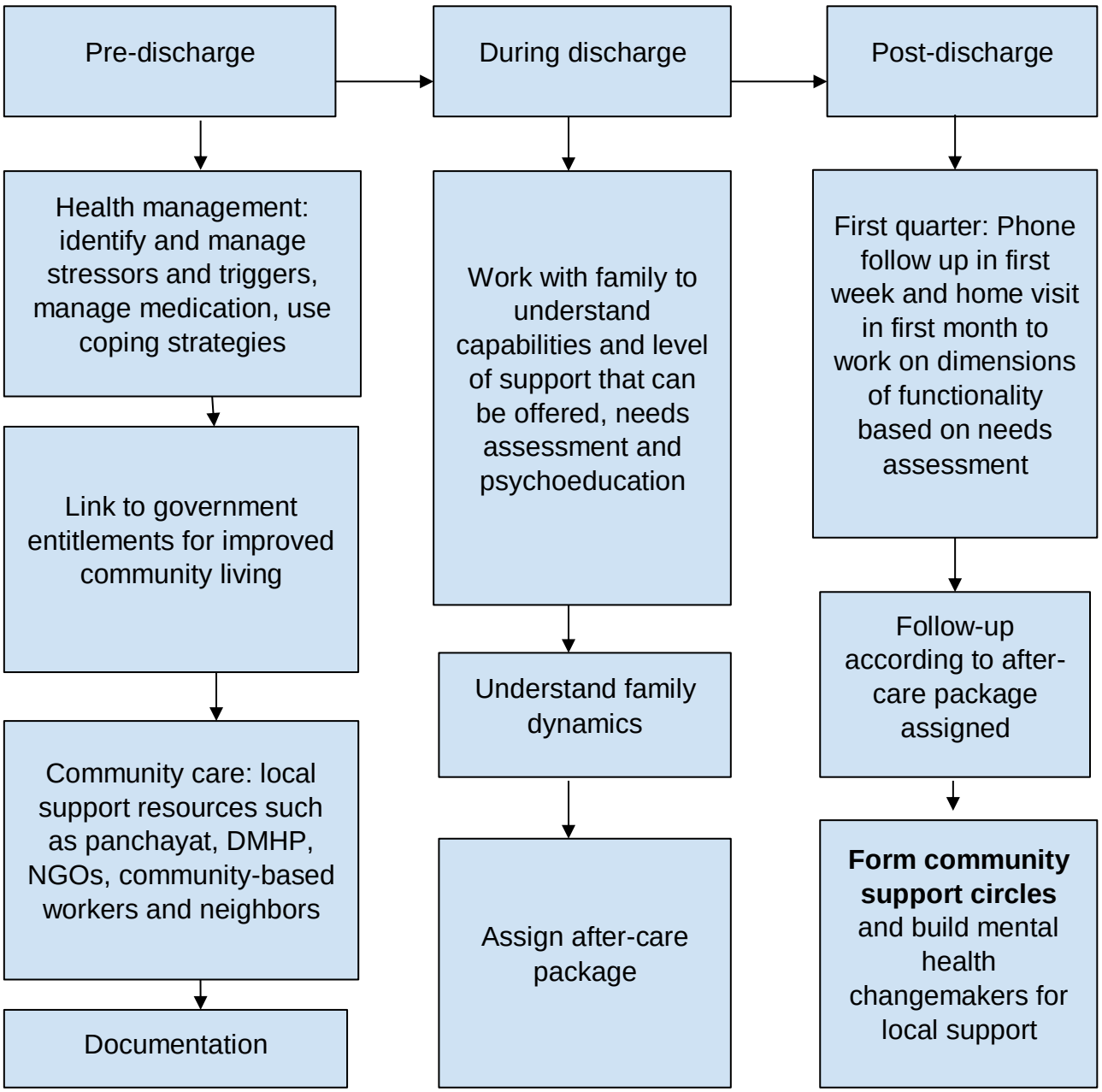
1. Consult with treating psychiatrist and escalate for formal discharge.
2. Facilitate an appointment with resident and discharge committee. Upon approval by discharge committee, request Director authorization for discharge with medication details signed by treating psychiatrist. Facilitate access to government social entitlements such as disability allowance, public distribution system (PDS), employment and housing.
3. Coordinate family visit or plan reintegration trip if not identified.
4. Pack reintegration items: basic assets, money on-hand for client, medication for three months per current recommendation, aftercare kit, consent form for family signature.
5. Educate identified family on resident's illness and status, importance of medication and how to reinforce do's and don'ts.

[17] Adapted from *Structures & Processes Manual,* 2018

[18] Adapted from *Structures & Processes Manual,* 2018

6. Plan service arrangements such as local and postal access to medication and follow-up recommendations. Explain services plan, and terms of escalation. Set recovery expectations.
7. Offer resident history, including homelessness, and treatment only to the extent resident is willing to share with family.
8. Help client identify living arrangements and logistical issues.
9. Assess family preparedness to accept resident and fulfill ongoing care needs in a manner that upholds well-being.
10. Elicit detailed introductions to all household members and identify relationship dynamics with resident.
11. Observe resident in home environment for two days, problem-solve with family and resident for emerging challenges.
12. Identify and gather collateral contacts such as: engaged neighbors, nearest post office and visiting post office personnel, VHN/ANM/ASHA worker, Panchayat/Ward member, and 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 shelter through telephonic feedback on resident status.
13. Escort resident and primary caregiver to nearest facility for psychiatric review and/or medication and introduce them to the health care provider.
14. Upon successful reintegration, obtain treating psychiatrist signature on prepared. Make two copies - one for filing with the institution and one for local project case file.
15. The scores from the pre-discharge screening will feed into aftercare plan.[19]

[19] Adapted from *Structures & Processes Manual,* 2018



*Adapted from "Aftercare" from *Structures & Processes*, 2018

Aftercare Packages

Quarter 1

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

Goal: Self-care & Activities of Daily Living

Weekly phone follow ups for the first month and fortnightly thereafter:

A) Medication intake regularly

B) Adjusting to the new food and understanding how to use new bathrooms

C) Family dynamics and care arrangements

D) Home management: folding clothes, preparing bedding, arranging utensils after washed, sweeping

E) Daily routine: consistency over the 1st quarter

F) Self-care: combing, toilet, bathing, changing clothes

G) Medication side effects education and symptoms monitoring by caregiver

Bonds need to be established between The Banyan and caregiver to help strengthen monitoring and reporting of symptoms and side-effects.

I) Possible photo and video-sharing if caregiver may easily access a smartphone

J) Once a month phone call to address caregiver strain and explore possibilities together to help lessen it

K) Discuss engagement activities with client and caregiver [20]

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

A) Consistency with regular medication
B) Transportation and transactions
C) Role of client within family
D) Home management: complex, cooking, shopping for vegetables
E) Continuing vocational activities if resources available

[20] Adapted from *Structures & Processes Manual,* 2018

F) Harassment assessment: enquire if clients feel safe or threatened at home or neighbourhood
G) Develop coping mechanisms by answering: Are they able to articulate their needs? How do they manage if their needs are not instantly fulfilled?
H) Develop a proactive relationship with caregiver such they can provide follow-ups as needed

Quarter 3

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

Goal: Preferences identification and articulation

A) Money management
B) Daily Routine
C) Discuss socialization with client. Assess and discuss possible improvements.
D) Satisfaction of client: food, self, family members, home environment
E) Elicit preferences by answering: What is their favorite food so far? Are they able to cook it? Who are they closest to in their natural support system?
F) Identify and elicit interests in art/music/food/sports/dance/religion[21]

Quarter 4

Bi-Monthly need-based phone follow up by The Banyan team and bi-monthly visits by NALAM mobiliser

As individuals begin showing improvement, or in some cases deterioration, with community care, assigned packages may change and individuals may receive higher or lower levels of care based on need.

Goal: Sociocultural integration

A) Medication self-administration
B) Are they able to socialize with people outside their immediate family? Have they formed any outside bonds that have lasted over 8 to 9 months?
C) Discuss:
    Employment interests
    Contribution to household
    Personal point-of-view on illness and recovery
D) Discuss need for a supportive home with caregiver[22]

[21] Adapted from *Structures & Processes Manual,* 2018

[22] Adapted from *Structures & Processes Manual,* 2018

Safe client engagement. Along with access to quality care, the safety of residents should be at the forefront of priorities. Staff should be trained to take special precautions in approaching residents with sensitivity to physical space, contact and triggers specific to each resident who have likely experienced extensive maltreatment in the past.

a.) *Aggression by resident* – Shelter staff should understand the needs and behavioral histories of residents to aid in behavioral precautions. For residents presenting with agitation, staff should engage at a distance while standing closest to a doorway or exit. Staff members should be trained on crisis de-escalation. If staff is subjected to aggressive behavior by a client, they are advised to firmly hold the hands of the agitated individual as a countermeasure.

b.) *Running away* – Behaviors that aided the survival of persons subjected to traumas in homelessness may be reappear as they acclimate to safe environments. Therefore, incidences such as running away are not uncommon. Residents should be advised of the consequences of leaving for extended periods of time without notice. Occurrences of jumping over shelter walls into neighboring properties may also lead to unwanted attention, violence and/or arrest.

c.) *Sexual behavior* – Sexuality should be handled by shelter staff as other modes of expression – with guidelines prioritizing personal and residential safety. For numerous reasons, including experiences of sexual abuse or a lack of guidance in socially appropriate behavior, residents may demonstrate maladaptive behaviors. Monthly educational sexual health sessions and exposure to safe sex methods help address concerns of sexual misconduct by providing information residents can use in across settings. Residents engaging in consensual intimacy should be advised to use privacy to respect the comfort of others. Staff and multidisciplinary teams can help promote prosocial sexual behaviors by addressing frequent or public masturbation, or unwanted sexual attention towards others using an empathic approach. Shelter personnel are reminded that rules prohibiting sexual contact with others has been cited as a deterrent to engagement in shelter services.

d.) *Theft* - Residents found to be retrieving the belongings of others without permission should be supported in redirecting maladaptive behaviors, or previous behaviors that aided their survival in a previous context, to new strategies supporting their reintegration into society. Staff that receive a report of lost belongings should first conduct a thorough check of all residents' lockers and persons to validate the loss. Residents found engaging in stealing should receive counselling and reinforcements such as restricted television time. Alternatively, staff determined to be stealing should be addressed by counselling, suspension or dismissal based on the nature and frequency of the violation.

e.) *Suicidality* – Staff should be attentive to changes in resident mood or expression that indicates intent to self-harm. Shelters are encouraged to train staff on how to detect and escalate concerns of suicidality. Residents who may be risks to themselves should be observed continuously.

f.) *Pets* – The therapeutic power of pets, especially dogs, plays an integral role for clients of The Banyan. Dogs are a welcoming source of comfort for residents and help build

accountability on account of residents who oversee walking, bathing and feeding to ensure their well-being.

Pets also demonstrate radical acceptance and positive unconditional regard that mirrors the experience of residents with their multidisciplinary teams.

a.) *Abandonment by family* – Families sometimes become overwhelmed by the needs of their relatives with special needs such as the elderly or children with intellectual and developmental disabilities. As a result, families may become discouraged and leave their relatives at the shelter. Shelter staff may alert the police to assist with tracing families, so they may be engaged and oriented to services that build their confidence in meeting the needs of their loved ones.

b.) *Resident death* – In the unfortunate circumstance of a resident death at the shelter, staff should contact the Corporation and known family members. Residents without families will have their burial proceedings compensated by the corporation. Known family members should be asked to retrieve the body from the premises. Special attention should be paid to other residents who may likely reexperience loss and/or grief for which counselling services should be made available. A treating physician will issue a death certificate and treatment report when a resident dies at a general hospital. Suspicious deaths will result in an autopsy facilitated by the police. Copies of the autopsy reports are submitted to shelter management and corporation.

Internal Reporting Protocol

Residents are highly encouraged to mitigate, defend and/or report any instances of abuse – verbal, physical, or sexual – using readily available mechanisms. On the occasion that abuse is still in progress and staff is unavailable, residents may call for help immediately, as they should in the community. They should also know how to reach case managers by phone or email to report any maltreatment. If, for any reason, a resident is hesitant to report abuse directly, they should have access to "suggestion boxes" posted in a visible area that residents can reach easily.

Similarly, staff that witness maltreatment between residents, colleagues, or residents and staff should alert the designated authorities immediately, so the incident is reviewed and resolved on a case-by-case basis. Collateral information such as CCTV cameras and third-party accounts are used to validate all accounts of an incident.

Incidence of staff aggression towards other staff or resident will likely result in suspension or termination of employment based on the nature and frequency of behavior.

Communication to External Systems

The police should be contacted by staff for issues such as: significant and unmanageable aggression, theft by staff and abandonment of individuals at the shelter by family. Significant concern for resident suicidality may necessitate staff referral to a psychiatric hospital for stabilization prior to returning to the shelter. A healthcare worker should accompany residents for medical and mental health placements to facilitate admission and coordinate care. The Corporation should be notified immediately in writing if a resident dies at the shelter.

Emergency Planning Recommendations

Programs should consider existing resources and assets of their shelters when contingency planning for emergencies, or unplanned crises, that require safely remaining in place or evacuation. Although persons with disabilities are among those most vulnerable to harm during such events, shelter staff will feel more confident in handling a crisis with appropriate planning and practice.

Shelters may want to consider the following when emergency planning for their staff and residents:

- **List all foreseeable disasters prior to contingency planning.** Tailor disaster plans to respond to each event. Some incidences require relocation whereas others necessitate staying in place.
- **Consider relevant staff training and skills.** Consider how staff with specialized skills are distributed when creating staff schedules, especially for anticipated disasters.
- **Maintain a resident register.** Track population numbers including staff-to-resident ratio to plan for accountability checks.
- **Accommodate all abilities in planning.** Communication channels and mobility plans should account for the ambulatory, communication and health needs of all residents and staff.
- **Secure onsite supplies and resources.** Periodically check the functionality of fire extinguishers, first aid kits and smoke detectors. Determine where and how much food and water to store. Consider the feasibility of moving medications for evacuations, and whether individuals will have "go-bags" of clothing and other necessities to take with them.
- **Select wardens.** Determine warden assigned to the same group of people to account for their safety. Groups may be divided by however is most efficient. Successor plan for wardens in case the person is unavailable. Ensure wardens know who to report to and when. Communication should account for power outages.
- **Identify transportation and evacuation options.** Based on location, city layout, resources and safety, mobility as a group may be limited. Determine safe points, where you will go and how if you must leave the premises. Make necessary arrangements for the accommodation to be made in case of emergency.
- **Know local, state and national resources.** Research what resources are available and incorporate into emergency plan. Resources may include online registries for separated families, government assets or disaster response NGOs.
- **Be a resource.** Shelters should prepare to house persons and families who are homeless during and after natural disasters, if feasible. Those who decline care should be provided alternative resources or necessities like food or funds.
- **Attend to the emotional toll of a crisis.** Residents and staff may experience retraumatizing after a significant event. Shelter programs should determine how to best utilize in-house or external supports to help persons recover from such loss and devastation.

- **Practice emergency drills.** With the exception of emergency or crisis personnel, most persons do not respond to emergencies using their best judgement. Regular rehearsal of emergency drills helps programs from top-to-bottom move through steps to build confidence when a real crisis occurs. This is especially important when working with persons with mental, intellectual and developmental disabilities who may find crises most distressful. Disaster response preparation will also empower residents to protect themselves and loved ones after reintegrating into the community.

Client and Staff Power Dynamics

Power dynamics, or the existing authority between persons based on social identities, are typically inherent across all communal settings, regardless of the intent of individuals. Prior to shelter admission, homeless persons become intimately familiar with their positioning in society based on an intersection of factors such as caste, gender and socioeconomic status. They know the experience of being unseen and exploited, and how their status may shift slightly based on their environments.

At the shelter, nuanced interplays of power and privilege can be observed among residents and between groups such as shelter staff and residents. It is important that staff attend to disparate treatment between residents to ensure everyone is treated fairly and feels comfortable. Furthermore, staff should be sensitive to the histories of homeless persons and authority figures. Staff can implement a person-centered approach to disarm residents' distrust of persons in power by being patient, actively listening, being receptive to their needs, and honoring their dignity every day. Power exercised by staff may be experienced by residents as a raised tone of voice, labeling language and directives without explanation.

Group Meetings

Shelters should designate a recurring day and time for residents to gather with staff and share basic grievances regarding their care. In-person platforms are ideal spaces for residents to practice assertive communication, conflict resolution techniques and being seen by others in an inviting space. They also experience their power by seeing change occur as a result of their voices. Shelters should also maintain a human rights committee comprised of community members, the corporation and residents that collectively monitor shelter activities.
Residents of the men's shelter meet on a weekly basis to address organisational issues such as basic amenities or day care and vocational training. The staff also use this venue to disseminate information on shelter developments, and review their services and basic rights. Residents participate in human rights committee meetings at least one to two times per month.

Complaint Process Description

Residents are invited to submit complaints which are to be maintained by the shelter coordinator in a register and resolved within 24 hours in cases of emergencies. Examples include: water, plumbing or electrical issues. Less urgent issues should take no longer than one week to address.

Human Resources

NULM staffing guidelines. NULM recommends that shelters have the following staffing: one (1) full-time manager, three (3) caregivers on eight-hour shifts, one (1) to three (3) coordinators, one (1) social mobilizer and two (2) sanitation staff.

The Banyan found further success by appointing one (1) additional nurse to be trained in basic physiotherapy and vocational training, one (1) healthcare worker for primary care, rescues and reintegration,

Shelter Coordinator Qualifications: Social Worker, Psychologist or Counselor		
Responsibilities	● Rescues/regular resident surveillance ● Case intake ● Monthly to biweekly sessions based on resident needs ● Counselling ● Care referrals ● Reintegration linkage with families, NGOs and police	● Aftercare linkage with families/NGOs of reintegrated residents ● Day care overview with Day Care nurse ● Data entry, Individual Care Plan, discharge summary and referral letters ● Social care ● Legal aid
Human Resources and Administration	● Corporation point of contact ● Staff attendance, leave, conflict resolution, etc. ● Register maintenance	● Stocks maintenance ● Vouchers, bills, expenditure statement for submission to Corporation and other funders ● Staff training calendar maintenance
Reports	● Monthly Corporation reports ● Funders' reports ● Registers overview	
Auxiliary Services	● Links with external stakeholders ● Coordinates street engagement ● Community engagement and awareness	

Nurses Qualifications: Male/female nurse assistants with graduate diploma		
Responsibilities	● Comprehensive evaluation upon admission, lab tests as ordered by general practitioner/psychiatrist ● Monitor vitals (e.g. pulse, BMI, BP, respiratory rate, temperature, etc.). Diabetes, hypertension and chronic illness checks at least weekly	● Administer medications as prescribed. SOS injections used in emergencies per doctor in-charge ● Monitor medication side effects under advisement of psychiatrist ● Weekly training of client personal hygiene and self-care

	● Monitor vitals for acute illness (e.g. fever, diarrhea, vomiting, etc.) and transport to hospital, if urgent	● Daily monitoring of client ADLs and self-care ● Facilitate evening events such as exercise and games
Administration	● Complete shelter rounds beginning and end of duty ● Update rounds register regarding cleanliness of premises, especially kitchen and toilets	● Maintain drug stock of amounts dispense, balance and upcoming expiration ● Procurement of drugs from Corporation to ensure all drugs have a long-expiry. Short expiry drugs should not be accepted.
Reports	● Sick, Hospital, Drug, Injection, Aftercare (twice per day), Health and Mental Health records for each client monthly	
Auxiliary Services	● Update client files for emergencies or change in medication in absence of shelter coordinator	

Security Workers	
Responsibilities	● Ensure long-term clients have written permission from shelter coordinator to exit ● Be able to reason with residents who want to leave the shelter with discretion and kindness ● Assure residents that shelter is safe ● Alert when resident tries to jump or fight ● Check soup kitchen clients are screened for safety, drugs and alcohol
Reports	● In and Out, Asset, Staff Rounds

<table>
<tr><td colspan="3">Residential Nurse-cum-Day Care Coordinator
Qualifications: Male/female nurse assistants with graduate diploma, preference for those with day care and physiotherapy training</td></tr>
<tr><td>Responsibilities</td><td>● Day care scheduling with resident, psychiatrist, duty nurse and case manager
● Customize day care training to meet unique resident needs. Residents with similar needs may be clustered into one group
● Planning and organizing positive reinforcements</td><td>● Potential employer linkages: new job orientation, point of contact for employer
● Monthly phone follow-ups and home visits upon reintegration
● Emergency resident care in absence of duty nurse</td></tr>
<tr><td>Reports</td><td colspan="2">● Day care register, After care register, Soup kitchen register</td></tr>
</table>

<table>
<tr><td colspan="2">Healthcare Workers</td></tr>
<tr><td>Responsibilities</td><td>● Accompany residents during rescue and assist with shaving and bathing, as needed
● Oversee activities of Daily Living (ADL) – brushing and bathing, daily clothes laundering, weekly bedding laundering, adult undergarment assistance
● Accompany and support residents in inpatient or intensive care
● Respond to emergencies
● Mediate conflict
● Monitor side effects and alert nurse
● Day care register, Housekeeping register, Client care register</td></tr>
<tr><td>Reports</td><td>• Day care register, Housekeeping register, Client care register</td></tr>
</table>

Interns and Volunteers Qualifications: Undergraduate or postgraduate nursing, psychology, social work, law and business students, or professionals with relevant work experience	
Responsibilities	● Street outreach ● Client escort to hospital in case of medical emergency and/or review ● Protection of all client information outside of the organisation Activities vary based on volunteer/intern assignment: ● Physical and mental evaluations ● Reintegration assessments and preparation ● Aftercare preparation, including legal considerations ● Vocational training assistance, employment assessments, sales and marketing assistance ● Community mapping and outreach, awareness campaigns, psychoeducation ● Help Desk assistance, eligible welfare scheme enrollment, obtaining identification cards, fundraising and research
Value	● Neutrality, informality to care, positive changes to the lives of residents

Multidisciplinary meetings and trainings. Shelter staff are comprised of a variety of professionals across disciplines of health and social care. They are committed to adapting and developing culturally relevant techniques to enhance their quality of service delivery. Through regularly scheduled interdisciplinary case presentations and skills training, staff are empowered to approach their care with confidence through a multifaceted lens.

Development opportunities. Preselected staff from different projects are encouraged to rotate participation in a monthly meeting to present complex issues arising from client cases. Peer training is also available to case managers once per month.

Although shelter providers draw from branches of existing knowledge, they continue to refine their specialized talents through supervision and subject matter training. Staff also engage in informal cross training through daily interactions. Professionals that more closely identify with the socioeconomic backgrounds of the client population are valuable assets of contextual insight into cultural or community nuances that may be overseen by their colleagues. To promote an environment of professional development, staff should value the knowledge and contributions of all personnel, regardless of their role at the program.

Housekeeping and Maintenance

The orderliness and cleanliness of a shelter residence honors the dignity of the residents receiving shelter care. As self-care is one of the first activities of daily living to regress during setbacks with mental illness, shelter staff should actively foster a neat environment.

Without the pressure to verbally communicate or a meet a performance standard, residents are free to build community by collaborating on housekeeping tasks such as:

- Sweeping
- Mopping
- Table cleaning
- Bathroom cleaning
- Kitchen cleaning
- Dishwashing
- Waste disposal
- Dusting
- Laundering
- Clothes sorting
- Storage room cleaning

Healthcare workers supervise and document cleaning by residents in the housekeeping register. Resident rosters are changed monthly to allow a rotation that conduct maintenance.

Waste Management

Workers from the corporation assist with clearing dustbins every day. Staff should be trained in waste separation to practice proper recycling procedures, and model eco-friendly disposal for one another and residents. Shelters should also hygienically plan syringe disposal procedures.

Expired Medicines

Safe disposal of expired medicines ensures the safety of residents, community members, pets and others that could potentially encounter the medicines. At the men's shelter, all expired medicines are melted down and discarded into the sewage system.

Repairs

The Sanitation Inspector should be alerted by complaint letter on the same day of a discovered maintenance need such as wiring, plumbing fixtures and breakages. Critical repairs like wiring and plumbing need to be addressed within 24 hours per NULM guidelines. To avoid incidental injury, repairs for leaks and breakages should not exceed one week. NGOs may manage the repair using a preapproved corporation budget and file for reimbursement

of costs as needed. Substantial repair requests require a letter be submitted to the Zonal Office and followed up with the NGO, Sanitary Officer and Electrical and Engineering Department. The NGO should accommodate delays in repairs accordingly by actively communicating with the Zonal Office.

Legal Aid

Residents of the shelter may require legal assistance and advocacy on issues such as those related to property disputes. Shelters should know the local network of government-attorneys available to residents or arrange for legal services to be available on-site. Shelters may consider referring their residents to the District Legal Services Authority's District Legal Aid Cell for legal counselling, according to the *Shelters for the Urban Homeless* (2014).

Clients and residents of The Banyan may consult government-attorneys for legal advice on Wednesdays at the Mogappair office.

Police and Magistrate Coordination

Although local NGOs and the police do not have a long history of partnership or collaboration, The Banyan has forged a meaningful relationship with local police as correlative informants and advocates for one another's respective functions. The Banyan strongly recommends communicating with police at the first point of contact with a new admission in order to obtain a police memo that verifies the status of the person. The police have been operative assets in helping shelter staff reconnect residents with families who may be searching for them or aiding in locating missing residents. They have also joined in facilitating resident hospital admissions.

For the social inclusivity of homeless person, The Banyan has worked closely with police and magistrate to infuse law enforcement with a social justice approach towards restoration as opposed to punitive measures that perpetuate homelessness.

Monitoring and Evaluation

Shelter providers committed to disrupting cycles of homelessness approach their care using an empathic social justice framework. Rooted in the work of equal opportunity is the promotion of accountability by society and persons who are homeless. Shelters must model social equity by producing systems of checks and balances through service audits and surprise checks. Organisational accountability not only strengthens the programs ecologically surrounding clients, it allows service providers to feel supported and competent in using effective methods that allows them to see their impact.

Accountability is determined by evaluating care team adherence to individual care plans, whether intended services happened and symptomatic changes as they relate to phase of treatment. Shelter staff can further evaluative efforts by providing detailed written accounts of regular communication with providers and team members, and ensuring staff availability to process shelter admissions for data tracking.

All quality audits during site visits led by managing trustees, the director and senior management will check for the following:

1. **Aesthetics and hygiene** - entrance, and rooms including storage, kitchens corridors, dormitories and restrooms
2. **Dignity and care** – matching clothes, appropriate size, preferred colours, undergarments
3. **Nursing and health care** - oral hygiene, body odor, quality of hair and skin integrity
4. **Personal spaces** – lighting, decor, bedsheets, pillows and pillow covers, cots, lockers, preference list
5. **Accessible critical information** - clearly marked signs in different languages near fire exits, information on The Banyan, grievance redressal options, emergency phone numbers and resident rights and responsibilities list
6. **Resident and staff interactions** - communication with residents on available services such as personalized therapy, clinical team case management session options, support groups, therapeutic communities, employment opportunities, social cooperatives, social entitlements, outings recommendations and designated exits
7. **Documentation** - doctor, case manager, nurse and personal assistant reviews. File reviews will investigate physical health parameters, symptomatology, personal distress, requirements, aspirations and responses from clinical care team.

Surprise checks are also randomly conducted by project heads and managers once a month. Reports are shared with project teams to resolve issues (barring emergencies requiring resolution in 24 hours) within a week. Complex issues that cannot be managed by the shelter team alone, the senior management, director and founder trustees will assist.

Internal Monitoring Mechanisms

Effective program monitoring should utilize a spectrum of data channels from resident feedback to care documentation.

1. **Resident feedback.** Informal individual or counselling sessions with case manager, casual conversation, and groups such as Shelter Management Committee or focus groups.

2. **Security cameras**. CCTV cameras installed in corridors, near entrance, inside office and day care rooms, inside and outside kitchen, near all compound walls and outside

toilets. Shelter coordinators should have access to all images on their computers and phones for remote monitoring.

3. **Suggestion boxes.** Per NULM guidelines, at least two suggestion boxes should be stationed at the shelter. Print contact information of the case manager and sanitary inspector in case of emergencies or if resident prefers to speak with them privately.

4. **Staff meetings.** Weekly staff meetings headed by shelter coordinator to iron out details, resolve conflict and formulate systems for enhanced shelter management.

5. **Shelter Management Committee (grievance cell)**. Case managers and duty nurses should conduct weekly meetings with all clients to receive feedback on shelter services. These meetings are more effective when conducted in an informal fashion - over a meal, tea or outside the shelter. Residents feel more at ease to speak on issues that need immediate attention, including concerns with staff members or other residents. These meetings also serve as icebreakers for new residents.

6. **Rounds**. Daily, weekly and surprise rounds are one of the most effective ways to ensure quality control. Nurses and coordinators should conduct rounds of the entire premise. Nurse rounds should total six (6) rounds and shelter coordinators must complete two (2) per day. Monthly surprise rounds conducted during different hours of the night are also useful in determining shelter responsiveness to unplanned events, or emergencies.

7. **Pharmacy maintenance**. Nurses should maintain a pharmacy register to track dispensed medicines, balance medicine stock and medicines with upcoming expiration dates.

8. **Assets and stocks maintenance**. Nurses should track stock room content with an asset register. The shelter coordinator must monitor the stock room weekly to deter pilferage of clothes, dry rations and toiletries. Residential staff should ensure that all stocks and assets registers are kept up-to-date.

Registers Mandated by National Urban Livelihoods Mission (NULM)

Register	Function	Writer	Reviewer
Shelter Asset Inventory	Updated every 15 days upon new shipment arrival	Shelter staff	Corporation
Attendance	Reviewed morning and evening	Shelter staff	Corporation
Housekeeping & Maintenance	Records daily client housekeeping participation Roster changed monthly to allow full resident participation	Healthcare worker	Corporation, shelter management
Shelter Management Committee Meeting	Records meetings every first Saturday each month	Shelter coordinator	Government
Corporation Medical Camp	Records status of medical medications	Shelter coordinator	Medical team
Accounts Register / Cash	Monitor daily expenditures and bills	Shelter coordinator	Management
Personnel Register with Salary Payment Details		Administrators	

Registers Mandated by Shelter

Register	Function	Writer	Reviewer
Call	Tracks data from incoming calls Database is updated at end of month or beginning of next month. Calls are categorized by rescue, external organisation referral, internal program referral, donations etc.	Shelter staff	Shelter staff, internal research team
Death	Records resident name, file number, cause of death, death certificate and doctor signature	Medical team, shelter management	Corporation, medical and psychiatry
Night Visit	Details date, time, location and activities of visit Notes number of homeless persons identified Follow-up action required Included in governmental quarterly reports	Shelter coordinator	Corporation

Referral	Used to prepare resident for referral to external institution Includes resident name, admission number, age, diagnosis, reasons for referral, referred organisation and closing date or follow-up action	Case manager	Shelter management and aftercare network
Reintegration	Used for resident reintegration Includes resident name, file number, age, diagnosis, admissions date, discharge date; name, relationship and contact of caregiver Notes current medication, medication duration, nature of follow-up and remarks	Aftercare staff	All team members
Master Register	Serves as a resident facesheet for status overview Includes name, age, religion, rescue call details, admission reason, police station for issued memo, admitting staff, date of discharge, caregiver information	Shelter staff	Corporation
NGO Referrals	Tracks aftercare NGOs Team engages and orients NGOs requiring additional monitoring support Aftercare conducts monthly visits to residents referred to Chennai NGOs	Shelter staff, Aftercare team	Shelter management
In and out	Reviewed morning and evening to track resident activity	Shelter staff, clients, security (responsible party)	Shelter management
Medicine Stock		Nurse	Head of pharmacy
Provision Stock	Tracks consumable items such as clothes, dry rations and toiletries	Shelter coordinator	Shelter management
Corporation Visits	Documents governmental visits Government remarks provides written remarks to shelter after visit	Corporation	Shelter management
Left	Tracks unplanned resident departures Staff reports to police and communicate to locate resident	Shelter staff	Shelter management, Corporation

Donation	Captures in-kind donations Used to create quarterly 'thank you' letters to donors	Shelter staff	Administrative unit (Mogappair)
Rescue	Includes rescue details	Shelter staff	Shelter staff, Internal research team
Street Engagement	Tracks outreach information Individuals assigned code for confidentiality	Shelter staff	Corporation
Visitor Feedback	Captures visitor input	Internal/external visitors from Banyan projects	Head of corresponding project
Apollo Medical	Refers to medicines issued by Apollo Hospital	Nurse	Pharmacy head (Mogappair)
Medication/Drug	Includes daily register medication administration schedule	Nurse	Nurse
Soup Kitchen	Tracks evening visitors receiving dinner Register reviewed monthly	Shelter staff	Shelter management
Human Rights Committee	Highlights data from HRC meeting	Human Rights Committee	Shelter management
External Employment	Monitor residents working outside and days they are offsite for employment	Day care coordinator	Shelter management
Staff Rounds	Documents daily rounds conducted for quality control Surprise rounds conducted different times of night to ensure alertness and responsiveness to emergency	Nurse, shelter coordinator	Shelter management
Sick		Nurse	Medical team
Health		Nurse, case manager	Medical team, shelter management

Nurse		Nurse	Medical team, shelter management
Hospital Admissions	Book travels with healthcare worker accompanying resident during admission	Healthcare worker, case manager, medical team, shelter staff	Medical team, shelter management
Lab		Nurse, medical team	Medical team
Hospital Expense		Shelter staff	Shelter management
Medicine Bills		Shelter staff	Shelter management
Monthly Reports		Shelter	M&E, management
Lab		Nurse, medical team	Medical team
After care (soft copy)		After care team	
Vitals		Nurse, medical team	Medical team
Anemia		Nurse, medical team	Medical team
Diabetes		Nurse, medical team	Medical team
Pharmacy	Tracks dispensed medication, balance medicines stock and medications nearing expiration	Nurse, medical team	Medical team
Incentives/Reinforcement	Records incentives and signed by residents upon receipt	Day care coordinator	Shelter management
Staff Movement	Tracks staff arrival and departure times Notes destination of off-site work	Staff shelter	Shelter management
Day Care	Tracks training type, hours worked and level of participation Randomly audited by management for worker compliance	Healthcare worker	Shelter management
Client Care	Resident-to-resident activities of daily living assistance with standing, prompts, guiding	Healthcare worker	Shelter management

Client Files

A resident case file is an effective resource to collocate facets of a resident's care including medical, psychological and social interventions. Shelters should organize client files to best meet the needs of their facility. At the shelter for men, files are arranged into four categories:

a.) Physical assessments
b.) Case manager notes
c.) Lab tests
d.) Scales data

Ideal client files are updated at least once a month by the case manager. Interventions and significant changes should be promptly recorded in the file. Case notes should be clearly written with detail relevant to the individual care plan and safety. Shelters may endorse a documentation format for uniformity and clarity of case notes.

Confidentiality. The Mental Healthcare Act of 2017, Sec. 23(*1*) grants persons with mental illness the right to confidentiality in their healthcare. The bill also provides health care professional guidelines to oversee the protection and release of treatment information. Protection of healthcare information may encourage individuals with mental illness to be receptive to care. Shelters should be mindful of how resident information is stored by hard copy and computer. Shelters should consider strategies for sharing enough information between multidisciplinary personnel to meet treatment needs without disclosing excessive details that may be uncomfortable for the resident. This discretion applies to case reviews as well.

Client files at the shelter are securely stored and, in some registers, assigned codes are used in place of individual names for privacy.

External Monitoring Mechanisms

To eliminate program bias, the shelter also evaluates service provision through external individuals and entities. Governmental bodies play a pivotal role in gathering and evaluating information through visits, records reviews and meetings with residents, staff and community members.

- **Sanitary inspectors and officers.** Verbal feedback collected from residents and staff during weekly visits to the shelter. Visitors maintain a separate rounds register that is inspected by the Zonal Health Officer once a month.
- **Human Rights Committee.** Residents, staff, community members and government representatives meet monthly to gather resident feedback and provide guidance to staff on complex issues such as interpersonal violence, sexual behaviour, reintegration challenges and behaviour management of residents with intellectual and developmental disabilities.
- **State and central government auditors.** Government auditors visit yearly to review bills, vouchers and finances, and ensure records are current and adherent to NULM formatting. They also conduct unannounced quality and social audits at which time interviews are conducted.

Supporting Client Feedback

An essential underpinning of person-centered care is utilizing existing bodies of knowledge to inform best practice with a client population, as well as evaluating the efficacy of services and interventions being delivered. Contextual understanding of persons entering a shelter not only inspires empathy from a conception of their lived experience, it also allows personnel to determine how best to approach homeless persons in a dignified manner that intervenes in the cycle of homelessness. Shelters should take advantage of the growing system of local research findings relevant to those they serve, including risk factors to homelessness such as tribe, caste and socioeconomic status.

Shelters have a special opportunity, or what many may consider an ethical obligation, to contribute to the field of homelessness and mental health by evaluating the quality of their own service provision through internal and external mechanisms. External evaluators enable residents to be interviewed by unbiased parties on their care from food or water to programming.

The shelter for men uses both internal and external forms of information-gathering to collect feedback through periodic sessions with residents. For basic in-house issues such as maintenance, residents are provided immediate updates on their feedback to validate their contribution. The Banyan's Internal Ethnic Committee reviews all research proposals for consideration.

Linking with Other Stakeholders

The holistic needs of persons who are homeless are best served when shelters function with the support of the government and the local community. Residents depend on the competence and positive reinforcement of stakeholders as part of a larger ecosystem that impacts their ability to also thrive outside of the shelter.

While the list below is not exhaustive, it comprises many of the key players that interface with both residents and the shelter on a regular basis:

1. **Corporation of Chennai**. Please refer to *Division of Labour Between Government and NGOs* for role and responsibilities.
2. **Urban Primary Health Centres**. Primary care and periodic psychiatric care.
3. **Government hospitals**. Emergency health care (fractures, dislocations, high temperature, acute infections, ischemic heart disease, cerebrovascular accident, etc.) and outpatient services such as Ophthalmology, Orthopaedics, Otolaryngology, Cardiology, Gastroenterology, Urology, etc.
4. **Rehab Centres**. Referral services are made for inpatient and outpatient substance abuse treatment. Outpatient referrals to psychiatric clinics often require admission for detoxification that cannot be managed at the shelter.
5. **NGOs.** Referrals to old age homes, residential facilities for children and adults with intellectual and developmental disabilities, physical disabilities, shelters for women with or without special needs (e.g. domestic violence, mental illness, pregnancy), palliative

care, etc. Referrals are also made to NGOs for assistance on intelligence quotient (IQ) tests, and other psychological assessments for inpatient and outpatient clients.

6. **Other governmental departments**. Water, electricity, engineering and sanitation.
7. **Police**. Memo for rescues, assistance for admission to mental hospitals, conflict resolution with the community, etc.
8. **Local governing bodies**. Urban Panchayats for permissions related to community activities.
9. **Local community for auxiliary services.** Youth clubs, education support, women's self-help groups and shared housing services.
10. **Shelter.** Other corporation shelters for night visits, surveys and enumeration, street outreach, mental health support, outpatient care, psychological assessment, emergency/disaster responses and sharing of resources when necessary.

Shelters should provide awareness and orientation programs on mental health and shelter services to their community stakeholders. A greater understanding of the client population will aid communication and coordination during rescues, referrals and conflict resolution.

Partnering with External Systems

The potential for organisational growth and impact is heavily interdependent on the same external systems that affect persons who are homeless and/or mentally ill. The Banyan has built and maintained valuable relationships with NGOs and government institutions to enhance the prevention and aftercare phases of persons who are homeless.

Investing in such partnerships has involved an exchange of ideas, collaboration and a streamlining of functions. For example, residents preparing to transition from shelter to long-term care require oversight from the Banyan in ensuring care continues to meet individual care needs upon entering long-term care. Information is shared by phone and in meeting formats where institutions can answer questions and preemptively address concerns. Similarly, meetings with government officials can serve as platforms to exchange supportive ideas. Shelters or programs serving homeless persons should approach the construction of new institutional relationships with patience and persistence as shifting familiar policies and methods of practice takes time.

Financial Planning

Properly operating a shelter without service disruption relies on creative strategies to supplement the annual central government budget of Rs. 1 million, or 10 lakhs, to each shelter. The current budget aims to account for three meals per day and six shelter staff. In consideration of market rate differentials for personnel alone, shelters should consider fundraising alternatives in order to hire and maintain staff. Additional funding is also needed for meals and other operations. Shelters should pay particular attention to financial marketing approaches that engage community stakeholders. Public promotion not only generates awareness around the availability of services to homeless persons, it also builds familiarity and trust in the "brand" of a service provider.

Determining Length of Stay

Related to budgetary constraints is a complex issue of determining resident length of stay while managing discharge ethics: specialized needs versus the number of quality resources available, and proximity to the resident's community of origin, or preferred aftercare location. To best serve residents, shelter providers will need to both find and create resources, and consider service alternatives. Shelters must identify quality care institutions, especially for residents who traveled a great distance from their point of origin, and balance other factors such as whether family is available to assist with service supervision or the quality of oversight the referring shelter is able to provide from a distance. The Banyan works collaboratively with aftercare NGOs to disseminate information on how to best care for clients referred to them. More often, feasible aftercare options are unavailable and shelter providers must ascertain whether extending length of stay best meets the needs of the resident, ethics of the shelter and limitations of the budget. Shelter committed to ethical practice should explore additional resources to assist in accommodating such cases.

Financial Management

The Corporation allocates Rs. 10,10,000 for each homeless shelter per year. To adequately operate the shelter at full capacity, the Banyan fundraises from corporates and individuals to cover costs that exceed the corporation budget.

Corporation budget allocation: Rs 10,10,000 annually

- Three (3) meals per day
- Six (6) shelter staff:
    - One (1) shelter coordinator – Rs. 10,000 monthly salary
    - Three (3) nurses – Rs. 8,000 monthly salary each
    - Two (2) security guards – Rs. 5,000 monthly salary each

Expenses exceeding corporate budget: Rs. 8,76,000 annually

- Lab visits and hospitalization travel – Rs. 2,000 monthly
- Emergency repairs – Rs. 2,000 monthly
- Additional medicine costs – Rs. 10,000 monthly
- Special diet – Rs. 2,000 monthly
- Day care and client reinforcements – Rs. 10,000 monthly
- Administration costs – Rs. 5,000 monthly
- Salary deficit:
    - One (1) shelter coordinator – Rs. 10,000 monthly
    - Three (3) nurses – Rs. 2,000 monthly each
    - One (1) additional nurse – Rs. 12,000 monthly
    - Two (2) security guards – Rs. 3,000 monthly each

As a reminder, NULM recommends shelters have the following staffing: one (1) full-time manager, three (3) caregivers on eight-hour shifts, one (1) to three (3) coordinators, one (1) social mobilizer and two (2) sanitation staff to operate.

Salary considerations:

- Salary should match market rates for male and female nurse assistants, shelter coordinators and security guards
- Three (3) duty nurses working 8-hour shifts inadequate for 30 clients with mental health issues
- One (1) healthcare worker needed for rescue management and activities of daily living assistance
- Market rate for one (1) healthcare worker at least Rs. 8,0000 monthly

Meal considerations:

- Street engagement and outpatient clients access shelter daily (10 – 20 persons)
- Fifty (50) packets of food allocated for street engagement and soup kitchen
- One (1) packet of food costs Rs. 20, an additional Rs. 30,000 needed for only dinner
- The Banyan receives sixty (60) food packets by Oriental Cuisine

Accounting and Billing

Reimbursements for bills submitted to the Corporation may take up to 90 days prior to release. Shelters should account for the delay by creating a financial buffer while awaiting distribution of funds. Shelter staff should provide timely bills to the Corporation using the following guidelines:

- Bills should be maintained by staff for all expenditures, regardless of amount
- Staff should submit all bills to the coordinator on a weekly basis
- Bills should be adjusted to specific line items indicated in budget
- Bills should be submitted to the corporation with an expenditure statement
- The Corporation requires quarterly submission for an amount of Rs. 2,52,000, the quarterly budget limit
- The Corporation releases advance payments quarterly subject to the approval of bills from the previous quarter and a request letter signed by the shelter coordinator
- All bills submitted to the zonal office for approval from the Zonal Health Officer and sent to the Corporation for final approval
- Reimbursement check from Corporation sent to Zonal Office for collection

Fundraising

Shelters need to consider additional funding streams to satisfy increasing costs of salaries, food and operations. Fundraising from corporate and individual sponsors has assisted the Banyan in meeting specialized needs of the shelter population. Community awareness initiatives such as newspaper articles, free advertising, door-to-door campaigns and word of mouth marketing help supplement financial resources. Alternative resources also help subsidize special events and religious festivals.

Managing Funders

Sharing the positive impact of institutional and individual donor investments highlights how contributions to persons who are homeless generates worthwhile results. Outcomes may be shared by reports submitted to funders on either a monthly, quarterly, semiannual or annual basis, along with a grant utilization report.

Periodic reports. Capturing donor attention through periodic reports is as essential as initial engagement. Shelters should illustrate donor interests using quantitative information such as the number of: rescues and reintegrations, residents employed, referrals to other NGOs and total hospitalizations. Such information is maintained by the data collection team.

Donors can also review outcomes through resident testimonials which provide an altruistic benefit of being a part of successful reintegrations, awareness programs and community outings. Such external reports are released by the Banyan on a semiannual and annual basis. The Banyan shares monthly internal reports of resident advancements from a holistic perspective.

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Annexure

THE BANYAN
REGULAR NIGHT VISITS

Date of Visit	Time of Visit	Area of Visit	Details of Activities undertaken during the Visit	Follow up action Required	Number of homeless Identified during Visit

MASTER REGISTER

THE BANYAN - GREATER CHENNAI SHELTER FOR HOMELESS MEN WITH PSYCHOSOCIAL NEEDS
7, DOOMING STREET, SANTHOME, CHENNAI - 600 004.

No.	DATE	FILE NO	RESIDENT PROFILE			RESCUE CALL DETAILS / SOURCE OF RESCUE				REASON FOR ADMISSION	NAME AND CONTACT OF THE POLICE STATION THAT ISSUED MEMO	STAFF INCHARGE	Remarks	PP SIZE PHOTO OF THE CLIENT AT THE TIME OF ADMISSION
			NAME	AGE	RELIGION	NAME, CONTACT & ADDRESS OF CALLER	TIME OF RESCUE CALL	LOCATION / LANDMARK OF CLIENT IN	ACTION TAKEN & TIME					

THE BANYAN

6th Main Road, Mogapair Eri Scheme, Mogapair West, Chennai - 600 037

DEATH REGISTER

DATE	NAME	FILE NO	CAUSE OF DEATH	DEATH CERTIFICATE	DOCTOR'S SIGNATURE

THE BANYAN

REFERRED REGISTER

Inmate Name	Admission Number	Age	Education	Reson for Referred	Referred for (Long Term Care, Institutional Care)	Referring Organization Address	Action taken by Referring Organization	Follow up	Closing Date

THE BANYAN

PHONE CALL REGISTER

DATE	TIME	TO	NAME Prefix included	PH No.	ADDRESS with landmarks

THE BANYAN

PHONE CALL REGISTER

PURPOSE Enq, de, dk, admission, referral, Info-address, cheque, MOTI, Bank Details Payment, follow up, general, A.O personal DETAILS	ACTION ... DATE ... PRIORITY Ch.sl/m,pu-, fu	ENTER reg, boc, follup, moti, ocfrmt de, dk, mms	TAK EN BY	REC BY	O V E R

REINTEGRATION REGISTER

FILE NO	NAME	AGE	DIAGNOSIS	DATE OF ADMISSION	DATE OF DISCHARGE	NAME & RELATIONSHIP OF CARER	ADDRESS OF CARER	CONTACT OF CARER	CURRENT MEDICATION (X DURATION)	NATURE O FOLLOW U