NAYA DAUR

[**STANDARD OPERATING PROCESSES**]

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ISWAR SANKALPA

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Acknowledgments

The author acknowledges the contribution made by the entire team of the Naya Daur team of Iswar Sankalpa who provided time and space to observe their work and provided explanations on how things worked.

The document was reviewed by Iswar Sankalpa. Naya Daur team is doing a splendid job and this document is a tribute to their hard work.

Preface

The genesis of this document is in the idea to replicate the outreach work of Sankalpa to other locations; especially within the community mental health programs. The homeless person with psychosocial disability (person) are a group for who no concrete solution is in sight many experiments are ongoing albeit. Any residential shelter soon runs out of space as the number of people on the streets who require care is larger than the space in shelters available for them. While each person has a start to his / her story and hopefully a suitable end to the tale where he/she spends time in an appropriate place post recovery, the main essence of this document is the interim period. No one knows if each time the perfect story of recovery and reunion of the person will play out, one hopes and prays but it does not always happen as the brutal hammer of reality keeps on telling us day after day. Many person, if not all, would spend a considerable time on the street. How does one take care of them to improve their quality of life; how does one do this without alienating them from the other people they stay in the midst of. How does one keep this work sustainable and create a culture of care in the streets. This is the main essence of the program and its use of community resources, participation by people from the street in taking care of the person, in this sense, it is a new age of care, a Naya Daur!

The intention to involve the public or the community in taking care of the person is paramount to the design of the intervention, a reality which all of us might have to get used to as family ties do not prove to be robust enough to help a person through times when a psychosocial disability comes calling. An experiment on the streets of Kolkata now needs to be replicated in other streets. The purpose of this document is therefore to unbundle the activities and processes that are part of this street based program of Sankalpa.

All those who would like to replicate this experiment are intended audience of the document. This includes funders, implementers, governments and other interested parties. Each intervention hence replicated will be unique and will add to the intervention for homeless person with psychosocial disability on the street, through this a body of knowledge would appear and more such documents would be written; this therefore is just the beginning.

Along with other audience, this document is also to be used as an Induction Manual for the new staff who joins the outreach program therefore you will find that the document addresses this audience directly. Several small messages are included in the

document such as – "give water to drink!" It is in the minor details where the soul of the program rests and the new staff has to first understand the soul; the processes would follow from there. The philosophy of the program is the need to support, treat and care for the homeless person with psychosocial disability in the public, to avoid their isolation; the science in measurement of different things and art in negotiating with the person and involving the community. As Will Durant, famously said *Every science begins as philosophy and ends as art!*

This document was written through observation of the actual program, interview with the staff implementing the program and discussion with some of the person who received the intervention.

The document has been written by an author who is not part of the implementing team. The rationale is to describe the program as it appears to the uninitiated, similar to the intended audience. This document would therefore require supplemental information through actual site visit to see the operation, discussion with the implementers, and constant training and learning. The implementers are all the time doing it, they don't have the time to write, so even after so many years, there is nothing to read and encourage the other to enquire more about such an intervention. This document details out each single process, explained in very simple language, avoiding any jargon or technical term describing "as is" with suggestions for improvement. Fidelity to the ground work is the main intention of the document. It is possible that some of the processes could have changed during the writing of the document since the writing process also provided feedback to the team through several rounds of iteration, even then, this document is closer to anything else you would get to read on the intervention.

There are rich annual reports of Sankalpa, case studies that will add information to this document which you should read to understand the program.

For those who would like organized information, this document tries to introduce a framework to place the piece of work in a neat order. This is not a framework adopted yet by the project, though the author feels it would be sooner than later. It would also help the information to be placed inside an information system currently under development at Sankalpa. The outreach team is comprised of several youngsters who constantly think of the program and continue to add layers of information inside the detailed notes in the files, for the outside public none of it is therefore available. While these are personal records of clients, they provide invaluable insights into experiences

of staff and clients. The knowledge has to be broadcasted to the outer world that is the reason Sankalpa commissioned this document.

In the end, it is in the writing of this novel work that many new insights emerged which perhaps the eye could not find during observation. It is important that more programs get written about to reveal new truths in them than pure implementation ever reveals.

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Introduction

If you have recently joined the Outreach team or are currently working in it, then you know that the project is unique in its ambition and implementation. Perhaps nowhere else or not in many places is there similar work that cares for person with psychosocial disability rendered homeless on the streets of a city with the participation of community resources and in full public view. This is both interesting and a challenging task. At this juncture, you should read and familiarize yourself with the values of this work – what does the organization believe in while starting this work. It will allow you to interpret the processes instead of reading them as to do list or something you have to do being staff.

You should read the Vision, Mission and Values that the organization holds dear. In realizing its vision, Sankalpa has initiated different projects of which "Naya Daur" was the first. You will read about the philosophy of Naya Daur that defines the processes in its work. The "why" these processes are adopted is answered by "how" we want to work. The process embodies the spirit of Naya Daur.

You should be conscious of Quality of intervention and of outcome in your work. Hence indicators that help gauge the result are mentioned in different places. Naya Daur project is an open community project in which the quality is held in eyes of community by the work of the staff; no later packaging or processing is possible. Each staff is holder of quality and therefore minimal supervision is in the design of the project.

In this chapter, you would get familiar with the nature & character of Naya Daur. You would know about its history in brief, underlying philosophy and in details about how the work is and should be executed.

As member of the outreach team you have to perform specific roles and have responsibilities, it is suggested to read the entire chapter since roles of different project members are enmeshed; it is after all a team effort.

Each process has been captured to stand out on its own. You can re-read to assess if you have trained yourself in the process or are only aware of it. Processes specific to Naya Daur are detailed in this chapter but processes common across the organization are mentioned in the "Shared Processes" section of the document to which the reader is referred as and when such processes are encountered.

Naya Daur Framework

Naya Daur framework differs from the UMHP framework since it shows the interplay between the role and contribution of project and community in the care of the homeless person with psychosocial disability. The journey of a homeless person is charted from the first milestone, when he/she gets identified by the project, to the eighth (last) milestone when the once homeless person with psychosocial disability has found a place to stay and a way to support him/herself. This milestone marks the ultimate aim of the project. The framework captures the shift of role and resource contribution from the project to the community / family or the person him/herself.

The project itself is implemented in three phases within which the milestones, roles and resource contribution is located. The phases of the program are:

1. Program Initiation
2. Maintenance and
3. Handover

The framework shows the different role and resources provided by 4 key stake holders in the journey of the client. Since supply of resources change during the project, it is included as an important stake holder in the frame. These 5 key stake holders are:

1. Client
2. Community
3. Volunteer / Care giver
4. Outreach Worker
5. Resource / Supplies

The table below captures the Milestones while the graph below captures the entire framework. In this graph, role of Outreach worker and Volunteer / Care giver is tracked to understand role shift from main to supporting as milestones are achieved. The framework identifies a "Zone of Change" where major role and resource shift happens. The aim of the project is to achieve the zone of change within a set time limit and then move to the right. All clients are located at one milestone or the other. The frame

allows an understanding in the progression stages of a homeless person with psychosocial disability and the efforts being done to further the shift.

Table of milestones		
Phases	Key Term	Brief Description
Phase 1:	Initiation	Starting the program interventions
Milestone 1:	Identify	Identification of the suitable end user*
Milestone 2:	Observe	Keeping the end user under observation
Milestone 3:	Register	Registering the end user as a client of the service
Milestone 4:	Assess & Initiate treatment	The first assessment of the client by mental health team and initiation of the treatment
Phase 2:	Maintenance	Ensuring service provision and utilization by client
Milestone 5:	Regular treatment phase 1	The provision and responsibility of treatment is by the project
Milestone 6:	Regular treatment phase 2	The volunteer or care giver takes responsibility for treatment and accesses government services
Phase 3:	Handover	The treatment, care and support of the client is handed over from the project to the community care giver / family or by the client him/her self
Milestone 7:	Earns for self	The client earns a stable income and supports him/herself
Milestone 8:	Place to stay	The client finds an appropriate, suitable place to stay, could be with family or elsewhere

*:		A suitable end user is a homeless person with psychosocial disability in the project area

Framework Exhibit

	Role / Resource	Role / Resource	Role / Resource	Role / Resource	Role / Resource	Role / Resource	Role / Resource	Role / Resource
Support		Community			ZONE OF CHANGE Caregiver / Community / ORW / Project		ORW / Caregiver / Community / Project	
Main	ORW / Project	ORW / Project	ORW / Project	ORW / Project	ORW / Project / Caregiver / Community		Caregiver / Family / Self	Caregiver / Family / Self
	Milestone 1	Milestone 2	Milestone 3	Milestone 4	Milestone 5	Milestone 6	Milestone 7	Milestone 8
	Identify	Observation	Register	Assess & Initiate Treatment	Regular Treatment Phase 1	Regular Treatment Phase II	Earns for Self	Place to Stay
	Phase 1: Initiation				Phase 2: Maintenance		Phase 3: Handover	

Client Axis

Date of Recording								
Days to Milestone								

1. NAYA DAUR

A Community based service delivery intervention that reaches out to homeless persons with mental illness on the streets

1.1 About Project & Problem Statement

People with psychosocial disability become homeless not because they were indigent; did not have families or home. They are rendered homeless due to untreated or poorly treated disorder. The resultant cognitive dysfunction, loss of touch with reality including memory loss make them wander away from home into distant and alien areas from where they are unable to find their way back. In these unintended destinations, street is their refuge and they remain there alone and untended, wandering further and further away from home, with their physical and mental condition progressively deteriorating. There are men and women, often late adolescent or older. They are of all languages and culture, religion and caste

Each day several men and women come to Kolkata or any other large city of a country, many of who fit the description of a client described above. Treatment of the psychosocial disability, care and support to the person would improve dignity of the person. Resources to provide such service inside custodial institutions are not available or they have poor Human Rights track record. Naya Daur project presents an alternative solution wherein treatment, care and support of the client is provided in the community with their participation including resource contribution

Naya Daur was initiated in June of 2007 in Kolkata, the same year Iswar Sankalpa was registered earlier in March, 2007. This was the first program of Sankalpa.

The client has a psychosocial problem which is both serious and severe; this needs appropriate treatment. In addition, the client also has other needs such as personal safety, physical health, earn a living and perform social roles as expected.

The project strategy is to initiate the treatment, care and support of the client in the community in their full view and then to involve the community in this process and slowly handover the treatment, care and support to the community while keeping oversight and facilitation.

The project team of doctors, counselors and social workers provides care, treatment and rehabilitation support, on the streets itself. Intervention includes identification, negotiation for treatment, services such as providing psychiatric medicine, general healthcare, counseling, nutrition, clothes and hygiene items. During the intervention period, the social workers build a care and support network in the community around the homeless person with psychosocial disability. This network consists of community caregivers, local police, NGOs and CBOs, social welfare department of the Government and government hospitals. For emergencies, critical situations and difficult scenarios, the network provides their mandated service. This process also helps sensitize stakeholders about psychosocial disability and de-stigmatize mental illness.

For clients who would benefit from time away from the street, a Drop-in-Centre provides vocational training & other services that aids rehabilitation of the client. The centre is located within the community and is an open centre.

As the person responds to the treatment and gains functionality, efforts are made towards his rehabilitation. If she/he has a home somewhere, Iswar Sankalpa reunites the family. If this is not possible, community caregivers are motivated to provide a supportive employment to the person. In the past 8 years, Iswar Sankalpa has helped 3,239 homeless (June, 2017) of which intensive services have been provided to 391 persons (June, 2017) with psychosocial disability to live a better life. 91 person have gone home from the outreach program.

1.2 Main clients / beneficiaries of project

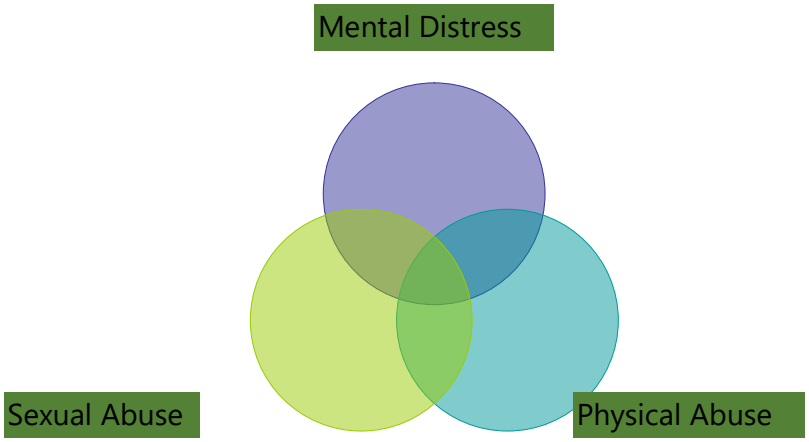
The project is targeted towards person with a serious psychosocial disability who live on the streets of Kolkata city. The clients could be homeless i.e. they stay on streets by themselves or could have a family nearby but spend most of their times aimlessly on streets. Clients include both adult men and women.

The clients live in full view of people and live their lives on street. Only a minority is cause of any nuisance to people but a vast majority is recipient of nuisance from people. Clients are vulnerable to physical, sexual and mental abuse. They harbor unclean wounds and scar that although seen on the body run deep down to the soul. They are emaciated, unclean, and unkempt and move around with their belongings stored either on their own person or in rundown sacks.

They are often isolated, ridiculed and left alone to fend for themselves. A few community members though provide them with several daily needs. The stress and

threat from night is an issue that is difficult for community to respond as well as for clients to report since their illness hampers their ability to comprehend and report information.

They do not have any identity and are deprived of any benefit from health and social justice departments. They sleep in difficult locations such as railway stations, under flyovers, near temples, dargahs and other such places where there is access to food and reasonable safety in night. However, they are considered vagrants and often targeted by police in cleanup drives across city when they are cleaned from streets and sent to distant homes, out of sight.



1.3 Project Philosophy / Principles & Quality Framework

The core philosophy is that community takes responsibility of recovery in homeless people with psychosocial disability. This is a reflection of integration into

community. Therefore, all project activities are conducted in full view of the community; with their participation and with resources available in the community.

The three basic principles are:

1. Ensure **dignity, freedom** & **self-determination** of homeless persons with psychosocial disability;
2. Keep intervention as minimal as necessary
3. Use community resources optimally to support client's recovery.

The program creates 'familial' bonds within the neighborhood with a network of voluntary 'caregivers[1]'. The State, private and community are stitched together into a network of resources that not only cares for this forgotten population, but works towards making them productive members of families and community.

1.4 Project Goal Statement

Rehabilitation of homeless person with psychosocial disability

1.5 Project Objectives

1. Improve physical and mental health of enrolled clients
2. Create a network of community caregivers for enrolled clients
3. Create an enabling environment through linkages with relevant stake holders to reduce stigma, discrimination against person with serious psychosocial disability
4. Facilitate supportive employment for client in community
5. Restoration of client

1.6 Expected Project Outcome

1. Significant reduction in disability of the client
2. Creation of service providers in the community
3. Reduced isolation of the client
4. Increase in self-esteem & functionality of client
5. Increase in demand for mental health services in community
6. Improved awareness on mental illness in community

1.7 Components of the project

The Naya Daur (Outreach) project has two main components:

[1] Iswar Sankalpa, Annual Report 2012-13

1. Care in the community by an outreach team
2. Drop-in-Centers (Rehabilitation Centre)

The outreach team provides its service within certain area boundaries of the city.

1.8 Stakeholders of project

Important stake holders of project are:

1. Clients themselves
2. Community members
3. Opinion makers and gate keepers of the community
4. Local Police
5. Office bearers of local municipal corporation
6. Office bearers of the health, social welfare department
7. Media
8. Other NGOs, CSOs
9. Funders

1.9 Information parameters of project processes or activities

- Clients identified in the field area
- Clients enrolled into program
- Clients negotiated with for intervention;
- Clients provided treatment and care;
- Health status of clients post intervention;
- Addressing other needs (child care, major surgeries, reporting sexual abuse, etc.) of clients
- Community caregivers identified;
- Clients receiving regular treatment from a government facility
- Clients returned to their homes;
- Clients provided supportive employment in community;
- Clients transferred to Sankalpa or any other organization for supervised care;
- Community awareness meetings;
- Medical Camps conducted
- Clients attending DIC

1.10 Challenges of the project

Street raids and Vagrancy home deportation: Clients are unknowingly carted off by street raids by Kolkata police to the city vagrancy homes, where they are left to

suffer indefinitely in anonymity and silence. They do not receive treatment for their psychosocial problem

Missing-in-Action: Clients go missing from their 'home on the street', which is unfortunately a part and parcel of the nature of homelessness, drifting and wandering

Clients living on the street are vulnerable to crimes against them including serious crimes. Community members have boundaries within which they can function, it is therefore a challenge to ensure protection of the client throughout the day and night

1.11 Evaluation / Audit of project

An annual internal audit of the project should be undertaken routinely. The aim of the audit should be to see if objectives are met; strategy as defined by philosophy of the project is intact and process fidelity is maintained.

Results of the audit should be made available to stake holders

Alongside, an annual needs assessment of the clients should be undertaken to understand their needs in the context better and align services accordingly. The above should be done by a team of insiders and outsiders to the organization

1.12 Overall Process Map

See below

IS_Outreach_Processes.pdf

Outreach_LogicModel&ActivitySchedul

2. Component 1: Care in the Community by an Outreach team

Core Processes of Component 1

1. Identification, Observation & Building Rapport with the homeless person with psychosocial disability
2. Negotiation with clients for treatment, care and support
3. Initiate and continue psychiatric assessment and treatment
4. Provide general health care including emergency care
5. Provide Counseling services to the client
6. Provide food, clothes and items for personal hygiene
7. Identify community care givers
8. Build a network (of community care givers, local police, NGOs, CBOs, social welfare department of the Government and government hospitals)
9. Conduct awareness / sensitization meetings on psychosocial disability and de-stigmatize mental illness to build enabling environment
10. Organize Medical Camps primarily for clients but also for community people
11. Facilitate Supportive Employment
12. Restore clients back to an end destination (family or other)

3. Project Phase 1 / Preparation Phase / Identification & Observation

Process Holder: Outreach worker

Needs Change	Good ☺	Standard

3.1 Scope / Overview of the process

This process covers identification of a homeless person with psychosocial disability (universe) in a field area; a period of observation about him / her

TOOLBOX:

1. Definition of a Homeless Person is enclosed in textbox

2. Guidelines to Identify a homeless person with a psychosocial disability is enclosed in textbox

3.2 Policy guiding this process

The process of identification and further on enrolment into services is guided by approval from local Municipal corporation, police and community members to work in the location. Further, identification is guided by past experience of Sankalpa in managing homeless person with psychosocial disability and presence of qualified staff members to treat and support the clients

TOOLBOX:

Introduction of proposed work and self to office bearers should be done formally

3.3 Purpose / Objective of process

The purpose of this process is to be able to identify a client with who the project would work with to make a significant difference in his / her life & to build rapport with the person to allow for further processes

3.4 Result expected from process

At the end of the process, Outreach Field Worker should be able to identify an eligible client & build rapport with him / her

3.5 Criterion / Preconditions in process

The precondition to identification of client is a mapping of areas in city to know where chances of clients being found are higher. Then, field areas are identified. Sanction often oral should be obtained from the local counselor or representative of the ward on the work being initiated

The criterion for distinguishing a client from the universe of homeless person with psychosocial disability is mentioned in text box. The basic determining factor is a member of the universe who is less mobile and therefore found located in the field area most of the time during day and almost always during night during a 15 day period of observation

3.6 Key stakeholders in the process

Key stake holders in this process are:

- Counselor or Representative of the local ward where the field area is located
- Local Police – they do not harass either staff or client when program activities are underway. They also could inform if any drives to clear away the homeless is being planned
- The clients
- Community members who would become partners in the work

3.7 List and Description of Key process:

Key Activity	Main Role	Supporting Role
1. Demarking the field area and Identification of the Universe by transact walk	Outreach Field Worker	Outreach Project Coordinator
2. Observation of the potential clients for a period of 15 days & Rapport Building	Outreach Field Worker	Outreach Project Coordinator
3. Identification and Introduction with Volunteers in field area	Outreach Field Worker	Outreach Project Coordinator &

		Psychiatrist

3.7.1 Demarking the field area and Identification of the Universe by transact walk

1. If a new field area is to be decided then you should search for locations with following features: Rail stations, flyovers with markets nearby, large drain pipes, religious shrines

2. Undertake a transact walk in the potential field area and identify number, age and gender of homeless person

3. Make note of those you think have signs suggestive of a psychosocial disability

4. Repeat the walk each day for 15 days, with at least 4-5 days being at night or late evenings

5. Once you have identified person with signs of psychosocial disability, accompany a senior staff or psychiatrist to confirm if the cases could be designated to have an illness.

In parallel, approach the Councilor of the area and inform him/her of proposed work and its objective. Hand over a letter requesting help in treating homeless person with psychosocial disability. Inform him / her that if they come across a homeless person with psychosocial disability they should refer such a person to you, leave your official mobile number

6. If there are around 8-10 potential clients in the area, then this area is good for a field area

TOOLBOX:

- In Identification form for Homeless person, mark all those with perceived psychosocial problem with a symbol
- Fill the Case intake form at this stage even though the person has not yet become a client. It will allow more information to be captured in one place
- Stakeholder Form: Details of all stakeholders should be captured in a dedicated form with their contact details. This form is called a Stake holder form

3.7.2 Observation of the potential clients for a period of 15 days & Rapport Building

1. For a period of 15 days (this period could be spread over a month) you should visit the field area and observe the homeless person with psychosocial disability. ***Note your observations in a diary for the 15 days or better create a Daily Observation Form***

2. Observe the person from a distance; try to explore local resources for food (local food stalls), water or tea (local tea stalls), local hospitals or anything that is needed for his / her survival in the area.

Remember, homeless person with psychosocial disability who are relatively stable in their movement and are often found in the field area should become beneficiary or clients. People who are very mobile and are not often found in the area have to be approached with caution. Discuss with a senior colleague or Psychiatrist if you come across such a person who you think needs services but is currently highly mobile.

3. After 2 or 3 days, if you are the Outreach field worker, you should approach the client a bit closely, in a non-threatening body language and could offer tea/ biscuit/water or anything for basic need.

The key activities in rapport building process are visit to the client each day by the same Outreach Worker who talks to the client till the point tolerated and secondly providing a food packet. Both these processes endear the outreach worker to the client. The food packet is important because not all clients in all field areas find food easily. Homeless person are in any case malnourished and might not have eaten for several days. Each time a food packet is handed over to client, place a tick mark on Client Form.

4. During this phase, as the outreach worker you should visit the client every day with a mission to start verbal conversation –

"Would you want to have tea/ bidi/biscuit/water"?
"What is your name?"

"How long have you been here?"

You should proceed according to pace and choice of disclosure by the person

5. Pay visit every day consistently.
The identified person should feel that this meeting is desired and important too for the stranger who is visiting without fail

6. Build Rapport with the person by talking to him about what he does during day, what he finds interesting and general chit chat.

"My name is Ashish" - let him know your name, What is your name?

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

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

"I will come again tomorrow, stay here only"

"Namaste!"

If name is informed, then enter in **Case Intake Form** (date, designation). If new name revealed in future, retain old names with date.

Close after informing that you would be coming again tomorrow so that the person should be available to meet you

7. Provide food packet, if the client takes it, make arrangements to give the food packet daily to the potential clients.

Nutritional Status Assessment Form
• Assess Nutritional Status, • Categorize • Plan of action

The food packet is intended for dinner and not for lunch although some may eat it right away. The social worker usually gets lunch (if the client had not already eaten) from a nearby hotel (an identified, fixed hotel) which is later paid by the project. The hotel owner could be one of the volunteer / caregiver. The client is also informed of the hotel and later when the client gets better he himself goes to the hotel to take lunch. The hotel owner keeps an account of the meals and IS pays him from the project.

8. This process of exchange should be continued and slowly clothes, hygiene could be negotiated.

9. Physical health of the potential client –

You should conduct a rapid screening of the client to ensure there is no open wound.

If you find an open wound then treat according to guidelines.

Use your supplies to treat and keep yourself safe by following safety precautions

10. Wound Management is very important and screening for wounds and their management should be done as per guidelines

11. Rapport building is completed when you know some personal details of the client, the person meets you when you tell that you would be coming, receives food packet from you, agrees for hair cut or nail cut, accepts clothes from you

TOOLBOX:

See the pictures below to understand how person with psychosocial disability rendered homeless could appear

Note: Approaching the person is one of the most important actions. Keep the following in mind:

- Do not stand and talk down to the person
- Crouch down or sit to his position; this way you would be able to make eye contact with the homeless person
- Since you would be spending time in this process, better to be as comfortable as possible. GIVE TIME. This is the most critical part of your work

- Always speak gently. The person would be able to distinguish that you are the only person who speaks to him / her gently, does not tease, ridicule

Daily Client Work

Enter daily details of the work you have done with the client. The MIS should calculate number of days spent with client in this phase.

Highly mobile client

The process of rapport building is challenged by a client who roams a lot and does not stay at one place. It therefore becomes difficult to work with such a client.

Note: You should be trained to treat open wounds as per guidelines mentioned in Physical Health Checkup & Management guidelines

In Daily Observation form, add a personal hygiene section. Each day, make note of personal hygiene status of client

Develop Physical Health Check Up & Management Guideline

Develop Physical Health Check Up Form

Note: Rapport Building is also friendship. Since homeless people are lonely and isolated they are eager to make friend

3.7.3 Identification and Introduction with Volunteers in field area

1. During Observation period, you should identify those who are providing tea, food, shelter or enter into any other transaction with the potential client

2. Approach them and introduce yourself.

3. Ask them why they have a transaction with client – "*Tarun dada, You support Bijon, that is very good, why do you do so*?"

4. Once you are convinced that the person has no ill intention and has been in the area for some time then consider making him / her a volunteer

5. You should explain to him what you plan for the person and if he /she thinks it is suitable for the person and challenges likely in this process

6. Request him / her to play a role in the process but by being honest and not adopt any covert practices

Role is to provide medicine to the client along with food / tea or whatever the volunteer provides

Some are convinced while others are not; fearing an untoward outcome like side effects or even death. Allay the anxiety of the volunteer and inform that local councilor, police have been informed of this work. This should allay anxiety of most volunteers.

7. Invite him to a volunteer meeting happening in some other area (Optional) or to meet any other pre-existing volunteer

8. Thank him for his / her involvement

9. Ask him / her for mobile number and leave yours with him / her telling clearly this is official number

10. You should be able to conclude if the person can be a client of the program

11. The location of the person should be marked on a map

TOOLBOX:

Note:

Your introduction to anyone in the community should be consistent and should contain following important messages:

1. Your name
2. You represent Iswar Sankalpa
3. The purpose and work of Sankalpa
4. What you propose to do in the area, what has already been done in the past and is currently working as projects
5. Why it is important to work with the intended clients
6. Change is indeed possible and the essential items for change are treatment, community support
7. Inform risks of taking a person to an institution and treating

HANDOUT – INTRODUCTION with CONTACT DETAILS
Hand out is the best accompaniment in this step

Create a Volunteer Details Form:

Map the volunteer and note his / her contribution in the volunteer section. Form contains:

- contact details of the volunteer;
- Main motivation of the volunteer;
- Location where the person is playing a volunteer;
- role currently performed (food, medicine, or both and
- staff in contact with the volunteer

Taking consent from the volunteer:

Record the consent from the volunteer and mention same in the VOLUNTEER FORM but do not get any signature from the volunteer unless he/she is willing to. This is not mandatory

3.8 Key Conclusion / Decision

Rapport building is completed when you know some personal details of the client, the person meets you when you tell that you would be coming, receives food packet from you, agrees for hair cut or nail cut, accepts clothes from you.

3.9 Information Capture & Tracking the process

An ID should be given to the person at this stage, this ID is a permanent ID and part of a register of homeless person with psychosocial disability

TOOLBOX:

ID for Homeless Person with Psychosocial Disability

Services and material provided should be noted in Service provided forms, Material Request & Material Utilisation forms.

Service & Material Forms

Daily report should be given by Outreach worker

Develop Daily Report Format. It should have two sections – Section 1: Summary of a field area and Section 2: Client wise details of an area

3.10 Internal Check & Balance of process

The Outreach Coordinator should visit the field worker and make at least two contacts with the potential client at this stage

3.11 Evaluation / Audit of process

Reasons for a person not eligible for client should be evaluated on an annual basis by the project team to see if the program has not been able to incorporate large section of potential clients in service net

3.12 Gaps and Suggestions

Staff needs to be trained on physical health checkup

3.13 Training Requirements

Intensive training on physical health

What is the next process?

Negotiation with the potential client to become a client

Homeless Person	See Definition
	
Homeless Person with Psychosocial Disability (Universe)	See Guideline for Identification
	
Client of project (Sample)	See Guideline for Identification

Personal Hygiene - Gender Issue!

Clean person is an important milestone for the project since it improves the chance of getting a job in the local community which is usually with a local shop. The other requirement is ability to follow command. Therefore improvement in these two areas can be seen as success measures of the program. For a male client, use of public taps which are available in each outreach field area are helpful in maintaining personal hygiene, the same is not the case with female clients.

However, improved personal hygiene poses danger to female clients. With treatment and care, homeless women start recovering. Once girls were clean local coolies started harassing them. One woman was brutally raped and killed and this prompted Sankalpa to open the shelter for homeless women with psychosocial disability.

4. Project Phase 1 / Preparation Phase / Assess & Initiate treatment, care and support

Process Holder: Outreach worker

Needs Change	Good ☺	Standard

4.1 Scope / Overview of the process

This scope of this process is to discuss with the potential client and seek his / her agreement to receive the services of the program.

4.2 Policy guiding this process

The policy of informed consent guides this process. Sankalpa provides service to client after informing contents, rationale, opt out clauses

TOOLBOX:

This policy has to be prepared and made part of Induction Manual

4.3 Purpose / Objective of process

The purpose of this process is to establish Trust as a bed rock in therapeutic relationship that is going to be established both in the mind of the client and the service provider. The service provider should also understand that client has a choice and the client should be given a chance to understand what services are going to be offered.

4.4 Result expected from process

The person should understand that he / she has a choice and should be able to express same either spoken or written or by gestures. The expected result is not to obtain a Yes to being a client

4.5 Criterion / Preconditions in process

The precondition is that Rapport should have been established before this process is initiated

The activities are undertaken at the speed of response of the person and not at any pre-determined speed

4.6 Operational definitions of key stakeholders / events / activities or terms used in the process

Negotiation

Capacity

Consent

The process means that personal hygiene, clothes, food packet is provided as part of care and support.

Treatment refers to initial assessment by Psychiatrist

4.7 List and description of Key processes

Key Activity	Main Role	Supporting Role
1. Negotiating for Personal Hygiene, Clothes	Outreach Field Worker	
2. Negotiating for Doctor's treatment	Outreach Field Worker	
3. Assessment by the Doctor	Outreach Field Worker	Outreach Project Coordinator & Psychiatrist
4. Negotiation for Medicines	Outreach Field Worker	

4.7.1 Negotiating for Personal Hygiene, Clothes

1. After Trust has been built and person is accepting food packet or accepting meeting with the outreach field worker, you should softly suggest to the client to wash hands before eating.
Provide soap and water if acceptable, or given soap and ask to go to nearby water facility to complete hand washing

2. If the above is accepted, then you should proceed after a few days to ask about bathing - where the person takes bath, is there an accessible location? Does he / she worry about safety of belongings during bath?

As part of resource mapping of the area, you should identify public taps or ask volunteers for same. Accompany the person to the location and give soap to enable him take bath

3. If a medical camp is organized then request person to come and take a bath else

Dates:

Record dates of each transaction (food packet, clothes). They count number of contacts and therefore effort

provide soap and a pair of clothes, if person agrees. Male person can also be offered to come to DIC for a bath in the camp, you should assist the person to take a bath

unlike bathing in community. This assisted bathing has an advantage it cleaning person thoroughly. Fresh clothes are provided and then food is served.

4. You should offer to the person to cut nails, shave beard, crop hairs at a local barber shop.

Identify a local barber shop, inform him of requirements and that he would be paid for services.

You should accompany the client and supervise the cutting.

Pay the barber there and then.

Do the same for nail clipping & shaving.

In an area, prefer to have a single or maximum two barbers. They would then get used to the project work. Many barbers charge more than their regular charges, bear with that

5. If person agrees, take him / her for personal hygiene measures.

6. In this process, if you see a wound or a medical condition, then treat it as per guidelines

7. Offer fresh pair of clothes. Suggest alternatives for washing – Advice the person to wash clothes he / she is wearing. Suggest that DIC is a safe place where washing can be done; use help of volunteer to suggest a place in field area where clothes can be washed. Leave it to person to accept or decline advice

8. Show him / her a mirror before and after the personal grooming

9. Take a photograph before and after and share it with the person, keep softcopy for records after informing person that you would be doing so

10. Record in the file on consent for personal hygiene that person has agreed to personal hygiene and then activities that were done

11. If the person consents, provide him / her with client ID

Client ID and a file is opened

TOOLBOX:

Consent form section in Client file should be available

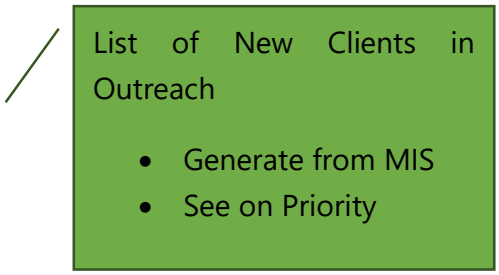
4.7.2 Negotiating for Doctor's treatment

1. Inform the client that he / she should get consultation from a doctor since he / she has been staying on street for a long time and a doctor could help him / her

2. Tell the client that it is not going to cost anything and it would be for his / her benefit. The doctor is going to visit the location or someplace nearby.

3. If client agrees, then arrange for doctor consult within 15 days. Inform the client when the doctor will come and see and ensure that the client is there on the day. This means visit the field well in advance of the doctor visit and ensure client's presence. Inform the volunteer as well of the doctor visit and to ensure client is present. This could be a challenging task. Clients could agree to see the doctor just because you are saying so while internally they might not be convinced. Talk to them repeatedly to let them know what will happen in the doctor examination

Enter consent to treatment in the suitable location in file along with date of consent



4. If client does not agree, then try again later, and if persistently refuses, then respect the decision

Enter Client File ID in the Psychiatrist appointment sheet mentioning - NEW CLIENT

5. Doctor's assessment also includes assessment of physical checkup
If after your screening, the client has some physical ailment, then take him / her for physical checkup and treatment
This should be done from a government hospital or ask the psychiatrist to review the person when mental health assessment is done

6. Ensure that assessment is done within 15 days

4.7.3 Assessment by the Doctor

1. Psychiatrist will see clients as per appointment schedule

Appointment schedule to be managed by Outreach Coordinator for each field area

2. **Priority** is given to New Clients and those in a bad condition

3. Inform Volunteer identified for the client that doctor is going to come and if you have time why don't you join. This would act as proof that doctor checkup has been done to the volunteer.

4. Initial clinical impression should be made on assessing the client; a diagnosis may not be required at this stage

TOOLBOX:

Initial / First Clinical Impression Form

The Psychiatrist should ensure that 15 day observation period has been completed for the client, this is mandatory

The doctor should examine the client with following guidelines in mind:

1. Oral history is taken while being seated or standing comfortably in close proximity to the client. Since the doctor has come the first time to meet the person, this is a crucial meeting
2. Measurement of Blood Pressure, Weight should be done as shown below
3. The doctor then should inform client of his observation and tell him/her what has been planned and should request his / her consent and explain rationale for treatment

Consent Form
Note consent in consent form. Remember repeated consent needs to be taken so consent form should always have date and reason for consent

5. Any scales to be done at baseline should be done at this stage

6. The doctor would note his / her observation in the file and a prescription would be prepared

7. Treatment is charted out for the first phase
Choice of medicines is governed by expert choice but also availability in inventory

8. Plan of who will give medicine is to be mentioned in the file

9. During the initial few days, the outreach field worker should give the medicine

10. During this activity, a volunteer should be identified who has the best chance of providing medicine to the client

11. The outreach field worker should approach the volunteer and discuss with him/her role of providing medicine in case he / she is unable to come

12. It should be clarified that primary role of giving medicine is of the Outreach worker and that volunteer has been requested to fill in during absence. This is essential for medicine to have an effect

13. If the volunteer agrees to give medicines, then hand over the quantity of medicines that suffice for the days when outreach worker would not be available. Record date of this event in the client case file

14. The psychiatrist would do a **Physical Health Screen** including examination of the client. Findings are recorded in the Case Intake Form

Include Physical health condition in the intake form

15. If there are many clients for review, then all can be mobilized to one spot, else for a new client or a skeptic client, consultation might be provided at location of the client. The number of clients to be seen on a field trip should be a maximum of 15 in half day

16. Transport services should be ensured for the travel to field

TOOLBOX:

Note about Baseline scales sheet:

Remember Scales as selected are taken at Entry (Baseline), regularly during care (could be quarterly) and at the point of discharge or restoration (End line). Scales serve purpose of tracking progress of clients and also better insight into their condition.

Note with regards to providing medicine to client:

- The field worker should be trained on the essential steps in starting a medicine The medicine is given in once-a-day dosage to all clients
- Medicines are given ether by the social worker or care giver directly to the Clients.
- Clients know that they would receive medicine although they do not know the medicine name and are unlikely to be able to buy on their own.
- Even for recovered clients, their dependence on care giver or staff for medicine is established.
- Note the primary provider of medicine in Case file of client
- The Outreach worker should be trained on the initial effects of medicine
- Similarly, training on most common side effects and adverse effects of medicines should also be informed to the Outreach worker

To cover these points, it is recommended that a manual for outreach worker is created including these points. One section in this manual for outreach worker may be called "Psychotropic Medicines in Outreach - Essential Learnings"

Note with regards to Insight in client:

Currently, there are no clear processes to build insight in clients to take some more responsibility of treatment. In many cases, Clients care of their own selves but in such cases treatment adherence might suffer since dependence on medicine delivery continues

4.7.4 Negotiation for Medicines

1. Medicines should be given as per prescription of the doctor only

2. From the prescription, the Outreach worker should copy details onto an Individual Client Medicine requirement form (Currently called Medicine Requisition Form, S.No.12). For each client, a form should be available at generation of a prescription i.e. monthly once. Even if the client is repeated the same treatment, the form should be generated. The prescription should be scanned to the Electronic case record or kept in the file.

All clients in a particular field area should be collected together and the supply handed over by the Pharmacy in-charge to the outreach worker against tally and signature. The Weekly Medicine Requisition Sheet (Currently S.No.18) should be auto generated from the MIS entry of each client for the field area they belong to. The current format which states demand for each medicine should be retained for its ease of operation.

This weekly requirement should be approved by the Project Coordinator. The MIS therefore needs to incorporate in its Process Flows, an approval for Project Coordinator for individual, field area and overall project weekly medicine requirement that is then submitted to Pharmacy in-charge.

Each project should have its pharmacy budget and estimated requirement of different medicine based on past experience. E.g. In field area 1, the overall budget could be Rs. 1000/- for weekly medicines of all clients. If this limit is exceeded or left unspent beyond comfort limits, then MIS should warn / intimate the project coordinator. Same set up for the medicines being used, e.g. if Amisulpride 100 mg is set at usage limit of 10 tablets for the field area for a week, and the demand is raised for 15 tablets, then the project coordinator should be intimated and only after his/ her approval on the variance should the demand be sent to the Pharmacy in-charge. To set up such guidance or estimates, previous 6 month experience should be used. Over time enough experience would be build up to set more realistic limits.

On presentation of Weekly Medicine Requisition Sheet approved by the Project Coordinator, pharmacy in-charge should indent medicines to the Outreach field worker. Pharmacy in-charge should check on the MIS that all clients enrolled in the field area have the prescription copied in the module. She should then check the box for each client to who the medicine has been indented. If for any reason, medicine is not indented to a client, then this box should not be tick marked and MIS would show the clients who have not received the medicines from the inventory. If the medicines are received from a source other than the project, information would be brought by the Outreach worker and shared with the Pharmacy in-charge who would then record this observation. The MIS therefore needs to identify source of medicines for each client against each medicine as shown below:

Medicines for Week: Week 49 / FY 2014-15

Field Area 1 / Client ID: 2015/ND/098

Date: March 1, 2017

Medicine 1: Supplied: Yes; Source: Project

Medicine 2: Supplied: Yes; Source: Government Hospital

Medicine 3: Supplied: No; Reason: Not available

As the Pharmacist or person in-charge of dispensing medicines, you should issue medicines to the client file and hand over supplies to the Outreach project worker. For convenience medicines could be pooled and handed over. This should be recorded in the Weekly Medicine Disbursement Sheet (Currently S.No. 17). The consumption can also be recorded in the space provided in this sheet. As for any material, receipt is matched physically and signatures received at every exchange.

3. During the introduction of the medicine, the outreach worker has to be trained on what to expect when a medicine as prescribed is introduced into the body of the client. At this stage, note the consent (in the consent form) of the client for receiving medicines

4. As the Outreach worker you should discuss with doctor's advice with the client and if medicines are prescribed then discuss pros and cons of medicine.

You should mention that it is advisable that client starts medicines with your support (and If a volunteer has been identified, with his / her support as well). You should inform the client and the volunteer that initially you would give medicine daily to the client. In case you are unable to come for any reason, please convey who in your absence would give medicine to the client. Preferably, this should be the volunteer. If the client is ok with this arrangement, note this consent in the form. Remember, when you initiate medicines, ensure that client recognizes the physical form of the medicine – round tablet in blue colour; white tablets like a button of your shirt. This precaution to prevent anyone else giving something else to the client posing as medicine.
If your client does not agree to take medicine for any reason, negotiate with him / her. Ask and discuss her apprehensions. Note them in the **Client Medicine Refusal Form or Consent Form**. Record date of refusal and reason. If you are unaware how to answer then go back and discuss with colleagues, then give a suitable response to the client. Build trust, counsel the client and continue for one week, if the client does not agree even after one week of negotiation, then call in the counselor and the psychiatrist, if the client still refuses, then note that Client has not given consent to medicine hence

not started. You could also refer the client to a medical camp and see if other colleagues could discuss the medicine issue, but do not force medicines on the client.

5. After consent, the first dose should be given (Consent Form, **See Annexure 2)**

6. Routinely thereafter medicine should be given

7. Preferably start medicine on a Monday so that at least for 5 days medicine is given by the Outreach worker to client

8. If there is any problem, contact the doctor

9. Inform the volunteer that medicine has been started and ensure that he / she is nearby when medicine is given for direct observation

10. 2 processes are critical in treatment adherence and should be kept in mind:

1. Fixed Outreach Worker
2. Medicines under Direct Observation (initial period)

Fixed Outreach Worker

As an Outreach worker working for some time in the same field area, you should have developed good rapport with clients& community. Since you had started giving medicines, there would be a few clients who would only receive medicines from you (they don't trust anyone else) and no one else.

It is therefore crucial for you as the outreach worker to work in the project for sufficient period of time to build rapport. This is a tough job but rewards are good. If you face any problem discuss with your superiors.

Directly Observed Dispensing

You, as outreach worker should give medicine to the client yourself. This process is required for wellbeing of client and ensures consumption of medicine.

Not all clients need to be on Direct Observation. Mark clients in the Client Form those are under Direct Observation

Clients could take medicine in hand and then forget to take it, to avoid such and similar situations you should ensure direct observation. You should advice the caregiver to

follow similar practice. After some time, you would know which clients take medicine honestly and others who are fussy so be discretionary towards direct observation accordingly. Steps are mentioned below

11. You should take medicine out of its blister packing. Place medicine in mouth of client

12. Provide water to drink

13. Ensure that medicine has been swallowed

14. Inform volunteer that it is necessary to ensure that medicine is swallowed

15. In case the volunteer is unable to provide medicine, ask him / her to inform you

16. When you go back to field after a period of absence, enquire from volunteer if the medicine was given, check the medicines you gave and count them for consumption. Record this in the Weekly Medicine Disbursement Sheet (S. No 17)

17. Ask the client separately if the medicine was given

18. Ensuring that the medicines were taken is important. Record this outcome in the client form – volunteer successfully give medicine to client in absence of the outreach worker

19. Add the client to list of those on **regular medicine** and ensure supply from

Pharmacy

You have now achieved **Milestone 5** for the client.

TOOLBOX:

Note regarding conditions that affect treatment continuity:

1. At times, clients leave the field area and disappear for varying lengths of time. This is usually during their recovery phase and seldom amongst the recovered clients. This disappearance interrupts treatment which has to be restarted on their return. The reasons for disappearance are usually the following:
    a. Client takes a train ride and goes away somewhere and returns back after some time;
    b. During major festivals, visits of important person the Vagrancy Department or the Railway Protection Force (in Sealdah station) conducts raid and takes people on the street away. At times, people hide or reduce their activity if they have witnessed a raid.
2. Substance abuse: Clients who has started to consume substances become irregular with their treatment. This specifically poses a difficult challenge for the program. The services for de-addiction are available in government hospital to which the government psychiatrist could refer and admit the client, but getting back on the street the client is likely to fall into the trap again. The caregiver is requested to keep an eye out on the client for any such habit.

Note on information related to medicine inventory:

- Individual client wise demand,
- Aggregate demand for one field area of the outreach worker,
- Indent for medicines from Pharmacy against demand
- Receipt of medicines from Pharmacy against demand and issue slip

Note regarding Consent from the client to take medicines:

The consent from the client should be noted in a Consent Form

At the end of each month:

- Identify all such clients who have not provided consent & strategies to take care of them should be discussed

Note regarding regularity on medicine:

CLIENT ON REGULAR medicine is an important observation which should be captured. Criterion for what is regular medication should be arrived internally but if the client is taking ¾ of months' supply then that could be regular. If the clients is on several medicines, then core medicines should be the yardstick for the criterion.

✓Use a checklist to perform essential actions:

Did you receive medicine during my absence?

Count:

Medicines with care giver & medicine handed to care giver by you.

Tally consumption

4.8 Key Conclusion / Decision

1. Decision is made if the person becomes Client of project

This is a milestone in journey of a client (1st Step)

2. Consent for different services of the project is taken or refused

3. Treatment (Initial) is planned out for the client. This should be recorded in the Individual Care Plan as the First treatment plan.

All subsequent changes are recorded in similar format

4. Volunteer is identified who would be part of medical management

5. Material supplies for the person have to be now ensured on regular basis

4.9 Information Capture & Tracking the process

1. Client ID to be given to the New Client (**UNIQUE ID**)
2. Appointment diary of the Psychiatrist to be managed to allow for New client examination
3. Consent form or box to be created in file and suitably recorded
4. Volunteer ID to be given to the Volunteer who agreed to be part of Medical management
5. A new client added to demand list of medicine requirement

REMEMBER: Medicines are issued against a client, therefore a client ID should be given to the pharmacy for them to release medicines

6. Risk Stratification of Clients should be done (Optional)

7. Progress of each of the dimension is marked on the MIS

4.10 Internal Check & Balance of process

Outreach Coordinator should ensure that New client gets priority and is seen within 15 days of their consent to Doctor assessment

Outreach Coordinator should ensure that clients complete their 15 day observation period before being taken up for Psychiatric assessment

New Client is added to Drug Distribution list only after a prescription is issued.

A doctor's prescription unlocks the ability to issues medicine for the client by pharmacy. The unlocking can be done only against scanned prescription by Outreach coordinator. MIS should link with pharmacy inventory to see that these checks are not bypassed

4.11 Evaluation / Audit of process

Consent should be seen by Project Director

4.12 Gaps and Suggestions

Staff needs to be trained on physical health checkup

4.13 Training Requirements

Outreach worker should be trained on Outreach worker Manual

TOOLBOX:

Outreach worker manual

What is the next process?

Regular Service to Client

5. Project Phase 2 / Project Maintenance / Regular treatment phase 1 & 2

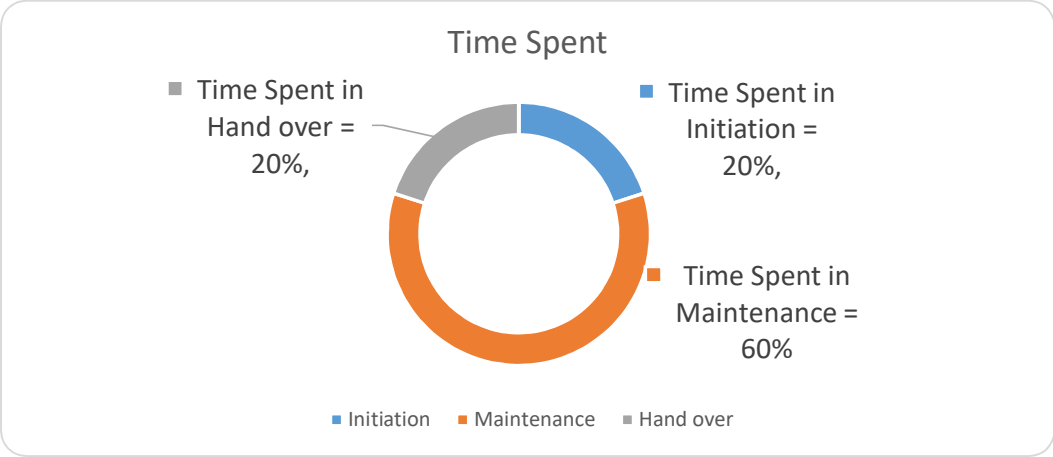
Process Holder: Outreach Project Coordinator

Needs Change	Good ☺	Standard

5.1 Scope / Overview of the process

This process is core of the Outreach service. It describes services to registered clients provided on a regular, day to day basis; activities involved in maintaining regularity in service provision and acceptance at client level. This process marks the shift of the client from **Initiation phase to Maintenance Phase**. The bulk of time of all outreach staff is involved in this process.

The backbone of service provision for a chronic problem is facing challenges and solving them on a day to day basis. The principles of outreach are to be kept in mind



and community resources have to be used while making client independent. Along

with the Outreach field worker, the Community Care giver becomes an important pivot in the program.

5.2 Policy guiding this process

Currently, there is no policy governing this process. A policy is required to guide servicing clients beyond three years or those who have not found a place for restoration or the caregiver is not available

5.3 Purpose / Objective of process

The objective of this process is to reduce the symptoms; improve functioning of the client by providing treatment, care and support package for an optimum duration, regularly. The second objective is to make the Care giver a part of the recovery process and take over as the main anchor for the client (Milestone 6).

5.4 Result expected from process

The client improves in their symptoms, functioning as a result of this process. They also recall significant details about their past which helps in their restoration with family or understanding their condition better. They become amenable for support services like employment.

During this process, an attempt is made to make Caregiver the main anchor for the client and achieve **Zone of Change** which is when the Caregiver takes over the main role and Outreach worker changes to support role (Milestone 6); source of resources shift from project to community.

Bonus result from the process is that the community which was witness to significant changes in condition of client starts coming out with their own personal issues to the team for resolution with the hope that mental health issues can be resolved.

Milestones: This process achieves milestone 5 & 6. 

5.5 Criterion / Preconditions in process

Clients should be available for treatment process to act for suitable duration on a regular basis. Any raid by Vagrancy department hampers this process. A client leaving the area compromises the process in a similar manner.

Preferably the same outreach field worker who was involved in Phase 1 with client should continue in Phase 2. There should be smooth supply of material for the client specially medicines. Clients with substance abuse problem do not recover as others and skew negatively the results of the process. Resources in community should be available for the shift to be seen

Substance Use problem in a client should be marked by a red flag. Since it is dynamic, the flags could change colours from red to green (no problem)

5.6 Operational definitions of key stakeholders / events / activities or terms used in the process

Regular Service Package includes service or material provided to the client by either the outreach worker and / or on his / her advice by the Community Care giver that would improve the functioning of the client. This includes

1. Provision of food (food packet by outreach field worker/ regular meal by volunteer on payment or voluntary basis)

2. Items & service of personal hygiene (soap, services of barber) and clothes to clients

2. Regular review by Psychiatrist (in the field area)

3. Initiation and regular Counseling of the client

In addition to regular services, emergency services can be provided to the client as per need, it is mentioned as a separate process.
The Community Care Giver is an important stake holder in this process. During this process, the volunteer is converted into Community Caregiver who would form pivot of treatment, care and support of client in community.

5.7 List & description of Key processes

Key Activity	Main Role	Supporting Role
1. Daily Contact with Client& Volunteer / Care giver	Outreach Field Worker	
2. Regular Review of Client by Doctor	Outreach Field Worker	Outreach Project Coordinator Psychiatrist Counselor
3. Introduction & Regular Review by Counselor	Counselor	Outreach Field Worker
4. Transfer of Care from Field Worker to Care giver	Outreach Field Worker	Community Care giver Outreach Project Coordinator

5.7.1 Daily Contact with the Client

1. As number of clients in a field area increase, as a field worker you would be challenged to meet them all during the day time when they are available and provide supplies. Hence, it is necessary to identify and involve a Community Care giver for smooth conduct of this process. Identification and involvement of Care giver is detailed in the process title - "Community Care giver"

2. You should prepare a schedule to meet the clients and accordingly inform clients of the location and possible time of your coming. Inform the same to the

Community care giver. Same time instills habit in the client and he / she comes to expect you at that time.

3. Spend 10 minutes with each client and enquire on following points:
"How are you feeling today?"
"What did you eat last night and today morning?

"Do you want tea?" GET ONE
"Do you recall anything where you came from, where is your native place, who all are in your family?

"Did anyone threaten you yesterday or steal something? Did the police or anyone else come and threaten you to leave?

"I think you should work, will you work, I will find something for you?"

Observe the personal hygiene and prompt the client to take bath, shave, crop hairs, clip nails. Encourage him / her to do so on own. If they can't arrange for them to avail services of local barber and get them in shape

4. If the client needs clothes, then you should provide them if you are carrying or come back next day and give clothes. Record your daily observations in the Observation Sheet (Serial No. 6)

Daily Observation form (DOF)	
Record daily activities in it	
Divide DOF into two sections	
Section 1	Checklist on daily observation items
Section 2	Narrative notes

5. Ask and if required, examine the client to see any marks of injury or physical illness. If there is suspicion of substance abuse, advise client to leave it, consider medical methods of treating substance abuse

Mention any injury marks the client might have. Protection might be needed if client is vulnerable. Violent Victimisation is common

6. Encourage client to visit DIC and enroll in a skill building course there

7. Handover the food packet,
Provide medicine under direct observation
For clients who are now handled by Community Caregiver, meet the care giver and enquire on the status of medicines of the client and other items of Daily Enquiry and Observation

8. If client is unavailable, ask Caregiver, volunteer or others on possible location and trace the client. If untraceable, inform care giver and volunteer that if they see the client, they should inform him / her to meet you at same place tomorrow. They should also call you and inform if they see the client.

5.7.2 Regular Review of the Client by the Doctor

1. All clients should be reviewed at least **once a month by the doctor**. The appointment diary should be arranged in such a way. New Clients are however prioritized.

Review is done in the field area on designated days of doctor visit.

It is important to get client reviewed regularly, in case, the project doctor is unable to come for review, take the client to a nearby government hospital with psychiatry services and get him / her reviewed. Inform the government doctor about the client, yourself and project, current treatment.

Later, the project doctor is informed and the prescription and the client is reviewed by the project doctor when possible and if required the treatment is revised. The medicines received from the government hospital is mixed with drug inventory and used across projects. The medicine is received as donation in kind. The process for receiving donation in kind is explained under Common Processes Across the Organisation module.

2. Note changes in drug prescription and understand progress made by client since last time client was evaluated.

Progress parameters:

Note that the progress of the client is recorded in three different sources: (i) Your own daily observation schedule in which you use the checklist; (ii) Notes of the doctor and counselor and (iii) Scales. All of these inform you on progress made by client. You should have prior assessment on three categories – (i) Shows improvement since last visit: (ii) No Change; (iii) shows deterioration since last visit. To decide on degree of progress, you should wait for analysis of scales data.

3. Discuss with the doctor additional measures to be adopted for recovery

5.7.3 Introduction to the Counselor and regular visit by Counselor

1. Counseling Assessment and Intervention Plan should be made part of the overall Treatment Plan

Counselor is introduced to the client by the Outreach field worker. This is done after the initial assessment by the doctor is done. Rapport building starts by Counselor through regular visits to the client. Initially these visits are along with the Outreach field worker, later i.e. after 2-3 months, the Counselor has to chart his / her own travel plan and attend to clients

2. Phases of work of Counselor: The Counselor works in three phases:

2.1 **First Phase of Counselor's work**:

The first phase is spread over three months.

During this time, you as the Counselor should:

1. Work with the client to:
    a. Build your rapport with the client

b. Constantly negotiate with the client to enhance client's ability to receive the service package (food, clothes, hygiene, and medicine) for at least 2 – 3 months.
c. Work as per the pace of recovery of client
d. Meet the client at least once a month but more on as needed basis
e. You should record your observations of the client in the Observation Sheet of the Counselor (Currently called Counselor Report)
f. You should score the client on selected psychometric scales. This is baseline score. Enter them into each scale and label them as BASELINE SCORE
g. You will develop the **Individual Care Plan** for the client over the first phase.

ICP format needs to be adopted from Shelter or UMHP

This keeps into view doctor's opinion, but also counselor's observation on what are the main barriers that need to be worked for the client to achieve the goal of phase 1 i.e. receive all services consistently. Approach to Individual Care Plan is same as for others. Plan for one quarter and make therapeutic targets, at end of the quarter summarise progress and then make another set of targets. At end of year make summary quarter by quarter on progress seen in client

2. Your other task is to visit the identified Community Caregiver along with the Field Outreach worker and establish initial contact. You should work with the Caregiver over the second phase more intensively for the third phase to be successful. Meet the care giver each time you meet the client.

2.2. Second Phase of Counselor's work:

This lasts for the next 3-6 months.

The aims of this phase are:
1. To promote communication with the client and improve his / her understanding of own situation
2. To prepare the Community Caregiver take more responsibility for care and support of the client

Client should demonstrate regular consumption of treatment including medicine

You should use Interpersonal communication with both client and caregiver as your main strategy.

You should train the client to share information with the counselor.
You should prompt the client to take self-care. Your success is when the client takes self-care on self-initiative. Such days should be marked in your observation report.

You should impress on the client to consider engaging in some work in the community and share more information about him/herself. The information is recorded in case history format with specific sections dedicated to more details on personal history.
The progress of the caregiver towards agreeing to take more responsibility of the client should be recorded in your observation sheet. The Counselor should organize a meeting of potential care givers and felicitate them and encourage them to adopt the role.

2.3. **Third and Final Phase of Counselor's work:**

In the final phase, you as Counselor have to focus on ensuring there is more initiative by the client in taking care of self. An important role in this is played by the Caregiver hence counselor will have to meet the caregiver at least once a month beginning from phase 1 to understand the care giver better and involve him / her more in care of the client.

You should have inbuilt an understanding in the client to take treatment, if possible focus on creating hope in client and a dream for better future

3. Home address / Family details: During the interaction with client, the counselor should try to extract information on address and or family details of the client. However, counselor should tell the client that the family would only be contacted on consent from the client. The consent if received should be recorded in the file. Thereafter, efforts to contact the family should be done. This is done by Reintegration team

4. Team Review: Whenever Psychiatrist reviews the client, all those involved in his / her care should be available to understand and discuss the case. However, this is the main work of the Project Coordinator who should ensure that regular client

reviews happen. If the psychiatrist is absent, then Project Coordinator should take lead and get the review conducted.

TOOLBOX:

Note about Observation Sheet:

Progress of the client should be recorded in your observation sheet. Work with Caregiver should be recorded in a dedicated separate section in this form. A simple visual tool should be used to see at what stage the caregiver is in taking involved role in care of the client.

You could use the milestone approach as suggested or create some other tool. Quarterly psychometric scales are done and recorded in suitable sheets

Daily Observation Form (DOF)	Daily Observation Sheet of Counselor
Record self-initiated activities in the DOF	2 Sections: Section 1: for client Section 2: for caregiver

Note about Counselor Observation Sheet:

All observations are made in the Counselor Observation Sheet
A closure is done each quarter. See instruction on Individual Care Plan above
There should be a goal for each quarter and a plan for activities
At end of the quarter, the plan and activities should be reviewed in the team in presence of the Outreach Project Coordinator, Senior therapists, Outreach field worker and if possible, Psychiatrist

Note about Home address

Home address and Family details to be filled in Personal History section of client file along with date of such recording and person who recorded this information

Note about Team Review:

The file should contain notes of the Team review and revision (if any) of Individual Care Plan of the client;

The Regularity in review should be marked against desired / scheduled review. This is one of the Key Result Area for the Project Coordinator. The plan for clients who should be reviewed in a quarter against achievement should be reported to the superior. (**See Annexure 3)**

5.7.4 Transfer of Care from Field Worker to Care giver

1. This process has been detailed out as **next process**

2. Encourage the caregiver to get client reviewed at the nearby government hospital.

3. The first contact of the client with the government health services should be mediated by the outreach field worker. Once there is satisfaction of the quality and appropriateness of the service then caregiver should be encouraged to take the client to the government hospital.

4. Advocacy should be done with the government hospital which is described in the process number 5 (Creating a network)

5.8 Key Conclusion / Decision

At the end of this process, the Outreach field worker, Counselor will be able to identify clients who are regular in receiving service; observe change in their status (clinical, functional status); identify care givers who are taking interest in client and therefore client care could be transferred to them

5.9 Information Capture & Tracking the process

The Case File of the client will have rich data in following sections:
1. Observations and treatment of the Psychiatrist
2. Observation and treatment plan of the Counselor
3. Details provided by client that inform his / her personal details
4. Family address or details
5. The Individual Care Plan would be clearer
6. Community Care giver development can be tracked in the file of the client

5.10 Internal Check & Balance of process

Outreach Project Coordinator and senior counselors should review counseling notes to help counselor achieve objectives of different phases

5.11 Evaluation / Audit of process

At least once in six months, process fidelity should be checked on a random sample of clients

5.12 Gaps and Suggestions

Community Caregiver section should be developed

5.13 Training Requirements

Counselor's Manual

What is the next process?

Identification and Engagement of Community Care Giver

6. Project Phase 3 / Project Handover / Identification & Engagement of Community Care Giver – "We share, You Care"

Process Holder: Outreach Field Worker

Needs Change	Good ☺	Standard

6.1 Scope / Overview of the process

This process is concerned with identifying and working with an important pivot of the Outreach project - Community Care Giver. The process defines how to identify the care givers in the community, how to initially engage with them and how to bring them into a role of care giver from the role of a volunteer.

6.2 Policy guiding this process

The policy adopted by Sankalpa that treatment of clients should be done within resources of community and with their participation drives this process. The aim is to make the care of the homeless sustainable using institutions and elements that are going to be present beyond project life

6.3 Purpose / Objective of process

The purpose of this process is to provide guidelines to the outreach worker to be able to identify, engage and form an alliance with a Community Caregiver.

The aim of working with care giver is to let them take **more responsibility** for care of person, this is seen in terms of: increase out of pocket expenses on the client's clothes, food; accompanying client to government hospital for emergency and routine care, purchasing medicines for the client; providing employment, place to stay or in short get back to life

6.4 Result expected from process

At the end of this process, you as the Outreach worker should be able to identify, recruit a community care giver and work with him / her in care of the client and slowly transfer bulk of care on the care giver. This process marks the Zone of Change (refer matrix shown earlier) wherein care is transferred from you being the main person to care giver being the main person and resources spent from community gaining primacy over project resources. Successful completion of this process should enable you reach Milestone 6

6.5 Criterion / Preconditions in process

Criterion for Community Care Giver

1. One who has the maximum information about the identified client on that particular location and offers some service to him/her even before Sankalpa entered into the picture i.e. as observed during the observation period
2. These caregivers could be owners of tea stall, roadside hotels, hawkers, rickshaw-pullers, cobblers, regular pedestrians, common people, any kind of shop owners, local club members, etc.

6.6 Operational definitions of key stakeholders / events / activities or terms used in the process

Community Care giver: A person who is a member of the local community where the client usually stays and is involved in care of the client along lines of the project requirements. This is a voluntary role and no payments are made for the work done.

Role and responsibility is as follows:

1. Provide food, tea or facilitate same for client
2. Provide medicine to the client as advised by outreach worker
3. Keep an eye out for the client for his / her personal safety, substance abuse or any other untoward issue
4. Communicate / speak with client; suggest for personal hygiene, work involvement; enquire family details
5. Provide employment to the client, else, suggest to outreach worker where the client could get some work
6. Accompany client to government hospital for review as and when this process is suggested by Outreach worker or on his/ her own
7. Provide clothes, other items of personal use to the client
8. Facilitate a safe place to sleep in the night

Institutions: Refers to government hospitals that provide both psychiatric and general health care for the client and where the care giver can take the client for review or assessment of any condition including emergency care

6.7 List & description of Key processes

Key Activity	Main Role	Supporting Role
1. Identification of an eligible Community Care Giver	Outreach Field Worker	
2. Engagement with the Community Care Giver	Outreach Field Worker Counselor	Outreach Project Coordinator Psychiatrist
3. Forming an alliance with the Community Care Giver	Outreach Field Worker Counselor	Outreach Project Coordinator

6.7.1 Identification of an eligible Community Care Giver

1. Identify the Community care giver as per criterion laid out above

2. Observe the person at least for two months before labelling him / her as community care giver. The observation points during this two month period have been listed above

3. After a period of 2 months you should approach the care giver to engage with him / her

6.7.2 Engagement with the Community Care Giver

1. Role & Responsibility of a Community care giver are listed above

2. Approach the caregiver and give brief introduction of the work of Sankalpa and about your own self, also mention the client for who you are planning to work with

him. The Caregiver would have seen you already in the field working with the client and other clients

3. Request care giver to provide food to the client at least on once a day

4. Request the caregiver if he could encourage the client to take personal hygiene measures at least on Saturday or Sunday (once a week). Inform him / her of the DIC and that safe bathing space was available there for the client with security of assets.

Discuss with the Caregiver if a safe place to sleep in the night can be arranged for the client. This is very important and should be part of your checklist

5. Approach the caregiver and impress upon him/her the need to give regular medicines to the client

6. Inform caregiver of the day of the visit of the doctor so that he / she knows that the client is in treatment net

7. After the doctor's visit and team review, inform care giver what are the major changes in client and what is the main emphasis of the Individual Care Plan. Also let the care giver know what his / her role could be. The care giver is a voluntary person hence let him / her choose the role out of what is suggested.

Often, care givers take care of clients due to a spiritual reason. If you can know reason for same, then respect it and in cases where care givers are not available create a higher moral ground and reason for them to take care of client.

8. If agreed upon, keep the medicines initially for a period of two days every week (when outreach field worker is not present) to see if the care giver is able to perform this critical role

9. Trouble shoot any problem the care giver might be facing, remember the caregiver might be enthusiastic to help as a human being but might be ignorant of the illness and its manifestations, educate him / her on the illness in the context of the client

10. If caregiver is able to give medicine to the client over weekend and the client has passed the initial acute phase of treatment and is stable, encourage caregiver to give medicines to client for a period of 7 days

11. If you see an improvement in the client due to the work of the caregiver, congratulate him/her and encourage to do the good work

12. Encourage the caregiver to speak with the client often, since the client could feel isolated and lonely. At this stage, you should be ready to solve any conflicts between care giver and the client

You have been trained in Non-violent communication. This is important skill, use it to the maximum

13. Request the caregiver to suggest the client the need to get involved in some productive work and make efforts to find work for the client. Suggest if he / she could employ the client.

14. Invite Caregivers to Caregiver meeting and recognize their efforts publicly. Care giver meetings are important events. It is explained later at the end of this process

15. Suggest to the caregiver that if there was ever any medical problem with the client and if you were unavailable then he/she could take the client to a nearby government hospital. Care giver should inform the treating team of the medicines client is taking and history of client. You may consider keeping a copy of prescription with the caregiver just in case it is required.

16. Inform the caregiver of the activities in the DIC and encourage him / her to suggest the client to go to DIC to learn skills. Usually care givers are working people and very busy, but if possible take him / her to the DIC to show what activities are conducted there.

17. If the caregiver brings a member of the family with some mental health problem, ensure the same is treated or provided services so that caregiver feels part of a system that responds quickly

18. The outreach worker should continue to ask the care giver on provision of services so that there is an oversight on the process. The outreach worker should continue to meet and engage with the client and ask if he / she has received medicines and other items. At this stage you should not think that the care giver is taking care of the client so no oversight is needed. An oversight should be kept for any issue simmering between the caregiver and the client. As the client recovers, the dynamics of relationship could change hence an oversight is required

TOOLBOX

Note:

DOES THE CLIENT HAVE A SAFE PLACE TO SLEEP IN NIGHT?

Caregiver giving client medicine for 7 days is a critical outcome, ensure that this is only attempted once client is relatively stable

Give Care giver the message that three things are important for recovery of client:

1. Regular Medicines
2. Work
3. Daily prompting (at least in initial phase) by those involved in care – Outreach field worker, Counselor and Community Care Giver

With medicines, opportunities provided by the care giver and daily prompting by the Sankalpa team, people start recovering. They appear clean and tidy.

6.7.3 Forming an alliance with the Community Care Giver

1. As Counselor, you should meet the caregiver during your monthly visit to the client. You should ask his / her observations on the client. The observations of the care giver should be noted in the care giver section of the Counselor Observation Record.

2. If you are Project Coordinator, you should meet the caregiver, this would let the caregiver know that he / she is now part of a project. He / she would be able to meet all members of the team. In case there is some problem with one or the other team member, care giver could contact you hence your rapport with care giver is important. You must tell care giver that you are responsible for the project and he / she should feel free to share information with you

3. If required, and condition arises, senior caregivers might be approached to suggest solutions to some problems faced with other caregivers

6.8 Key Conclusion / Decision

At the end of this process, one community caregiver should have been identified from among the volunteers for a client.

The outreach worker should continue to engage with another potential caregiver since the first could drop out due to any reason. Hence the process of engaging

with other volunteers and potential caregivers should not be stopped after identifying and handing over the care to the caregiver

6.9 Information Capture & Tracking the process

The date of transition of medicines from Outreach worker to caregiver should be prominently captured in the form. The daily observation form of the outreach worker and counselor should record who the client is receiving medicines from and if it is the caregiver then following classification could be used:

Medicine 1: Source: Caregiver; Schedule: only on weekends / weekends and when outreach worker absent / Main Source.

The target is to make the caregiver become main source of providing medicine to client. This would mark achievement of Milestone 6 which is the **Zone of Change**.
You (Outreach worker) should fill in details of the Care giver in the Care giver form and provide him / her an ID and place this form in the file of the client.
Proceedings of Care giver meetings should be recorded in a dedicated register. Attendance of care giver attending meeting should be marked against each care giver. This would help know if the care giver comes or not for meeting. Notes of the caregiver meeting should also have photographs and signature of the attending caregivers.

A Suitable Form is required here

If there is any press coverage specially mentioning the caregiver, then a copy of same should be provided to care giver. During the field visit, the outreach worker should fill in notes of you think the caregiver is performing and if there is any visible conflict like situation.

6.10 Internal Check & Balance of process

The outreach worker should continue to ask the care giver on provision of services so that there is an oversight on the process. The outreach worker should continue to meet and engage with the client and ask if he / she has received medicines and other items. An oversight should be kept for any issue simmering between the caregiver and the client. As the client recovers, the dynamics of relationship could change hence an oversight is required

6.11 Evaluation / Audit of process

The outreach project coordinator should ask the psychiatrist and counselor if they are satisfied with the progress of client since transfer to caregiver. Date of transfer of client to care giver i.e. zone of change should be prominently recorded in the client's file

6.12 Gaps and Suggestions

The outreach project coordinator has to mention if the client's condition post transfer to care of caregiver is satisfactory or not (Outcome parameters prior to Milestone 6 and post it)

6.13 Training Requirements

Detailed above

What is the next process?

Build a network (of community care givers, local police, NGOs, CBOs, social welfare department of the Government and government hospitals)

A Place to sleep in the Night
Many clients have good rapport in the community and have found themselves several resources and services. While food is freely available to almost all, some even get place to sleep that are safe and weather proof

7. Project Phase 3 / Project Handover / Building a network of care

Process Holder: Outreach Project Coordinator

Needs Change ☺	Good	Standard

7.1 Scope / Overview of the process

The scope of this process is to identify stake holders in recovery of the client as well as those who could prevent homelessness or any adverse outcome amongst clients with psychosocial disability even if they are currently not homeless. The members or nodes of the network are members of the community (circumscribed geographical area); service providers (doctors in psychiatry department, casualty department, obstetric department, etc.); local police; other NGOs and CBOs working for community development or related issues; local councilor; local benefactors; local drivers; etc.

This process describes how these stake holders would be identified and mobilized to perform their role to meet the objective of the process. It would also elaborate the role of Sankalpa in this process and in potential scale-up of outreach work in other locations through replication.

7.2 Policy guiding this process

The philosophy of outreach is embodied in this process. A person with psychosocial disability rendered homeless can be taken care of by select members of community if appropriate resources are available in the community itself. However, initial facilitation has to be provided (in this case by Sankalpa) and community care givers guided through the process of care before hand over is attempted.

7.3 Purpose / Objective of process

The objectives of building a network are:

(i) To provide a safety net that aides the client in recovery – stake holders provide clients with personal security, food, shelter, treatment, employment;

(ii) To create an environment where community members have improved levels of awareness and education on psychosocial issues and their management.

The network has to have a feeling of its own and not appear disconnected

7.4 Result expected from process

At the end of this process, stake holders should be identified and they should have demonstrated their willingness or otherwise of performing their role in meeting the objectives

7.5 Criterion / Preconditions in process

Resources such as mental health facility should be available in the field area

7.6 Operational definitions of key stakeholders / events / activities

A stake holder is anyone who has either interest or influence on recovery of person with psychosocial disability in the field area. This could be a counselor who is interested in reducing number of homeless in his / her area or to be known as someone who is kind to poor and destitute; he / she could be a government casualty doctor who is likely to attend to wounds and other needs of homeless person; could be the in-charge of local police station; the leader of the small shops and traders who could address this gathering on the issue of interest, etc. We should try to identify person who are important in community and powerful like religious leaders, old people, etc. We should also find those who would be genuinely interested in the issue and would work on it.

7.7 List & description of Key processes

Key Activity	Main Role	Supporting Role
1. Stake holder mapping	Outreach Project Coordinator	Outreach Field Worker
2. Engaging with each stake holder and informing them of their role in the process	Outreach Project Coordinator	Outreach Field Worker Psychiatrist Counselor
3. Initiating the first action by each stake holder	Outreach Project Coordinator	Outreach Field Worker
4. Coordinating the Resource Network	Outreach Project Coordinator	

7.7.1 Stake holder mapping

1. As the Outreach project coordinator, you should conduct a stake holder mapping in the field area. It should be done simply on a one page format. The aim is to identify those stake holders who are critical and influential in the community in relation with recovery process of client

2. Identify the critical stakeholders and meet them.
Meet them in their work setting and understand what and how they work
Introduce the aims and purpose of the project and leave a handout with them in local language
Ask them to come to medical camp or an awareness meeting

3. As Project Coordinator you should always approach head of organisations that you intend to work with and not restrict your contact only to the staff who is likely to help you. For e.g. inform the head of department of psychiatry of the government hospital if you are planning to work with the psychiatrist working in that department or at least ask the psychiatrist if you need to inform the head or would he / she do it.

A letter should be given formally to heads of institution, if required

TOOLBOX:

Project Coordinator should be trained on Stakeholder Mapping and adding stake holders to the Resource Mapping already done in first process

Stakeholder form should capture basic information of stakeholder including whether he / she has agreed to perform their role. By now we have three different forms besides the client form – volunteer form, care giver form and now the stake holder form. It is possible that same person could be duplicated, in such case copy the details from one form to another. Keep these forms updated each year.

7.7.2 Engaging with each stake holder and informing them of their role in the process

1. Meet them once a month (for each field area) and inform them of the progress in work. Also inform them of the clients that project is working in the area. Inform them of the role they could play, seek their response, if they agree readily then note the same in the Stakeholder form, else, wait for more time. Always have more than one stakeholder for the same role

2. At each meeting, leave some reading material or a hand-out with them which is more pertinent to their role. For example, with the councilor, leave him list of clients who need Disability Certification

3. Invite them to the functions of the Organization such as annual event, exhibition, etc.

TOOLBOX:

Photographs are very precious, so ensure stake holders get their photo of attending the function. If there is no budget to print photos, WhatsApp it

7.7.3 Initiating the first action by each stake holder

1. The use of the stakeholder should be done for each client according to the role of the stake holder. The first time use should be facilitated by either outreach worker or project coordinator or counselor. For example, in case of police, a letter should be given informing of the client, nature of illness and that he/she was under treatment; trace any missing person complaint, etc.; for psychiatrist, take the client for a review in the hospital and so on

After this first action has been done, return to the stake holder and thank him /her. This can also be done by SMS or WhatsApp

2. The feedback on this interaction should be provided to the Community Caregiver

3. If the stake holder had not been supportive, reach out to him/her again continuing to inform on the progress of work and extend invitations. The contact should not be stopped unless there are major objections against the character or nature of the stake holder. If the stake holder is discontinued, mention reason for same in the Stakeholder form so that all know reason for discontinuation. Try to work with the alternative Stakeholder

7.7.4 Coordinating the Resource Network

1. Organize a stakeholder meeting area wise and invite all stake holders

2. Invite the local councilor or some other senior / powerful person to the meeting so that others attend.

3. Share the agenda of the meeting and do not present roles and responsibilities, but in general provide a higher Moral Reason for extending their services to the client population. This should be presented as not an additional work, but only an accommodation of the extra person

4. Organize these meetings keeping in mind that the higher moral purpose is always maintained

5. Build a feeling of a community within the network but this should be subtle and not obvious, avoid giving names to group, etc.

6. Accompany the Community Caregiver and the client to the Stakeholder and introduce each other, thereafter, do not accompany and let the Community Caregiver source services from the network

TOOLBOX:

At this stage, the main role of the Project Coordinator is to nurture the network and organize meetings that make sense to them - introduce new government schemes, felicitate them for their work, ask one of the stake holders to address the meeting and inform them of their work, etc.

7.8 Key Conclusion / Decision

At the end of this process Stakeholders are identified, and those who have shown cooperation are also known.

7.9 Information Capture & Tracking the process

Stakeholder form should capture progress of stakeholders. Stake holder form therefore has a static section with personal and other details of the person and then a dynamic section which notes the progress made with stake holder once each quarter

7.10 Internal Check & Balance of process

The Project Coordinator should in each project meeting, ask field outreach workers who in the community they think could replace project services while maintaining continuity. For example, a low cost food service providing nutritious food could replace or supplement the food packet; a free eye care service could arrange for eye care of clients, same for dental care; etc. However, caution should be exercised in involvement of stake holders, they need to be constantly mobilized; it should not be a one off event. Further, an oversight should be kept and contact with client and care giver are therefore important actions that should not be compromised

7.11 Evaluation / Audit of process

Nurturing the network is an important activity and audit should be conducted at par with the audit of the organization building process. Building networks would also give opportunity to project coordinator to emerge as a leader
Deputy Director or some senior person should meet the stakeholders and seek their view of the project and their own work to understand any issues faced

Annual Audit should be done

7.12 Gaps and Suggestions

It would be easier if a volunteer base is created in the field area with participation of school children and college students. This should be created around Urban Mental Health Program and volunteers should be asked to help out in DIC. These same volunteers should be rotated to help with homeless clients. Currently, no such base exists. The stake holders would also be active seeing the volunteer base.

7.13 Training Requirements

Stake holder Mapping& Volunteer Strategy

What is the next process?

Supportive Employment*

*The process of Supportive Employment, Restoration in Community and Awareness Generation are processes that follow common guidelines across Sankalpa, to read on them go to the Chapter title – Common Processes

8. Component 2 / DIC Project

8.1 About project & Problem Statement

Dr. K. L. Narayanan Rehabilitation Centre, first of the two Drop-in-Centers (DIC) was opened in 2009 in the premises of Hastings Police Station, a space provided by the Kolkata Police. The second was opened more recently in 2014 in Keoratala.

Currently, Hastings DIC serves homeless clients of Hastings field area who utilize this space for bathing, cooking and learning vocational activity. A few clients from the Men's Homeless Shelter also attend, off and on. The Keoratala center on the other hand is used more by clients from the UMHP of Chetla field area along with a few clients from Men's shelter. This shelter does not provide space for personal hygiene and is focused on vocational training.

It is envisioned that Day Care Centres would become a **Community Centre** for Sankalpa's work in a particular community or field area. The activities should be: (i) vocational activities, (ii) therapeutic activities; (iii) Counseling services; (iv) space for

personal hygiene. The community centre would service clients registered in both Naya Daur and UMHP. It would also be available to members of the community who would like to use its services. The homeless clients would also participate within the groups. The processes noted therefore are not only for DIC in its present form but also the direction it should take in line with the vision outlined above.

This is a space in addition to the clinic run by Sankalpa from Ward Health Unit. Unlike the clinic, this is a community space, open to all those who want to use it. If the DIC is located outside the clinic, it can operate beyond 2 or 3 PM which it is restricted to presently. It would also act as the local office space for Sankalpa from which it could coordinate its community activities.

8.2 Environment or context of project for the homeless person with psychosocial disability

There is no dedicated space for homeless person with psychosocial disability to take bath, learn new skills and socialize with those who are interested in their rehabilitation. Although the streets provide public taps to bathe, and generous locals do give clothes, none of them interact with the homeless and certainly recovery of the homeless person is not the aim, their aim is to ease present living of the person. None says, why have you not clipped your nails, why don't you learn some skill and earn a living? Human interaction and prompting that is purposeful! As a result, homeless person with psychosocial disability continue to live a way of lost living on the street. Easy availability of food, substances like tobacco slides them further away from the need to recover. At times, the homeless undergo crisis due to several reasons. They may not bathe for days on end, or eat and just lie down in one place. There is no one to interact with them. The DIC is therefore a place where the care taker brings the homeless person into the room away from public glare and starts addressing small issues – prompting to bathe, prompting to learn new skill, to talk, to change clothes, and so on. This space is important to make them pause and consider their recovery else the fast, noisy world of the streets won't allow recovery while time would pass.

8.3 Project Philosophy

The project philosophy is that homeless person with disability get into a routine that helps them survive in the present but is detrimental to their recovery and return to normal life. There is no direction for them in the street life. The project tends to disrupt this vicious circle and introduce recovery focus in the lives of the homeless.

However, this is not as easy and the project does in measured dose via bringing the person in the DIC. A different physical space is necessary to change the thought process of the client. In this space, away from the open street, homeless person is provided a routine and new skills that should help in process of recovery. Mixing with the clients from the shelter helps in the homeless person understanding the need for such intervention.

8.4 Main clients / beneficiaries of project

The Drop in centre is not only for person with psychosocial disability rendered homeless but also those who have the disability and spend most of their times on the street.

It is accessed by clients from Outreach program, Men's shelter and UMHP.

8.5 Expected Project Outcome

The ultimate aim or goal of the DIC is recovery and rehabilitation of the homeless person with psychosocial disability. The immediate outcomes towards which the services are targeted are:

- self-care and personal hygiene by the homeless person himself
- improvement in the self-esteem
- ingraining the concept of productivity and imparting skills to become productive
- social interaction skills
- rapport building with the DIC staff and trainers
- personal life skills and
- vocational skills

8.6 Stakeholders of project / Brief Description of Client

The police is one of the most important stake holder of this intervention since they understand and allow space for recovery of clients. Volunteers in the community point out the condition in recent past of the person and inform the project worker. Generous local donors donate material for the project. Food vendors provide food and inform the staff of new changes they see in the person. These are the people who express their concern for the homeless person with psychosocial disability by participating in the project.

8.7 Core Activities of the project / Service Package

1. Identification of person with psychosocial disability either homeless or dwelling on street

2. Negotiate treatment, care and support

3. Provide Psychiatric assessment and treatment

4. General Health care including emergency care

5. Counseling

6. Providing food, clothes and items for personal hygiene

7. Identify community care givers

8. Build a network (of community care givers, local police, NGOs, CBOs, social welfare department of the Government and government hospitals)

9. Conduct awareness / sensitization meetings in the project area on psychosocial disability to dispel myths and de-stigmatize mental illness

10. Organize Medical Camps in the community to make mental health services available to people in the community as also homeless person with psychosocial disability

11. Supported Employment / Independent employment

12. Restoration to a destination

8.8 Information parameters of project

Maximum & Minimum number of clients in DIC

Average attendance of clients in a month

Number of doctor visits

8.9 Overall Process Map (See Annexure 8)

8.10 History of DIC

In times when men's shelter had not started, the present DIC coordinator would take an ambulance to all the outreach field areas and bring clients to DIC. When the shelter opened, initially it was only a night stay facility hence clients would spend day at DIC and for the night move to shelter. However, now DIC Hastings serves only clients from Hastings outreach field and similarly DIC Keoratala serves only clients from that field including a few clients from UMHP

In general, clients do not prefer going to shelter. It restricts movement and is an enclosed place. They feel that their freedom would be lost. Their routine disrupted and having to follow shelter's routine. Clients earn cash on the streets; especially those who live in specific field areas earn a lot on the occasion of Friday Namaz. This money is used for either personal purchase or on bidi, etc.

A few clients save money and deposit their savings with the Outreach Field Worker. They keep account of the money. The outreach field worker keeps a box where the clients' money is kept. If the amount is high, a bank account may be opened.

9. Component 2 / Entry into DIC & Initial Assessment

Process Holder: DIC Supervisor

Needs Change	Good ☺	Standard

9.1 Scope / Overview of the process

Person on the street are usually isolated and lonely and do not show participation. The person also could have variable education background and language fluency making it difficult to understand and communicate.

This process covers the activities involved in enrolling a new person into DIC service and baseline assessment of the status of person on which improvement would be noted during regular contacts at DIC

9.2 Policy guiding this process

DIC services are offered in a catchment approach within Outreach services. However, the person has to consent to come to DIC. In case there is irregular attendance at DIC, the client is not denied any other service by Sankalpa

9.3 Purpose / Objective of process

The purpose of enrolment is to form an understanding of the client and include him / her in activities of DIC that could accelerate recovery

9.4 Result expected from process

At the end of the process, DIC Supervisor should have an understanding of the client and plan out interventions for him / her

9.5 Criterion / Preconditions in process

Clients already enrolled into Outreach program; Men's shelter or UMHP can avail services from DIC, if so advised. Clients are brought to DIC by the Outreach field

worker or by DIC Supervisor. The client from Men's shelter is accompanied by Shelter Supervisor first time and initial few times

The criterion for admitting to DIC program is:

(i) An outreach client scoring 2 or 3 on first nine items of LSP-16 regularly in a month
(ii) A client of men's shelter recovering well otherwise feeling trapped inside and would benefit from moving outside shelter and involvement in activities
(iii) A UMHP client, who is recovering but would benefit from group work and activities in DIC

The Psychiatrist, Counselor decide who should be referred to DIC

9.6 Operational definitions of key stakeholders / events / activities or terms used in the process

Key stake holders in this process are:

- Police – who need to know that DIC was a space for specific rehabilitation work with clients;
- Beneficiaries – should feel they gain from their visit to DIC and
- Community members who could donate for the DIC

9.7 What are the key activities in the process

9.7.1 Admission to DIC:

1. Greet the new client and welcome him / her to the DIC

2. Introduce DIC is as his / her own place where they could take a break and attend to their personal self

3. If the client is brought in by outreach field worker, then ask him / her the first name of the client

For Clients brought in by the Outreach worker:

Not all clients identified in the field area would agree to come to the DIC there. They have their own reasons not to come that day and force is not used to bring them in.

If you are the Outreach Worker, you should ask the client why they don't want to come and after knowing the reason and sometimes reasoning out with them leave it to their wish to come

In the morning while bringing the clients into the DIC, you as Outreach worker or DIC Supervisor should meet the care givers to know about behavior of client regarding work participation and any other issue that would have arisen since his last visit to the DIC.

If there is an identifiable issue such as client has left a job provided in the community, or there is some issue regarding payment or substance abuse problem or disappearance, you should take up the issue with the client at an appropriate time.

You as the Outreach worker take up the issue with the client to arrive at an understanding of the problem and then suggest solutions to both care giver and client to resolve the situation. Take help of Counselor or DIC Supervisor or anyone else to resolve the problem. Be Patient yet firm in handling the situation

RESOLVING CONFLICTS COULD HAVE AN EFFECT ON YOUR MUTUAL TRUST. DO NOT BEE JUDGEMENTAL OF THE CLIENT, DON'T THINK THE CARGIVER IS BEING GENEROUS IN HANDLING THE CLIENT, THINK AS OBJECTIVELY AS POSSIBLE

4. Do not ask details of the client from the field outreach worker or shelter staff in front of the client. First, assess the personal hygiene of the client and suggest him to take a bath

5. Provide soap, towel, oil to the client and guide him to take bath (only Hastings DIC)

6. Associate an older client with new client to guide him on bathing

7. Provide the client with a pair of clothes as per requirement

8. If client does not agree for a bath or has already had a bath (from shelter or home), then invite him / her for routine activities

9. Once the client is involved in an activity, request your colleague to inform you on the client. Since file is not available, make short notes of the condition

9.7.2 Initial Assessment:

1. Meet the client in absence of your colleague and make a rapid assessment using **LSP-16** or **Mental Status Examination**

> If you don't know LSP / MSES, then enroll yourself in the monthly training session or inform your supervisor. You should ask a colleague, but formal training is essential

2. In addition to points 1-9 of LSP-16, note the following points:

- Where does the person sleep?
- Do he / she engage in odd behavior
- You could add minor observations such as eye contact, etc. in your notes

3. Does he / she have **Capacity** to consent to two items

- Consent to Medical Treatment
- Consent to Admission (in case an emergency warrants so)

4. Make an entry of the new client in Register

9.8 Tracking the process

The admission and daily attendance of a client in DIC should be tracked in case record of each client. Inform the Outreach coordinator of the presence of client via phone. Attendance to be routinely tracked in an attendance register for DIC by Shelter supervisor

9.9 Internal Check & Balance of process

For Outreach clients, the Outreach coordinator should check the scores on LSP-16 (first nine items) during usual process of file review. If consistent scores of 2 or 3 are found during a month, then in discussion with the outreach worker, psychiatrist, counselor, a referral to DIC should be made. At any time, at least 10% of clients enrolled in outreach at any point of time, could have a DIC referral order

9.10 Evaluation / Audit of process

At each month, Outreach coordinator should enquire from the field worker of outreach if client who was advised DIC referral has availed referral service. Further, attendance of clients in DIC should be monitored

9.11 Gaps and Suggestions

A DIC specific assessment is not made by DIC supervisor which should be done. The usual assessment done in the project is not in view of the DIC process. Hence, in reference to the DIC process, an assessment should be done on following – levels of participation, level of motivation to come by oneself unescorted to DIC, interaction with other members of the DIC and so on.

Noting of attendance in DIC should be made in client file

Counselor should help plan intervention such that reason for which client was referred to DIC is suitably addressed

9.12 Training Requirements

The DIC supervisor should be trained in MSE and LSP-16

What is the next process?

Allow the participation of client in regular activities of DIC

The DIC should be called “BIC” because it is **B**rought-**I**n-**C**entre since clients are called in by the staff. Further, it should get an appropriate name, like Marudayan and Sarbari, since it connotes an important place or point in the care continuum. Here a breather is provided to the client who is not among the better off clients in the street cohort.

10. Component 2 / Regular Activities of DIC

Process Holder: DIC Supervisor

Needs Change	Good ☺	Standard

10.1 Scope / Overview of the process

This process describes the regular activities in DIC

Currently, DIC provides following activities in which all clients are involved:

- Cooking,
- Dance Movement Therapy,
- Art therapy, and
- Vocational Activity products

In addition, Counselor comes for counseling services and doctor provides regular review of the clients

10.2 Policy guiding this process

DIC aims to provide a break to the client from life on the streets and in many cases is important to train them on new skills as part of their rebuilding process.

10.3 Purpose / Objective of process

As DIC Supervisor, your colleagues and your interaction with the clients provide them suggestions and / or prompts them to do activities. Forcing them into a schedule helps to get into a time based routine which they otherwise do not follow in the street. Participation in activities and results have therapeutic benefits on morale and self-esteem of the clients.

In this process, as the DIC supervisor you should be able to plan, implement and evaluate activities for the benefit of each client attending DIC. You should therefore know the baseline status of client and purpose of joining DIC.

With assistance from the outreach field worker, counselor, doctor and Outreach project coordinator and similar counterparts in UMHP, you should design activities, keep an oversight on client and inform the appropriate person of your observations.

10.4 Result expected from process

The result of this process would be analysed by you keeping the baseline status in mind. You will use the LSP and the treatment goals in mind to make an informed decision on progress of client. You will also connect with counselor, psychiatrist and others involved in care to ask them if they think the client has made any progress or not

You should duly record your own observations, that of others and make a conclusion whether client has improved, deteriorated or shows no change

All the information you shall store in the case file of the client and share with your colleagues mentioned above

10.5 Criterion / Preconditions in process

Clients who you will receive in the DIC for regular services are those who have been advised by any of your colleague including Psychiatrist. The reasons for regular service at DIC are:

1. Learning a vocational skill would improve the client's chances for restoration hence client has come here to learn them
2. Personal hygiene – the client is struggling to maintain personal hygiene in the street and has come here to do the same, during their stay they should get habit of taking care of themselves, in this process you should take help from Counselor
3. Client of men's shelter would come regularly to the DIC even though similar activities are performed there. Such a client should be provided with a new skill not learnt in Men's shelter such that same can be taught back to clients in the shelter
4. Clients of UMHP come for specific purposes specially vocational training and social skills training

10.6 Operational definitions of key stakeholders / events / activities or terms used in the process

Key stake holders in this process are:

- Vocational Trainers: They have an important role to play and selection of trades should be in line with jobs or sale possibilities. As DIC supervisor you should

engage with the Vocational trainer and request him / her to train clients as part of making item for sale so that sale and proceeds from it motivate clients

- Colleagues involved in care of the client: all colleagues mentioned earlier have some role and as DIC supervisor you should constantly communicate the current status of the client with them

10.7 List & description of key processes

Key Activity	Main Role	Supporting Role
1. Cleaning DIC & Personal Hygiene	DIC Supervisor	
2. Activity Circles	DIC Supervisor	Vocational Trainer
3. Lunch	DIC Supervisor	Other Clients
4. Rotating Activity groups	DIC Supervisor	Other Clients
5. Counseling Session	Counselor	DIC Supervisor
6. Review by Psychiatrist	Psychiatrist	Counselor DIC Supervisor

10.7.1 Cleaning DIC & Personal Hygiene

1. Request the clients to help you clean the DIC premises.

Sweeping, mopping, arranging things should be done together.

Let someone arrange incense stick or some similar item to indicate that the day has formally started

2. After the cleaning has been done, you should check clients for their personal hygiene.

For clients from street, prompt them to take bath and provide necessary items such as soap, clothes, etc. Keep a record of the items taken out and who you have given in the consumable register. You need to keep a check if any client is using items carelessly. Ensure hair, oral hygiene is done

For clients who are coming either from Men's shelter or from their home, inspect their hands, oral cavity for cleanliness. Impress upon them the need to stay clean and appear neat

Dressing is very important specially for clients coming from home, you should spend some time discussing appropriate dressing and ask the client to dress enthusiastically and take keen interest in dressing

3. Initiate activities by getting everyone in a circle

Ask everyone to introduce themselves. This would help them speak and express themselves.

In case any client is hesitant or unable to speak, find an alternative method such as joining hands to greet, is enough to begin with

Any new client should be welcomed

You should have your own welcome ritual – perhaps all others should clap and welcome a person, etc.

YOU CAN THINK OF OTHER INTERESTING METHODS

10.7.2 Activity Circles

1. You should divide the clients according to their interest and requirements into groups called Activity Circles or groups.

First Group is for cooking – in case you are not making hot meal, initiate some cold meal such as food chat, salad, for clients from UMHP, ask them to bring some food material from home or buy it. Preparing food is an important activity. Dedicate one group of people to prepare food following all steps. The cooking activities include

all steps from cutting vegetables to final cooked dish that is done by clients with different people pitching in for some or the other activity.

IF A CLIENT DOES NOT KNOW HOW TO COOK, TRAIN HIM/HER, THIS IS AN ESSENTIAL SKILLS

Cooked food is meant for consumption at Lunch

Similarly, others could be sent to Vocational group. All clients in vocational group should be given clear directions on what the output is expected and within how much time. The time should be set keeping in mind their current state and speed.

2. As DIC Supervisor, you should keep an eye on all activities specially cooking that cleanliness is not compromised. Encourage clients to do activities independently while guiding them, if required.

Encourage those who know the activity well to supervise if they agree to, else give them a specific task in that activity so they can inform you of their observations specially if something is done wrong. Any wrong should be corrected and person should never be shouted upon.

WE ALL MAKE MISTAKES

3. The Vocational activity circle should be guided by the Vocational trainer. As DIC supervisor, you should also know what the plan is for a week. Make weekly plans therefore. This weekly plan should have following items:

1. What is the target for product for your DIC?
2. What is the individual target for each client?
3. What was achievement against target for previous week?
4. Income and expenditure in previous week and budget for this week.
5. Put this up either on a white board or a wall

Convey target to each client and provide them with all material required for conducting the activity

Make one client in-charge of each activity circle and slowly transfer responsibility of coordination, budgeting to them while you retain supervision and conflict resolution

4. One day each week for half a day the Vocational trainer would come. You as DIC supervisor should use her visit for following purposes:

1. Improve technique of a client
2. Supervise everyone for the work and inform you if they are all doing as trained or who requires improvement
3. Inform on sales of products previous week and therefore which client has earned how much incentive
4. Train on a new skill

DO NOT USE HER VISIT AS A ROUTINE VISIT

10.7.3 Lunch

1. Serve food cooked for lunch else allow clients to open their tiffin and eat. At times, clients would want to go out to eat and not cook food, allow such holidays and keep sufficient budget with you (every day, since you don't know which day the desire arises!)

As DIC Supervisor, you should appoint one client to serve everyone, this would specially for UMHP clients provide an opportunity to you to examine how the client is serving

10.7.4 Rotating Activity groups

1. You should keep the activity circle for only 1.5 hours maximum

2. After that organize some relaxing activity such as song, or some game

3. The relaxing activity is done in a group and the aim of this is to relax the mind and body but also to build bonding amongst members. You should initiate some activity that allows this to happen

There is no fixed list of such activities, but you should learn a few activities that help in group building. The objective is that they help each other in hour of need and are not dependent on the DIC all the time

Use space below to note such activities

Then realign the members to a new activity circle.

Keep caution not to disturb those clients who are interested in the vocational activity and is keen to complete target. Therefore, keep interest, stamina and mood in mind before switching activity circles.

10.7.5 Counseling Sessions

1. One day each week, for half a day, Counselor visits the DIC and provides consultation to the clients

2. The counselor knows the members of DIC since they are existing clients

3. Based on her assessment and plan, the Counselor organizes either individual or group sessions

4. Individual or Group sessions are organized on similar principles across all projects and you should refer to the guidelines for them

10.7.6 Regular Review of the Client

1. All clients should be seen once a month whether in Outreach or in DIC.

If you are the Outreach Project Coordinator, you should ensure this.

2. As project coordinator, provide list of all clients and their schedule of review to respective field workers, DIC Supervisors and counselors

3. This list should be provided to Psychiatrist as well

4. Speak to outreach worker and decide if the review would take place in the field or outreach, leave it to them to organize it. The final location of review should be noted and informed to you

5. If you are the Counselor, you should see if you are able to complete your planned sessions in line with the schedule of review of the client. You should also make a review schedule and let the Project Coordinator know

6. You should conclude if the client has been reviewed by the Psychiatrist, Counselor, Vocational Trainer and the Outreach worker and DIC Supervisor (if applicable) and write a monthly summary of client

If you are DIC Supervisor, you should review the client yourself as detailed below:

Use LSP-16 for review; use first 9 items

In your notes, make a record of change in LSP-16 items 1-9. In addition to category, add notes why you are marking a particular response. E.g. if you are saying an improvement has occurred, record what you have seen that suggests improvement.

Changes in symptoms can be noted, if you understand them, else take help of one of your colleagues like counselor who comes regularly to understand if changes are happening in symptoms

7. As the Project Coordinator, you should take a sample of clients and visit them in the field to match the secondary information from above reviews with direct observation. You should note this separately and if there is any variance discuss it with respective professional

8. As Project Coordinator, you should also meet the Caregiver and record his / her observations on the client

9. You should then make a summary of the client and conclude if you think the client has – (i) Improved; (ii) Deteriorated or (iii) No change

10. You should then choose the cases you want to understand better in discussion with your team and post them for Case Conference scheduled next month

11. You should also follow guidelines to conduct Case Conference

10.8 Tracking the process

The admission of a client in DIC should be tracked in case record of each client. Inform the Outreach coordinator of the presence of client via phone. Attendance to be routinely tracked in an attendance register for DIC by Shelter supervisor

10.9 Internal Check & Balance of process

The Case Conference is the medium to ensure internal check and balance. Detailed discussion of cases will expose care processes.

IF you are Outreach Coordinator, you should take organizing Case Conference with utmost seriousness

10.10 Evaluation / Audit of process

Preferably six monthly but at least annually, review all clients and note their progress on important scales. Each person in staff should do this. As outreach coordinator you should facilitate this exercise. Do not use this as a learning event, this is strictly a review of all cases event. For each client create one REVIEW SHEET. On this sheet ask the outreach worker to fill in the points that come up for action. As coordinator, you should see that the outstanding items are completed in due time.

Independent Audit: If you know someone who is external, then ask Director, Programs if your program can be audited at least once annually.

The annual audit should take an overview of entire program, but you (Coordinator) should in discussion with Director, projects point out specific issues you want audited in detail. This would greatly help improvement in processes.

Remember to always summarize your statistics quarterly and cumulatively for six month and annual period

10.11 Gaps and Suggestions

The summarizing process has to be strengthened

10.12 Training Requirements

Summarizing cases,

Review of cases and template for same

What is the next process?

Discharge from DIC

INSERTS IN DOCUMENT

Client of Men's Shelter coming to the DIC
DIC serves as an alternative place for clients of men's shelter. A client from shelter could come to either spend one day or come routinely to the DIC. This activity is important since it enables interaction of the shelter client with normal activities such as taking a bus, taking a ticket, money transaction, walking to DIC, etc. which is otherwise not available in shelter. Although shelter clients do go out for morning walks, the park is area is close by. As DIC Supervisor you might have to accompany the client to DIC from the shelter. A shelter client could also be advised by the psychiatrist to venture out of shelter in view of quiet and non-participative behavior in any activity of the Shelter, perhaps change in environment would help. You would also have to drop the client back to shelter.

CASE STUDY OF CLIENT – MANTU

(Mantu worked for a care giver, at a road side eatery. His work performance was good and the care giver was satisfied with his work. When Mantu recalled the address of his house; the care giver traced it and went to drop Mantu to his house. Coincidentally, Mantu's house was close by the care giver's native place. Mantu wanted to return home with money from his savings; he wanted to buy a piece of land in his native village. Mantu took all his savings and went home. But he returned to work for the care giver after some time. There was a problem though. The care giver did not pay Mantu on a daily basis; he paid him weekly. This was not agreeable to Mantu who wanted money to be paid daily and add it to his savings and use in his next visit home. Mantu did not want to spend the money but only wanted to receive it every day to add to his saving. Everyone else he knew, on the street, was paid daily. After much patience, he left the work at the care giver's and found another job where he received daily cash. However, after a few days he left that job as well. When the Naya Daur Social Worker met the care giver, he informed of Mantu's recent leaving of the job. The Social Worker then met Mantu, at the DIC, and spoke to him about the situation. Mantu was currently unemployed. He discussed with Mantu - where he wanted to work; what his conditions were, etc. Mantu informed that he wanted to earn money and thus was keen about the cash. The Social Worker discussed the issue with the care giver. The care giver was amused why Mantu wanted money when he was giving food and other requirements. However, Social Worker told the care giver that since the money was anyways due to Mantu, it would do not harm to give it daily to him. After much persuasion, the care giver agreed and Mantu rejoined the job where he continues to work till the time of writing.

Interaction with Vagrancy department and Mayor's Office

How to prepare beforehand for raids by the enforcement branch of Kolkata Police:

- Raids on the streets of Kolkata deport several recovering clients to vagrancy homes, a place where neither mental health nor physical health and safety can be guaranteed.
- This is a major challenge and needs immediate resolution.
- Establish contact with the Vagrancy Department and the Deputy Mayor of Kolkata regarding the issue.
- Introduce the work with emphasis on current status of people
- Place a written request that if in future any raid is planned, the local councilor and police stations of the area are informed so as have prior information and prepare accordingly on part of Iswar Sankalpa for our clients' welfare.
- Thank them for their cooperation
- Inform local councilor and local police station of meeting
- Continue to ask them of possible raids every month
- Make a calendar of usual timings of raid and stay extra vigilant during such times
- Inform caregivers of threat of raids and train them how to intervene when such raids frisk away known clients
- Plan to visit Vagrancy homes if clients go missing in search for them
- Plan for release of client from Vagrancy homes
    - Pre-condition for release: Family member of client has to come, establish identity and get client released
    - Trace family on priority
    - If family is traced, request them to come to Kolkata and request them to meet the Controller of Vagrancy

What to do when a client goes missing (Missing In Action, MIA)

- Due to the nature of homelessness and drifting, the recurring event of clients going missing in the midst of their treatment regime
- Establish greater interactions with local police in this regard since they could have driven the person away
- Enquire from local care givers and volunteers and other locals on whereabouts of person
- Continue to visit site for consecutive days in search of client

Care at the government hospital

The relation with government hospital has proved beneficial for other services such as de-addiction and detoxification services which are available at government hospital and were availed for a client. This is a costly service and one much required. This is facilitated by liaison of the project psychiatrist with the government psychiatrist and by the social worker and the government hospital functionary.

The hospital is also useful for other medical care however in client hospitalization for any medical reason is done with the identified private hospitals.

List of Annexures

Annexure 1: Table for Forms, Manuals, Policies, Handouts, Auto Reports, Flags

	Naya Daur / Component 1	Create / Modify	
	Forms		
1	Daily Report Form	Create	Should be used during Observation, Regular Service periods
2	Consent Form	Create	
3	Physical Health Check Up Form	Create	
4	Nutritional Status Assessment Form (or section in Physical Health Checkup Form)	Create	
5	Homeless Person Identification Form	Modify	Mark with a symbol those with Psychosocial Disability
6	Case Intake Form	Create	Similar across Sankalpa; Add Consent Section
7	Stake holder form	Create	
8	Volunteer Form	Create	
9	Care giver Form	Create	Consent section add
10	First Clinical Impression Form	Create	
11	Adverse Event Information Form	Create	
12	Client Medicine Refusal Form	Create	
13	Checklist for essential actions during Regular Service Process	Create	

14	Individual Care Plan	Create	Similar across Sankalpa
15	Counseling Plan as part of Individual Care Plan	Create	Similar across Sankalpa
16	Zone of Change Observation form	Create	
	Manuals		
1	Physical Health Check Up & Management Guideline	Create	
2	Essential Learning for outreach worker on Psychotropic medicines	Create	
3	Induction Manual	Create	
4	Outreach worker manual	Create	
5	Counselor's Manual	Create	
	Policy		
1	Informed consent policy	Create	
2	Duration of follow up policy when clients are taken care by care giver	Create	
	Hand outs		
1	Project hand out to Stake holders	Create	
	Auto Reports from MIS		
1	List of appointment for the Psychiatrist for New Clients	Create	

2	Clients who have not given consent to medicines even after two weeks of negotiation , one month of negotiation	Create	
3	Clients on regular medicine (by Milestone)	Create	
4	New Clients reviewed within 15 days	Create	
5	Actual Reviews v. Planned Reviews	Create	
	Lists / Data bases		
1	Volunteer data base	Create	
	Flags		
1	Substance Use problem	Create	
2	Assault	Create	
3	Self-harm	Create	
4	Death / Very ill	Create	
5	Mark Zone of Change	Create	

Annexure 2: MIS of Outreach:

S.No	Name of sheet	Type	What does it record	Frequency
1	Client Information Sheet	Recording sheet	Records basic information of client	Event based
2	Field Supervisor Sheet	Report	Open ended report	Event based
3	Counselor Report	Report	Open ended report	Event based
4	Coordinator's Report	Report	Open ended report	Event based
5	Doctors Sheet	Recording sheet	Observation and Treatment planning by doctor	Event based
6	Observation Sheet	Recording sheet	Observation & Treatment Planning by Coordinator	Event based
7	Emergency Medicine Requisition Slip	Material Request	Request for Emergency Medicines	Need Based
8	Hygiene Requisition	Material Request		Need Based
9	Stationery Requisition	Material Request		Need Based

10	Medicine Requisition back up	Recording sheet	Individual Prescription and M,D and E drugs	Monthly
11	Individual Medicine Disbursement Sheet 5 days	Checklist	Tracks medicines consumed by clients over 5 days	Weekly
12	Individual Medicine Disbursement Sheet 7 days	Checklist	Tracks medicines consumed by clients over 7 days	Weekly
13	Weekly Medicine Requisition Sheet	Material Request	Weekly medicines issued to IS staff and to CG	Weekly
14	Weekly Medicine Disbursement Sheet	Material Distributed	Weekly medicines issued to IS staff and to CG	Weekly
15	Day wise	Checklist	A sheet for each area for all clients, records daily attendance	Daily
16	HOPE MIS Back Up sheet	Collection of sheets already discussed		
17	Caregiver New	Tracking Sheet	Monthly tracking of care giver	Monthly

18	Doctor Check up	Tracking Sheet	Monthly tracking of care provided by IS doctor and Hospital examination	Monthly
19	Supportive Employment	Tracking Sheet	Daily service of SE to clients in different field areas	Daily
20	Counseling Sheet	Tracking Sheet	Daily service of counseling to clients in different field areas	Daily

Annexure 3: Suggestions on MIS

1. Please number all formats and all fields within format
2. On top of each format, please specify the purpose of the sheet / report / instrument
3. Please also mention how information required would be used, this would enable person filling information think on what he/she is recording
4. Date of filling the record should be mandatory in all formats
5. Please place the formats that are in series with the current format, the previous order and subsequent order such that linkages can be established between formats
6. It should be clear who should be filling in data and who is checking or commenting on it.

Annexure 4: Care giver form

Section 1	ID of care giver	System generated
Section 2	Personal Details of Care giver	Filled in by Outreach worker
Section 3	Current Roles of Care giver	Filled in by Outreach worker
	Care giver as supplier of medicine: 1. Only on weekend 2. Weekend + whenever Outreach worker absent 3. Regular / Main provider (Milestone 6)	
	Date when Milestone 6 achieved	Outreach worker
	Date wise log of who is providing medicine. If there is loss of Zone of change, then note date of same	Outreach worker Checked by Project Coordinator (One outcome is – Number of clients who have achieved Zone of change / Milestone 6; Mean duration of time since Milestone 3 (Registration) to achieving Milestone 6)

Section 4	Your observation on how care giver is performing	Filled in by Outreach worker, Counselor and Project Coordinator (each)
Section 5	Attendance in the Care giver meeting	Outreach worker
Section 6	Future Plans of working with Care giver	Outreach worker
Section 7	Felicitation of care giver	Outreach worker
Section 8	Photographs	Outreach worker

Annexure 5: Consent Form

	CONSENT FORM	
1	Date	
2	ID of Client	
3	What is the matter for which consent is requested	
4	Has the client given consent <Yes / No>	
5	If consent refused, any reason given for refusal?	
6	Member of the staff reporting the form	
7	Signature of the staff	
8	Signature / Thumb impression of the client	

Annexure 6: Review by the Outreach Coordinator

Review Period: <Start date , End date>

Overview:

	Old	**New**
Total Clients:		
	Routine	**First**
Total reviews planned		
	Routine	**First**
Total reviews completed		

Section 1: New Clients

Summary:

Total New Clients: <Numeric> (x)

Total New clients whose first review was done within 15 days of identification: <Numeric> (y), % (y/x)

Annexure 1of Section 1: List of items

S.NO	Name of Client	ID of Client	Date of Identification	Date of First Review

Section 2: Old Clients

Summary:

Total Old Clients in the program:

Total Old Clients who review was done as per planned date of review:

Annexure 2 of Section 2: List of items

S.No.	Name of Client	ID of Client	Date of Planned Routine review	Date of actual routine review	

Annexure 7: Process Map of Naya Daur

NayaDaur_IS_Outreach_Processes.pdf

Annexure 8: Logic Model of Outreach and Activity Schedule at DIC

NayaDaur_Outreach_LogicModel&Acti