REINTEGRATION

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Standard Operating Processes

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1. Program Overview

1.1 About Project & Problem Statement

The mission of the field of psychiatric rehabilitation is to help persons with long-term psychiatric disabilities increase their functioning so that they are successful and satisfied in the environments of their choice, with the least amount of ongoing professional intervention (Farkas & Anthony, 1989). The major methods by which this mission is accomplished involve either developing the specific skills the person needs to function effectively and/or developing the supports needed to strengthen the person's present levels of functioning (Anthony, Cohen, Farkas, & Gagne).

Participation in life roles has been termed Community Integration and return to participation in life roles has been called Community reintegration (Resnik, et al., 2012). The term reintegration has been used in the context of discharge from an institution such as a hospital, prison or other setting in which the individual is separated from normal community living and returns to community life. Community reintegration is inherent in the definition of recovery which is variously defined but in the context of this project it might be defined as the ability of the person to live on his/her own, work, interact with others and perform a few social roles. However, symptom control is essential before the person can start on the path to reintegration.

The process of psychiatric rehabilitation starts when the first contact is established with the person. However, only after the acute symptoms of a person with psychosocial disability residing in either of the shelters or in the outreach program of Sankalpa, stabilize, the process of their reintegration starts. Reintegration is to reintroduce the person back into society with a new identity -of a complete citizen; not as a person with a psychosocial disability. This phase of the recovery process is extremely important perhaps, the most important. The goal of the reintegration services of Sankalpa over the next 10 years is Inclusion of persons with Psychosocial problems in the prevailing community units especially those who are in the state of homelessness in Kolkata and belonging to socio-economically marginalized section living in Kolkata.

1.2 Main Clients / Beneficiaries of the project

Clients discharged from the shelters operated by Sankalpa and its outreach program are end users of reintegration services. In the case of the former, their families are traced and the clients are taken back to them with assistance of reintegration services. The clients are continuously supported by this service till the time they establish safe connection with another service in their local area. In case, for clients from the shelters who have recovered but families are not a station to go to, another location is found where clients are supported by this service. For clients in the outreach program, if the family is traced similar care as provided to a shelter client is provided. Most of the clients suffer from schizophrenia or some other form of severe psychosis. There could be other, additional, co-morbidities both physical and psychosocial, that a client has when (s) he becomes a client for reintegration team.

1.3 Goal and Expected Project Outcome

The goal of the reintegration process is to enable a client perform roles appropriate to his / her life situation in the society on their return to a suitable destination context where there is a chance for a fulfilling life within accepted realms of pragmatism and accepted social norms. For program purposes, Sankalpa refers to these destinations as "Community Units". The destination or community units includes but is not restricted to family; it could include other arrangements in the society such as working women hostel, living by themselves (Independent living), living with an employer, etc. Many a times, destination is a visit back to the context or point of origin from which the person had come but it could also be different. It is the lapse of time, sometimes significant, and intervening experiences that makes this going back akin to a visit to a new context. It is possible for one person to experience several community units before settling down. The project eases the return to the community unit through its interventions and is therefore facilitatory in nature.

Outcomes of Reintegration

The desired outcomes of reintegration process are:

- Client should find a community unit to which (s)he is reintroduced to explore next phase of life;
- Client is able to participate in social roles appropriate for life stage and conditions, as a complete citizen with optimum independence.

However, the group of clients is very diverse in terms of their age, diagnosis and their situation at the time they became homeless. To understand what roles they were performing at that time and the course they had set themselves up for is important, for example, someone who is in early 20s might have got married and had young children and she was at the time of leaving her home taking care of the child and looking forward to nurturing the child; on another hand someone in late 30s or early 40s might have older children and would be involved in building her house when she became homeless. Reintegration for both of them depends on how many years they spent away from the original context and the new roles that await them. The project team therefore is faced with such individual tailoring of reintegration goals for each client. This variation in role functioning is a steep challenge that the project has to face on daily basis.

1.4 Project Philosophy & Principles

The project believes in the recovery of the person as a process by which the person should be able to live, work, learn and participate in their communities, appropriate to the context. In order to do so, both individual and environmental factors are important. By providing a regular follow up service that continues to assess the condition of the client, identifies its need, the project tries to provide support to the client (and family, where applicable) to improve chances of recovery.

The project realizes the role of the family in recovery of the client and therefore engages with it as a stake holder. The project exerts different pressures on the family if they shirk their responsibility of taking care of the client, at the same time, providing the family with total support.

The project places importance to the role of work in recovery of client and identifies work options that the client could be engaged in.

The follow up service is provided to clients both in the city and outside it for which the project creates a web of resources to support the client's recovery.

1.5 Program Objectives

The processes adopted in Sankalpa reintegration service points to the goal of independence of the person and his social inclusion. In pursuit of this goal, the primary stake holders are the person with psychosocial problem itself and the members of the community unit. For the person being reintegrated to have a successful outcome, three objectives have to be met:

- Optimum symptom remission;
- Optimum functioning and
- Optimum destination absorption

For the members of the community units, an important objective is to shed the pre conceived notion about the person and his / her past, related stigma and discrimination and allow a new opportunity. They also have to recalibrate their demand of expectations from the person. This influences all the three objectives the person has to achieve since the person has to start staying in the community unit.

The **specific objectives** of the reintegration process are:

1 To improve functionality of persons with mental illness

2 To improve skills for Productive living of the identified clients

3 To increase accessibility to livelihood options for the identified clients for continued employment

4 To create entrepreneurship models for livelihood engagement and continued earnings for identified clients

5 To ensure long term stability in terms of housing for homeless persons with mental illness

6 To ensure healthy continued community living of restored and resettled clients

<See Annexures 1a, 1b>

1.6 Program Design

The phase of reintegration starts during the stay of residents in shelter or outreach or UMHP program. This phase is third and final phase in care of person with psychosocial disability whether homeless or not. It also marks a continuing relationship with Sankalpa and does not have a definite termination point unless very recently when due to increasing number of clients, ad hoc guidelines had to be instituted to restrict those under continued care. Not all clients or residents however qualify for reintegration phase, and only those who are recovered and if not recovered those whose family are willing to take them back qualify.

The reintegration process is overseen by the treatment teams in the shelters and outreach and the reintegration team of Sankalpa. This is perhaps the only process where two teams come together and play a role in recovery of person with psychosocial disability who is homeless. Reintegration process starts with symptom stabilization phase from stay in shelter or in outreach and continues till the person remains in follow up services of Sankalpa.

The person is handed over to the reintegration team when he / she is fit for restoration and this team then is responsible for introduction into community units, maintenance and follow up of person while in the community unit. This chapter will describe the processes of reintegration team mainly since the tasks of therapeutic teams have been described under chapters that explain outreach and shelter services.

The first important milestone in the project is when the person is introduced into a destination or community unit which could be a family or non-family location; the second milestone is when the person is under follow up care while staying in the community unit.

While process of reintegration is universal i.e. each person has a reintegration plan, its operationalization and result is very different. The recovery is not a complete elimination of symptoms but an improvement in well-being / functionality of person. These reintegration services are therefore extremely important and also

present the biggest challenge yet in mental health services – long term care of a person with psychosocial disability.

The duration that a client / resident on discharge stay in the community unit is referred to as Community tenure. The events during community tenure present the highest challenge to the post reintegration follow up services.

Based on the community unit where the person is going, reintegration could result in one of three results shown in Annexure 2. They are different in terms of implication for the person and for the service provided by Sankalpa.

1. Restoration: When the end destination of person is the family / immediate relatives with who the person either stayed before homeless or are ready to receive the person back while she / he was not earlier staying with them

2. Resettlement: When end destination is a community other than family; community is a location or an ecosystem which could be a street, a corner and not family. The person could be staying alone or in close relationship with another, all who are biologically unrelated. Close contact with family could be newly forged or maintained in this state, they could even provide food, etc. but not stay together or in dependence. Clients may also find long term residence in old age homes, other homes run by organizations, some client do get admitted long term in mental hospitals. In addition, Sankalpa is experimenting with new facilities for recovered female clients to stay on their own – group homes in community, independent living options.

3. Repatriation: When a person foreigner in origin is sent back to country of domicile (end destination)

In the reintegration process, main constituencies or stake holders are:

- Client / Resident (hereafter residents are called clients since they are serviced by reintegration team)
- Client's Family
- Other project team members within Sankalpa

- Community members
- Members of the elected bodies such as village panchayat
- Police
- Employer
- Treating doctor and other hospital / clinics
- Not-for-profit organizations working in different parts of the country

While the teams are clear in their communication of the role they envisage for each stake holder there is no standard set of messaging and charting of effectiveness of each stake holder. It is therefore suggested that a module or rough guideline for interaction with each stake holder is developed and their involvement charted. This by itself would enhance mental health knowledge amongst stake holders. Further, Sankalpa could invite these stake holders once to Kolkata to hold a large convention of different participants from across country and share their stories and felicitate them.

2. Reintegration Framework

The reintegration framework depicts the work done with the client and the community unit over three phases:

- Pre Re-Integration Capacity Enhancement (**Phase 1**)
- Re-Integration – introduction to a new community unit (**Phase 2**)
- Post Re-Integration follow-up (**Phase 3**)

The framework shows the different key processes in each phase.

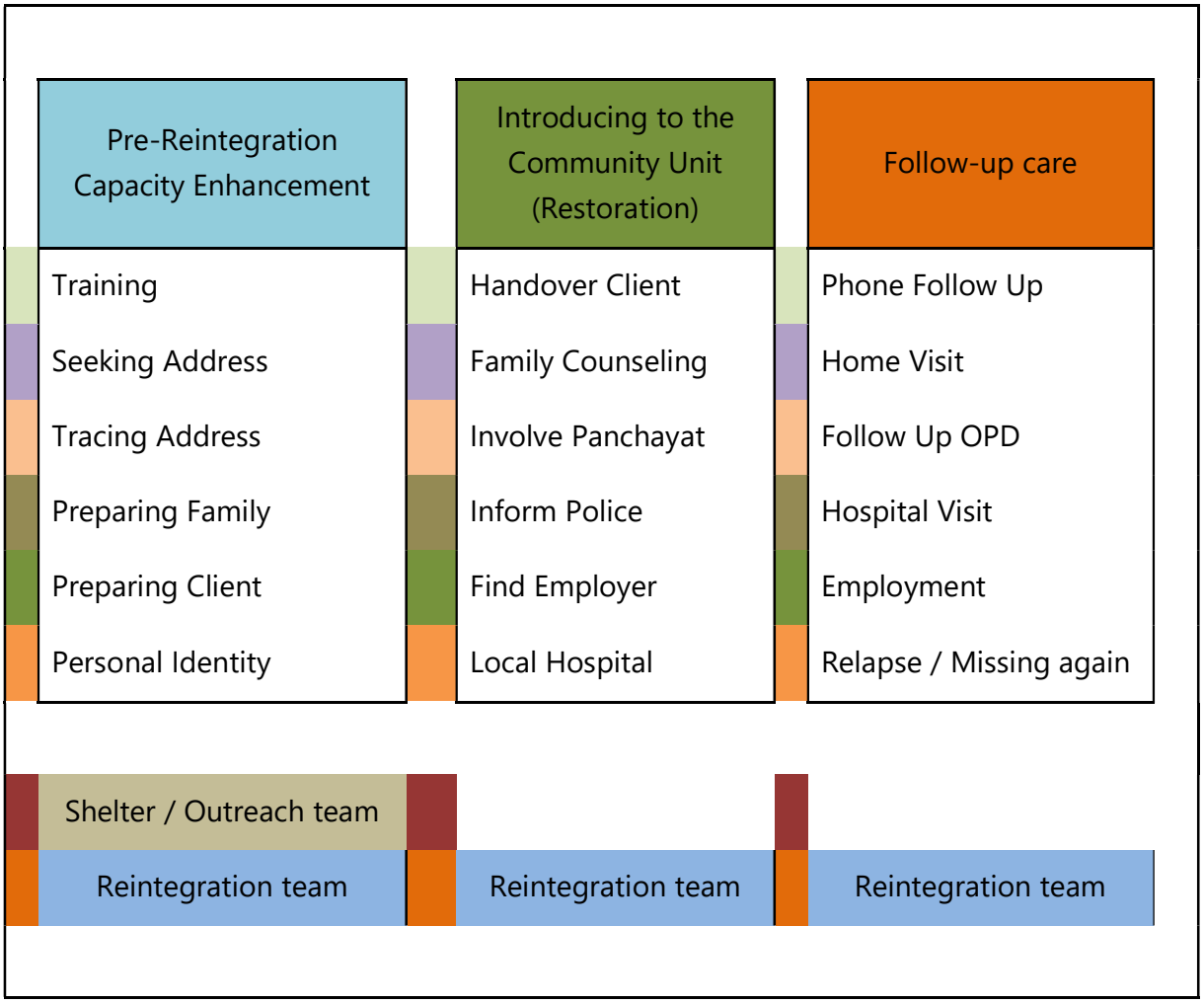
The starting point of Reintegration phase is a little fuzzy and overlaps considerably with the stabilization phase of stay at the shelter.

Two important end points can serve as yardstick to differentiate stabilization phase from reintegration phase:

- The clients clinical condition is stable with a treatment plan and
- Client participates in several vocational and other activities which are therapeutic in nature but also seeks out his / her interest areas. There could be income generation as well but not as a full time activity.

In the reintegration phase, in addition to the first yard stick being fulfilled, the client is involved in income generation activity either inside or outside the facility. The treatment and care of the client continues to be under the care of the shelter or outreach team and handover to the reintegration team does not happen at this stage. The reintegration process described here is an important event wherein the client is discharged from the shelter or the program to a new setting and has to live on his / her own with family / care givers /in the community. In this sense, the person goes out into the community and starts life on her own.

Reintegration Framework



3. Phase 1 / Pre Re-integration Capacity Enhancement

Process Holder: Vocational Trainer

Needs Change	Good ☺	Standard

3.1 Scope / Overview of the Process

The scope of this phase is to improve the capacity of the resident of the shelter or client of the outreach team to move towards role performance post reintegration. Activities towards improving capacity are supplemented by constant assessment. The aim of the assessment is to judge suitability of the client for reintegration. Recall that shelter and outreach services start their stabilization phase with an assessment of the capacity of the person (Baseline Capacity) in addition to an assessment of the symptoms of the person. The baseline capacity assessment is supplemented by repeated assessment during vocational training or supported employment as the case may be.

Pre vocational training is provided to the clients to enable them to engage in employment or some remunerative work. Clients mix with peers, employer, move outside the shelter to reach the work place, take on more responsibilities inside the shelter, all with the aim to improve their capacity to fulfil the social role expected of them once they go back to a suitable community unit.

Clients have to fulfil criterion for reintegration and only then are discharged from the shelters into the community unit. A format or checklist has been created which records the achievement of threshold levels of clients who are then called **FIT FOR RESTORATION** (Annexure 4).

Work is therapeutic and helps in understanding the client better. As the client gets engaged for most part of the day in work, more improvements are seen in his/ her condition. At the same time, insights into pressure the client can withstand at work, triggers for relapse are also well understood.

Clients are exposed to several vocations and in the ones they express keen interest, further training is organised. To this extent, the choice is limited to the ones that Sankalpa can manage.

Client has to reveal the address of the family which is then traced by the reintegration team and contact is established with the family. The client is prepared for reunion with family and is accompanied back home. Clients who are either refused by family or family is not traceable, alternative community units are identified and then the clients are supported to stay there.

<See Annexures 3 & 4>

3.2 Purpose / Objective of the process

The aim of the pre-reintegration phase is to achieve a threshold or cut off level of both the symptoms and capacity that would allow the person a suitable chance of maintaining recovery when reintegrated to a new community unit.

3.3 Result expected from the process

The result that is expected that the person should be able to perform in work, social relations, general activities and maintain treatment. This is the capacity that the person should gain while the family is traced. The family is expected to understand that the person suffered from a psychosocial disability and is first a person with a disability and not a disabled person. The difference is that there is a person and disability is only part of that person. The family is expected to change their demands and expectations from the person and provide him/her optimum conditions to fulfil the roles expected of the person.

3.4 Pre Conditions for the process

The resident should have overcome the acute symptomatic phase and should be on stable treatment.

3.5 List & Description of key activities & processes

Key Activity	Main Role	Supporting Role
1. Training	Vocational Trainer	Caregiver / Counselor
2. Seeking Address	Reintegration officer	Caregiver / Counselor
3. Tracing Address	Reintegration Officer	Caregiver
4. Preparing Family	Reintegration Officer	Counselor / Caregiver
5. Preparing Client	Reintegration Officer / Counselor	Caregiver
6. Personal Identity	Counselor/ Social Worker	Reintegration Officer

3.5.1 Training of the Client (Pre-vocational training)

The activities or tasks involved during this phase are largely in realm of treating teams in shelter or other programs and not a direct responsibility of the reintegration team. The reintegration team gets introduced to the client at this stage. Besides, maintaining recovery of the person, finding the address is a second important requirement of this phase. Even if the address is not retrieved, restoration is still attempted through field visit as per cue provided by the client of his / her address.

To find more details on this process, you are requested to refer to the document on Shelters

3.5.2. Seeking Address

Address & family details of a homeless person with mental illness is an important information. You are supposed to follow two processes to seek address from the clients, besides other you might think work. These are:

1. Proactive Address seeking:

In this method, you will actively seeks the address through a direct enquiry from the client many times i.e. *"Didi, Where have you come from? Where is your house? Where do your parents live?* This has two main activities:

- Build Rapport with client:

  The best way to make friends with the client is to spend time and speak to them. While the client / resident is at work, work with them and then speak in general. Spend time, take time, this is the mantra you should follow!

- Interview with the resident / client:

  You should sit in interview with client to enquire more about him / her including asking address. Hold these interviews as any other interview; held wherever the client is engaged inside the shelter or community, preferably at her place rather than at a place of your choosing. The information from this interview should be recorded in plain paper and kept in the file of the resident / client.

How to make friends?			
1. Talk	**2. Smile**	**3. Spend time**	**4. Make yourself available**

2. Passive address seeking:

As a member of the reintegration team, take advantage of your other colleagues interacting with the clients. Some of them have worked longer than you have and enjoy good rapport with them. In casual talk, encourage your colleagues to find the address or be sensitive to revealing the address. If they come across even hints of address, ask them to tell the same to you either on phone or anyhow. Address can be revealed by the resident any time – during picnic or any leisure activity.

While it's your goal to make rapport with the client, don't forget your own colleagues in other teams. If you have good rapport with them, they could be of big help to you.

Residents in the shelter know, after living there for a few days, that you and your reintegration team members are the ones who take residents back home, they might approach you directly and ask to be taken home, address could be revealed in this process as well.

Dada, take me home! When will you take me home? You want to go home. Where is your home?

Missing Person Advertisement: In the scenario that the person is unable to communicate (there was a resident who could not speak) or provide any details, then you must issue a "Missing Person" Advertisement in newspapers. Select few newspapers which are likely to have circulation in the area you suspect the person to be from. In this scenario, even though the person is unable to speak, you might want to try alternative methods of communication with her/ him – drawing, signs, help of someone who knows different language, just about anything that could be of help to you.

3.5.3 Tracing the address

A process of address validation is followed where you should use some tricks:

Keep a note of how many times the same area (locality, city, district, state, anything) is mentioned repeatedly by the resident – example how many times Bihar was mentioned when she said she is from UP, Bihar, etc.

This will give you some clue where the client is from.

You should use Google Map and try to locate address using the cues the client has provided to you. Note all information regarding address tracing of the client / resident in one form called the ADDRESS LOCATOR.

Currently, no such form exists but it would be good to create this in the file, it will focus attention to one place for all address related information.

RECORD IN AN ADDRESS LOCATOR FORM

At times, the resident could provide you with other details such as name of best friend, father's name, school or college of education. This could help you locate the coordinates of the person before being rendered homeless. This is Supplementary Information. All family details of the person are recorded in the **Client Interview Sheet**.

If your team is able to locate the area / location based on information provided by the client / resident but have not yet narrowed down whether a person fitting the client's description indeed belonged to the area, then contact the local police station, local Panchayat over phone and enlist their help.

Give them the description of the person, including circumstances in which you found the person and request them to search for a match with missing person complaints registered with them.

Send them a photo over email / WhatsApp.

You should also enlist the help of Local NGOs, SHG and CID could also be used to find the person in the address

Limited or no information:

In the scenario where either there is no information or information provided does not lead to any conclusion, continue with your effort to seek & trace the address.

You should make a field visit along with the resident / client to the location she might have vaguely suggested; going with her directions and familiarity. Just follow her cue!

Many times this process has been successful. Earlier, members of your team (seniors) have located houses of clients who had mental retardation or speech impairment, despite limited information. The mantra is to trust the information and trust the person (resident / client) to trace address.

If this effort is not successful, do not still abort the attempt, instead mention in the case file, the date of next effort. Record all results in the case file, as suggested above, do it in the "address locator form".

Team motto: "Never stop searching for address, till found"

3.5.4 Contacting the family

If you have traced the family, contact them as soon as possible. But remember, the reunion of the resident / client with the family depends on recovery status of client and their consent. Don't rush, this is a very critical decision. Read the scenarios below and decide how you have to proceed:

Condition 1: If the client has recovered and

Scenario 1A	**Scenario 2**
Family is ready to accept the person	Family is not ready to accept the person back:
AND	
Family is ready to come to Kolkata to receive the person (most common scenario):	The family's reason for refusal could be their greed for the client's property, their past frustration with care giving, relationship failures, poverty, etc.).
In this case, the family comes on its own expense to shelter. You should decide which one member of the reintegration team should become the contact person for the family to reach Sarbari.	In such a scenario, you should plan a reintegration trip is and take the resident / client along with you. This is a surprise visit to the family.
At times the village head man (Sarpanch/ Pradhan) accompanies the family to Kolkata. Ask the family, who all will come? If you find, that an important stakeholder is accompanying then encourage and welcome it!	One objective of taking the client along is to provide proof of his / her recovery to family members. It is often by seeing the state of client they recognize the difference.

"You need to see something before you can accept that it really exists or occurs"

Scenario 1B

- Family is willing to come to Kolkata but cannot afford costs:

In this case the local Panchayat is requested to get their one way ticket to Kolkata. Cost of return travel is borne by Sankalpa.

Scenario 1C

- Family cannot come to Kolkata for some reason: In such a scenario, reintegration trip is planned to the family address (details below)

If the family refuses to accept even then, then ask the local village headman, neighbors to intervene to ensure the client / resident is allowed to stay with the family.

3.5.5 Preparing the family for the visit

It is important for you to get to know the family and work with them towards their reunion with their family member. Before they leave for Kolkata, however, you must prepare them to bring the following documents:

- ID proof of themselves as well as of the resident / client
- Proof of kinship with the resident / client (a photograph, preferably attested proving relationship)

Condition 2

If resident / client has **not recovered yet**, but you have been able to track down the family, then contact the family and

Request them to come and meet the client / resident. Tell them that the resident / client needs more time to recover therefore needs to stay for some more time at the shelter. Ask the family to come as soon as they can.

Scenario 1: Once the family comes and they are agreeable for continuation of treatment at Sarbari, get an undertaking signed from them expressing their consent for the client / resident to continue to stay for treatment at the shelter and not hold Sankalpa responsible if the person goes missing. The family agrees to sign the undertaking then with this safeguard, the client continues to stay at shelter.

Currently, this process is under improvement to create a legal safeguard for Sankalpa in the eventuality of family filing charges against them for any mishap or adverse event.

Scenario 2: If family refuses to sign the undertaking and insists on taking the resident then issue a discharge against medical advice

If family is traced, advise them to register a missing person complaint for their family member, if not already registered. This allows the reintegration process to happen with the help of local police

3.5.6 Preparing the client / resident

Information for you

For you as member of the reintegration team, three main elements are important to ensure success:

1. The client,

2. Family and

3. Other stake holders, who, play an important role in inclusion of client into society and maintain his / her wellbeing. The first two however are critical.

As discussed above, the periodic capacity assessment and symptom charting of a client or resident has to meet a cut off criterion for him / her to be eligible for reintegration (**Fit for Restoration form, FRF**). The regular assessment process is

controlled by therapeutic teams of shelter or outreach. Currently, this process is disparate and progress of client recorded over several different scales and progress notes. There is no single converging analytic framework that helps to conclude if the client has achieved the cut off for reintegration.

Current process to identify fit for restoration:

It is the therapeutic team of shelters that approaches the reintegration team when a resident is considered fit for reintegration. The Fit for Restoration form is introduced by the reintegration team and is not a usual form used by therapeutic teams in their care processes. Therefore, currently the basis of therapeutic team to arrive at selection of a particular resident for reintegration is not known.

The reintegration team assesses the resident and discuss with him / her future scenario only after being invited to do so by the therapeutic team.

As member of the reintegration team, use the **check list** that is currently used as a guide to record the nature of interview with the resident identified eligible for restoration and to note the main categories in which discussions were held with the client.

Then you should request the therapeutic team to fill the Fit for Restoration form. FRF is integral to your work in the reintegration team and you request the therapeutic team to provide evidence in it why they think a resident is suitable to be reintegrate. **It means you should be well versed and trained yourself in the FRF administration**

After filling in the form, decision on fit for restoration could be in either direction.

There is lack of clarity / defined process who the final decision maker is in this situation. What is recommended is that the fields in the FRF be aligned with the fields of different forms used by therapeutic team. The cut off will just be then reaching a point in the categories of assessment. Once a client meets the cut-off, he/she should be eligible for restoration

It is also suggested that in addition to therapeutic team that fills in the FRF, the reintegration team should also independently fill the FRF. The two then should be tallied since the two teams have different perspectives and some

alignment of the perspectives is required. The shelter coordinator or respective program coordinator should then oversee the alignment and then take decision to discharge a client/resident

<See Annexure 5 >

Why the FRF?

The idea of the Fit for Restoration Form was to document the parameters on which decision to reintegrate and therefore to discharge a person from therapeutic process was taken. This is important since clients do relapse or go missing again from community units and in absence of any basis of release the onus of adverse outcome could fall on the reintegration team. This format considers different dimensions that are crucial to restoration and bears signatures of all professionals involved in discharge process. This therefore is a good process.

What you need to do?

Identity & Entitlement: An important part of pre-reintegration capacity enhancement is to provide each resident or client with an identity. This is considered an important entitlement of the person as a citizen of the country. The aim is to ensure that entitlements by the government under its different schemes can then be accessed by the resident / client but also that homeless person with psychosocial disability does not become invisible from government records.

Therefore, facilitate the following four documents for residents before discharge:

Aadhar Card: Aadhar Number bearing Aadhar Card issued by the Unique Identification Authority of India (UIDAI)[1].

[1]**The Unique Identification Authority of India (UIDAI)** is a statutory authority established under the provisions of the **Aadhar (Targeted Delivery of Financial and Other Subsidies, Benefits and Services) Act, 2016 ("Aadhar Act 2016")** on 12 July 2016 by the Government of India, under the Ministry of Electronics and Information Technology (MeitY). Source: https://uidai.gov.in/beta/about-uidai/about-uidai.html (accessed January 11, 2017)

Rationale:

Aadhar Number is unique and robust enough to eliminate duplicates and fake identities and may be used as a basis/primary identifier to roll out several Government welfare schemes and programs for effective service delivery thereby promoting transparency and good governance[2].

The Aadhar number is a proof of identity, however, it does not confer any right of citizenship or domicile in respect of an Aadhar number holder.

Aadhar can be used as a permanent Financial Address and facilitates financial inclusion of the underprivileged and weaker sections of the society and is therefore a tool of distributive justice and equality.

Voter ID card: A voter ID card is facilitated for residents of shelter and for those in outreach program.

Rationale:

This document allows the person to be registered as a regular voter and therefore a participant in the democratic process of the country. It also establishes his / her identity as a citizen of the country. A special provision has been made to allow homeless people to be registered in electoral rolls wherein address of shelter serves as their address.

Ration Card: This card is facilitated for the individual to gain access to subsidized food grains under the Food Security Act, 2013 of India.

Rationale:

This is particularly helpful for clients / residents who are restored back to families since their family need not spend out of pocket for the resident's food.

Savings Bank account:

Rationale:

[2] Source: https://uidai.gov.in/beta/your-Aadhar/about-Aadhar.html (accessed on January 11, 2017)

A bank account in name of the client or resident allows her to save her income and use it either for personal use or whichever way she wants. It also joins her to the formal economy and the opportunities it offers.

During the resident's stay at shelter, the incentives earned or if the person is employed the wages are saved in this account.

At reintegration, the amount of money in this account and that earned by the client is handed over to her for operation.

Besides the above four cards that any person in India can access, **Disability Certification** issuance is facilitated to enable the person access the benefits that the government offered under its various schemes for the disable. This certificate is offered as per the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 or its later equivalent.

In addition to above cards, it is suggested that following cards could be added to list:

Health Insurance Card: for residents or clients with mental retardation, "Niramaya Scheme" should be considered while for those with Mental Illness – "Swavalamban scheme" of The New India Assurance Company Ltd should be considered. This would provide adequate protection against out of pocket expenditure on OPD treatment and any hospitalization expenses.

Employment Exchange Registration with at least state employment exchange to get job offers and also other benefits.

Inform the client that the family is traced:

You should inform the resident / client that the family has been traced. You should also inform that the client / resident should start preparing for her way home and that this involves:

1. Taking charge of her treatment

2. Focusing on the vocation she is involved in so that she could continue it at home

Rationalize her expectations of the family. The counselor leads these interactions and the details are captured in the termination and exit counseling section of the chapter on Sarbari

Miscellaneous

Reclaiming Assets

If a client has an earlier bank account with positive cash balance and other investments (insurance policies, fixed deposits, etc.) but the client / resident does not have current possession of them or they have become inactive due to lack of operations, then as member of the reintegration team you should work to get back these assets to the resident / client.

This is an important step in justice else on his / her own it would be difficult for the person to claim her assets.

Many clients have a feeling of being wronged hence reclaiming some of their assets corrects that to an extent. A few clients who were recipient of pension earlier but had ceased to receive the same post the illness and homeless phase; help them to reinstate their pensions.

In Death

At time of passing away of a resident / client, if there is no address, then make one final attempt to hand over the body to a relative.

Earlier, the process was that Sankalpa would claim the body if the death was in a hospital and then perform the last rites, however, the new process is to let the government take over and perform last rites as per government procedure for unclaimed body / homeless people. Under this the body is kept for 3 days in the hospital morgue while advertisement is placed in newspaper informing of death and inviting any claimant. If none turns up, cremation is done by the government. Death Certificate is issued by the government hospital or any hospital where the client has passed away

3.6 Key Conclusion / Decision

The key decision to make is if the person has reached the cut-off required to meet discharge and therefore reintegration process

3.7 Information Capture & Tracking the process

The critical pieces of information in this process are:

1. Progress of the client in repeated assessment to meet the cut-off criterion for restoration. This is captured in the Fit for Restoration Form

2. The address of the family and establishing contact with them, for which one has suggested that a new form be put into place

3.8 Internal Checks & Balance

The shelter supervisor should in her independent evaluation of residents in the shelter and the coordinator of the outreach program in her independent assessment of clients should ask both therapeutic and reintegration team why some residents / clients have been or have not been earmarked for reintegration. This process has to be tightly monitored by the person in-charge of all projects as well, since this is a very critical step in the entire project works of Sankalpa

3.9 Evaluation / Audit of the process

An annual audit of all clients who were reintegrated in the past years should be done to understand their status at end of periods of one year since reintegration. This would give insights into both the therapeutic process' suitability for reintegration as well as the requirements of the reintegration team to refine its services. This should be done by an external person

3.10 Gaps & Suggestions

It should be noted that at this point, the therapeutic team is not aware of the community unit where the client / resident would end up hence the preparation to begin with is generic for all residents / clients. It is only after the address is traced and there is some likelihood that the resident / client is going to be restored that specific preparation for family stay could happen or rather should happen. This process is currently lacking in the Shelter for obvious reasons – large numbers of residents and difficulty in tailoring the solution to meet individual demand. The deficit area is social or interpersonal relations which cannot be taught in shelter environment, other skills like cooking and household chores, personal care, money management, working skills are rather stressed and done optimally. As part of generic skills, insight building and treatment discussion is also lacking and as we see later these have an effect on the treatment compliance and symptom remission as well as functionality of client when they stay in the community unit.

3.11 Training Requirements

Training of the reintegration team member on the FRF

4. Phase 2 / Re-integration phase

Process Holder: Reintegration Officer

Needs Change	Good ☺	Standard

4.1 Scope / Overview of the process

The resident is always hopeful of going back to the family or some other place that one could call as their own outside the shelter. Not all residents though want to go back to the family, so you should not have a value position that family is where everyone belongs. The issues of where the person will finally be rehabilitated depends on careful understanding of the story of the person and his / her preferences and of course the reality of the world in which we live in.

This process, focused on actual reunion or coming face to face of the resident / client with the community unit. Now, remember this need not be the last or final destination and a resident / client could move from one community unit to another due to several reasons before settling down in any one, so be open about the terminality of the process and retain your enthusiasm.

The Reintegration phase focuses on introducing the client to the destination i.e. community unit, usually family though not always. This section describe the restoration to the family in two scenarios – one where the family visits the resident in Sankalpa and the other where the resident is taken to the family at their native place.

4.2 Objective of the process

After fulfilling the cut-off criterion for discharge, the resident / client has to now start a new life in the new context. The first step of which is the introduction to this new context. The objective therefore of this process is to ensure that this introduction is healthy, optimistic and bears a realistic expectations from both the resident and the community unit.

4.3 Result expected from the process

The introduction of the resident to the community unit should lead to mutual acceptance

4.4 Pre-conditions in the process

Resident / Client should have the motivation or desire to go back to the community unit. This is essential. At the same time, the family should have had no history of past severe abuse towards the resident / client

4.5 List & Description of key activities & processes:

Two scenarios are explained in this process, one in which the family comes to Sarbari or to Kolkata to receive the resident / client and the other in which the resident / client is taken home to meet the family. They both have common activities and therefore the list below suffices, but for practical purposes, they are described as two separate scenarios.

Key Process / Activity	Main Role	Supporting Role
1. Handover Client*	Reintegration Officer	Caregiver / accompanying person
2. Family Counseling	Reintegration Officer	Caregiver / accompanying person
3. Involve Panchayat	Reintegration Officer	Caregiver / accompanying person
4. Inform Police	Reintegration Officer	Caregiver / accompanying person
5. Find Employer	Reintegration Officer	Caregiver / accompanying person

6. Local Hospital	Reintegration Officer	Caregiver / accompanying person

*: In scenario 1, the handover of the resident / client follows the counseling of the family while in scenario 2 the order is reversed

Scenario 1: Family comes to Kolkata

We have already discussed in the previous process, the preparation required for the family before they come to Kolkata to receive the resident / client. Here we discuss the actual process of meeting the family and what processes should be followed as part of that interaction and the scenarios that emerge from this situation. The key processes that play in this scenario are 1, 2 and 4 which are discussed below.

4.5.2 Family Counseling

Communicating the ten commandments to the family:

Once the family members reach Kolkata, you should receive them and lead them to meet their family member. Leave them all alone.

After a few minutes, brief the family on the following 10 points:

1. where and how the resident / client was found;
2. ask them about past history of the resident and enter all additional details in the case file of the resident to build a complete story
3. inform that the client / resident has a mental illness which is under treatment and that she / he has recovered sufficiently to continue rest of life at home with full participation in community
4. Inform on the need to continue treatment till they are advised to stop it by a doctor. Cautioned that against any interruption of treatment and that it could land the person in a similar state as in the past or even worse and that thereafter recovery would be difficult, usually.

5. Reassure them that they could contact you or any other member of the reintegration team if they have any worry, concern or crisis situation; share your phone number
6. Bring the prescription and show them the medicines physically. Explain how the medicines have to be taken and ask them specifically who is going to take responsibility of giving the medicines. If the person who takes responsibility is present, explain to him / her again how the medicines have to be given.
7. Then hand over one months' medicine supply.
8. In addition, inform them, that medicines alone are not enough for recovery. The family has to provide other supports to the client such as involving the person in the day to day work in the house and if possible even outside. Inform them of the stressors that spark a crisis or aggravate the condition of the client and educate them how to avoid such situations
9. Tell them that the client has been trained in a particular vocation, show them the product that the client has helped make and tell them what infrastructure is required for her to work. Share with them how the resident / client spent her day at the shelter, activities she liked doing and friends she made.
10. Hand over the discharge summary to them

Possible Scenario: At times, after having visited the shelter and seeing the care received by their ward, family feels that shelter is best suited for the person; that he/ she should stay back and continue with care and treatment there. In this scenario, as member of the reintegration team, inform them that shelter is a transit point and the overall goal is for the person to go back to the family and the community where he/she should be able to perform their roles with assistance and support of family.

Tell them that while care is good at shelter, it is not a natural place for a person to stay. Even if the family is poor or has some other pressing conditions, the support they can provide including emotional support can never be replaced by care in the shelter.

The current manual containing key messages used in this process should be refined and made more structured.

4.5.1 Handing over the resident / client:

1. After the family counseling, the resident / client is handed over to the family.
2. Handover the savings of the resident / client to the resident and not to the family members. Ask her again if she has understood the treatment.
3. You should also tell her that she should freely communicate with the family and tell them how she is feeling, this is crucial to her wellbeing.
4. Give her your mobile number and those of the care giver, counselor or both to whosoever she is closer to and tell her to call any time she wants to.
5. Give her the custody of her Identity cards and keep a note of their serial numbers in her case file, in case they are lost, at least you have the records. It is preferable that you either scan them or take a picture of them and store them with you
6. Take a picture of the resident with her family members for record
7. Give the resident your visiting card or an annual report of Sankalpa or any such document that has the address and phone number which she could preserve.
8. The medicine may be handed over to the family informing them of the review date
9. If the family does not have money, hand over them some money for the journey, pack food and some clothes for the resident to be used at home

4.5.4 Post Communication, police station:

Take the family member to the local police station and inform the police of the handing over of the resident / client to the family. Write an application and submit a copy of the documents the family has brought as proof of relationship. Also ask the family member to write an application informing the police that he/she is taking custody of the client / resident. Attach a copy of discharge summary along with a copy of the admission of the resident / client in the shelter or the program, as the case may be. Police records this as GDE. Note the GDE number and record it in the case file of the client for your records.

Scenario 2: Taking the resident / client to the family

This process is undertaken in one of the three following conditions:

1. If family is willing to accept the resident / client but does not have the financial means to undertake the journey to Kolkata, then IS team visits instead of asking family to come to Kolkata

2. If family is not willing over phone, but in presence of the resident / client there is a chance they could accept then restoration visit planned along with resident / client

3. Untraced address despite all efforts then visit made on the direction of the resident / client and if family traced, person is handed over

Restoration visit

Restoration Visits are a minimum one day but usually a three day affair depending on the distance and number of clients taken for restoration. Typically a few clients of one area are taken together. The visit involves:

Day 1: Arrival at main station. Then enquire location about the residence from locals. Spend a day or more in tracing and reaching address of the client, if successful. The reunion with family or relative is a very critical process and the key transactions during this meet are as per a checklist called the Restoration Visit Checklist (exhibit below).

It involves 6 key processes:

1 Hand-over of the person to the family;

2 Educate family and other stake holders on recovery process of person at the shelter or the outreach and requirements to maintain the same in the family. This means you should know the factors that maintains the health and those that trigger aggravation of the situation of the client and educate the family on those.

3 Involve the Panchayat president & local community.

4 Informing police of the handover:

4.1 To the police provide a written history of the client from the time of admission to point of handover to the family.

4.2 Also inform them that you would be calling if required and if they could check upon the client. This is important if you suspect that some foul play is possible once you leave from the location

5 Finding a prospective employer or place of engagement for the person:

5.1 A person can do nothing else for 8 hours a day, except work. Therefore, it is important that you spend time looking for prospective work for the resident based on the skills (s)he has acquired at the shelter. In rural areas, however, many options might not be available or the house might be far away from market places. In this scenario, the family has to be told to involve the resident / client in the work at home and also look for other work that could earn an income. The family if poor should be told that additional income would reduce their economic burden. If the family is rich, tell them that it is important that the person works for self-esteem and self-confidence.

6 Finding and meeting nearby medical facility where person can go for regular review and medicine refills.

Day 2: Local hospital contacted and resident / client linked up for treatment continuation:

Do this on day 2. It is important to personally meet the doctor and tell him of the history of the client, the current treatment and what role is expected from the doctor in future. If there is a nearby psychiatric service then it is easier, otherwise a general doctor has to be told how you want him/her to help.

Day 3: Local community, Panchayat contacted and asked to help / support the resident / client.

Key messages have been discussed above

4.5.1 Handover of the client to the family / relative:

Handover of the client to the family / relative: During an outstation visit, if handover of the client to family happens then following documents are taken from the head of household of receiving family as proof of identity and address:

- Voter Card
- Permanent Account Number (PAN) Card issued by the Income Tax Department of Government of India, if available
- Aadhar Card
- Driver's License, if available
- Bank document such as passbook
- Letter from police or Panchayat about the handover.

4.5.2 Educating the family and / or stake holders

Educating family and other stake holders on recovery process of person and requirements. The key messages given by the reintegration team to the family and other stake holders are:

1 The person is suffering from a mental illness and therefore any past behavior was due to untreated mental illness and not intentionally by the person

2 The person was on treatment and has made satisfactory progress and is ready to stay in family

3 The person can perform functions in the family and should be encouraged to work

4 The reintegration team was available to provide care and support to the family; mobile number of a team member is shared

5 The treatment should be continued and not stopped or interrupted

6 The local facility where follow up could be done is identified and family suggested to visit it

7 It was responsibility of the family to take care of the person and Sankalpa has fulfilled its role

Missing Process: The family plays an important role both in successful reintegration of the person as well as maintenance in the family environment. Studies have shown that families, relatives, clients and psychiatrists do not agree in their assessment of client remission. The interaction time with family is very limited and not enough information is provided to family to make them understand remission of client. This process needs to be developed further and geographic area to be restricted to Kolkata and neighboring districts.

Does the family appear to be ready to become partners in the treatment and recovery process of the client, how would you rate this on a scale of 1-10?

4.5.3 Involving the Panchayat president & local community

Give them the following message:

1 This is a person who has a mental illness, (s)he is not mental illness personified. We have to identify the person and not only with illness

2 The illness is under treatment and with it, the person performs and is able to execute several activities that most of us do

3 The person requires support in living a life of recovery, so do most of us, so there is no real difference

4 We should forget the past and allow the person a chance at a reasonable future. The past stigma, prejudice and discrimination should be let go. Some of the schemes that are available for person in distress should be provided to this person to make a start in life

5 The person has a support back up in us, so if there is a problem in the future, contact us, do not abandon the person and do not ignore the deteriorations in condition if there is in future.

6 The person is not dangerous, in fact there is more chance that violence is inflicted on the person rather than the other way around, so keep an eye out for any act of violence and don't turn your eyes away.

Do you see signs of a mental health advocate in this panchayat leader?
Were you able to hand over some material on rights of a person with metal health problem?

4.5.4 Informing Police both at origin and destination of journey

Informing the Police: Police is informed both at source of journey (Kolkata) and at destination (community unit location).

When you start your travel with a client / resident for reintegration, give a letter to the local police station at Kolkata (usually Alipore PS) providing details of the client you are taking and yourself and whosoever else is accompanying you.

Submit this letter in the "Process Section" of Police station and get a stamp affixed on it.

If this visit is based on client's sense of address and address is found on visit, then local police station at destination is informed and they are asked to check if any missing person complaint for the client was lodged with them.

If the handover to family is successful, then a General Diary Entry (GDE) is filed with the local police station at destination.

On your return to Kolkata, inform the local police station on the result of your visit via a letter which would be entered as GDE by the police station. Now, if the resident you have reintegrated was initially admitted by police referral, then write to that police station and file a GDE with them, while referring to the original GDE at admission.

4.5.5 Finding an Employer / finding work for the resident / client

It is an essential requirement for person with psychosocial problem to go back to the family and continue to work.

You, should explore work options for the person in the local community. This is essential and therefore you should spend some time doing so. The presence of work options depends on local context. If there is a possibility similar to that in Sarbari, it is an ideal situation but in rural areas, it would be difficult to find such places.

You should approach the local tailors and ask them if they would be able to employ or give some job work to the client. You should tell them about her skills and tell them how work would help her stay in good health.

The family members also need to be told on the need to encourage the resident / client to find work, continue to work. Continuous prompting and encouragement that was part of the process at Sarbari has to be explained to family members so they continue to encourage the client.

4.5.6 Local Hospital

To maintain treatment continuity, along with regular medicines, review is also essential. For sustainability, review should be done with a local doctor.

You should identify a local doctor usually at a district hospital or a mental hospital or private clinic where the client could continue her treatment.

Since psychiatry services and medicines are not widely available, finding a point of contact is a big challenge, however, review facilities can be found if the client and

his / her family are willing to travel for some distance; this would be once a month and not frequent.

This homework should be done prior to your visit to the area and local contacts of the psychiatrist at Sankalpa should be used to find a practitioner closer to the home of the resident.

Is maintenance pharmaco -therapy required for recovery in clients with diagnosis of schizophrenia? You must debate this in your team.

4.6 Key Conclusion / Decision

As the reintegration officer, you should make a quick assessment of the community unit and its context and mark the areas in which the support has to be provided to the resident / client and its family.

Further, an assessment should be made on safety and security of the person you are rehabilitating. If there is any threat, you should discuss with the person accompanying you or your seniors and take a call. The strength of network of support should also be gauged. Overall, a conclusion should be made on what is the likelihood that the resident / client would be able to pursue the goals of the process of reintegration.

4.7 Information capture & tracking the process

The current process is a checklist based series of activities. The checklist has been developed based on necessary and natural requirements and sequence of activities.

In this environment, would she be able to have friends?

However, the essence of this process is to formulate a hypothesis on the response of the reintegrated client to the new context. Would the recovery process suffer or proceed normally in this new context? When we have to answer this question, there seems to be limited information that is captured. If, the factors of hope, advocacy and peer support are important in recovery as indeed suggested by Mead and Copeland, then we need to know if the panchayat leaders will be able to undertake

advocacy on behalf of the client / resident (Mead & Copeland, 2000)? While effort is being done in right direction, is it enough to help the target audience reach the tipping point? This estimate is not captured in the information system. Further, one can't stratify risk of the client/ resident in the new environment and tailor the support according to the risk equation. Therefore, information system of the process captures the conduct of the activities on a checklist but do not bring back information to help in follow up decision making.

4.8 Internal checks & balance

In the current process, Senior Reintegration Officers and care givers handle reintegration; the process starts and stops with them. It is recommended that the project coordinator of the project from which the client was relocated should be informed via a detailed update on the processes & status during reintegration of the concerned person. Thus, supervisors of both the shelters and the outreach coordinator should be informed as also Director, Projects.

Further, the shelter coordinators or supervisors of both the shelters should earmark a few residents who have been reintegrated and request the reintegration team to continue to update on the follow up status of the client / resident. The linkage with the hypothesis framed on the risk of the failure of the client / resident to fall in between the lines should be kept in mind.

Can you put up on my notice board, the follow up status of this recently discharged resident over next three months to see how she is doing? Please also mark her risk status on each follow up.
(Shelter Supervisor to Reintegration Officer)

4.9 Evaluation / Audit of the process

A six monthly audit of all reintegration done during the period should be undertaken by the reintegration team themselves under supervision of a small group dedicated to study and refine process of reintegration in Sankalpa. The fate

of the reintegrated persons should be studied and the Risk Hypothesis model should be continually refined through this process.

4.10 Gaps & Suggestions

1. Building insight into family, panchayat and other local stake holders is very important but the process is not mature since the contact time at point of reintegration is short.

Person with serious mental illness who live in community and depend on follow up services of Sankalpa or others need social support to prevent isolation, loneliness. If the person with a serious mental illness is unable to establish communication with the family, relatives and friends, the social environment around the person starts adapting to the new condition. As a result, networks and other relations of the person start contracting leaving the person more lonely and isolated. The loneliness and isolation severely compromises quality of life of the person. Since not enough trust and insight is created in the minds of family, relatives and friends, they continue to relate to the person's life before the treatment and the prejudice persists.

It is therefore suggested that more time be spent in developing insight into the condition of the person so that social networks and relationships are made which sustain the person with psychosocial disability. A dedicated strategy and approach needs to be made for this. The current geographical area for this action should be restricted to Kolkata and neighboring districts as is for follow up home visits.

2. Currently, the process of finding work for the resident / client in the community is very limited due to paucity of time as well as lack of local knowledge with reintegration team. There is no local anchor hence the team has to rely on the word of the family members, neighbors and other stake holders like Panchayat members but all of these have limited reliability. It is not that family does not want the client to work, but the effort required to find the work and then continue to support the person through work is a demand that many families, given their socioeconomic realities, find difficult to cope with. Therefore, many clients end up not working which has an effect on their condition. As has already been noted in the Sarbari

chapter on matching skills learned in vocational training and other trainings with the actual employment opportunities at destination community unit, it must be said that work remains a big challenge and requires more thought and work to engage the client at destination.

3. **Missing Process**: In the telephone log register, an elaborate notation should be made on the work status of the client.

Following details should be included:

- Work place of the client
- Nature of work she is engaged in
- Number of days in past one month the client attended work,
- Terms of Payment for the work

The place where the client is currently receiving treatment should be noted in the register. A letter, in a predefined format, should be sent to that facility signed by the Director, Projects with the subject line – About Sankalpa, introducing the doctor or in-charge of the facility to Sankalpa and its work.

The details of local service should be noted in the follow up register. Comments such as "same condition", etc. should be avoided and a clear mention of what the current situation is should be written.

4.11 Training Requirements

The team should be trained in defining the role of family in supporting the client in maintaining recovery.

5. Phase 3 / Post Re-integration Follow-Up

Process Holder: Reintegration Officer

Needs Improvement	Good ☺	Standard

5.1 Scope / Overview of the process

The third phase – Post Reintegration Follow Up is to continue providing maintenance & crisis management services to all clients who have been reintegrated to maintain their state of well-being. During this phase, the reintegration team members follow-up in reintegrated clients and enquire their status. Based on the status, they provide follow-up support as required. The follow up support could range from home visits, issue of medicines from Kolkata to the residence of the client and requesting another organization to follow up on the client. Status of the client is constantly updated in the record systems to know present status.

The rationale for providing follow up services is well established. People who suffer from psychosocial disability need services and support in their daily lives and their quality of life depends upon, among other things, how their service needs are met (Rosenberg, Lindqvist & Markström, 2009). These service needs are for assistance that influences their physical, mental and social health. The individualized appropriate services can only be designed if the service need of the person is known. The purpose of Sankalpa's post reintegration follow up service is to continue to provide assistance in maintaining recovery of the person in the new context and facilitate a good quality of life.

5.2 Purpose / Objective of the process

The aim of this phase is to maintain recovery of client once (s)he is reintegrated back. Since majority clients have a psychosis, mostly schizophrenia, the aim of the support service is to support the client through the chronic illness. Most clients belong to poor

contexts and Sankalpa's service is mostly the only ones checking on them and helping them overcome crisis.

5.3 Result expected from the process

During this phase, the two main outcomes that the team focuses on are:

- To ensure good symptom control through treatment compliance or adherence
- To ensure the person is productive and as far independent as possible and continues to remain so through involvement in gainful work. This comment is based on premise that to achieve recovery along with symptom remission, affective and cognitive performance should also be optimum

These are important end points that team always checks on and are indirect measures of wellbeing of person and adaptation to the new destination (context)

5.4 Pre-conditions for the process

The only pre-condition for the process is that the clients should have a contact number on which they can be contacted. For clients who have been reintegrated far away from Kolkata there is no other way to follow up. In a few cases, in which another organization follows up on the clients, the client should be open to the follow up and not shut doors on the follow up process

5.5 List & description of key activities & processes

Key Activity	Main Role	Support Role
1. Phone Call follow up;	Reintegration Officer	None
2. Home Visit follow-up	Reintegration Officer	Care Giver
3. Follow Up OPD at Sarbari	Reintegration Officer	Care Giver / Counselor
4. Follow Up Hospital Visit	Reintegration Officer	None

<SEE ANNEXURES 8,9>

Category 1:

Based on the geographical location of the end destination, clients could be either outside or inside West Bengal. Following services are then provided by Reintegration team to their clients:

5.5.1 Phone Call Follow-Up

Definition

A phone call made by a member of the reintegration team to the active clients - registered contact person (client / any other mentioned below) on a number registered with the reintegration team with the specific purpose to enquire into current status of the reintegrated client is the phone follow up. It is the most important process in the entire Post Reintegration Follow Up phase. The phone calls are widely made and reach to nearly 150-200 clients on an average at any point in time.

Salient Features

- All clients are eligible to receive a call every month by any of the team members of reintegration team unless they belong to one of two categories mentioned later
- The call may not be made strictly every month, but at some frequency to ensure that clients do get a follow up at regular intervals
- Sankalpa defines Active Clients as those who had a previous stay in Sankalpa services and on discharge were restored back to their families and families allow Sankalpa to provide follow up services. These Active Clients serve as denominator for service indicators

Exclusions

Two categories of reintegrated clients do not get phone or any other follow up:

- Homeless clients who did not have a psychosocial disability but were reintegrated by the team
- Clients whose families refuse the follow up for one reason or another

However, not all restored clients are reachable or available. Most often the reason for unavailability is that the phone numbers of the contact person change and the new number is not conveyed to reintegration team or the phone is not received (perhaps the person is out working or some other reason). This leads this process to a dead end.

A similar challenge is faced when other contact details such as address, changes, there is no way to trace the person and therefore a dead end is reached and person falls out from service net. For all practical purposes this person should be considered a non-remitter in outcome analysis. To overcome this dead-end, the reintegration team has innovated and introduced the process of sending a SMS to the registered mobile number with a request to contact back. However, the utility of this new process is yet to be examined

Objective

The Phone call enquires information on the two key outcomes of this phase mentioned above:

1. What was the clinical condition of the client specially to rule out relapse:

2. Was the client employed in some productive work either at home or outside?

In addition, two more information points are enquired into:

3. How was the personal hygiene, sleep, appetite of the client?

4. Supplementary Information

Making the phone call

Prepare a list of clients every month who would be receiving phone call and then schedule them day wise. This list is made in a format called "Phone Follow Up Log". Here names, phone numbers of clients is listed along with name of the staff who should be making the call. Divide the calls amongst yourself and your colleagues. After the call is completed, note the broad impression in the column for status of client. Details of conversation is noted in a separate register called "Phone Follow Up Register" and this is described later. The Phone Follow Up log allows one to overview how many calls were successfully completed in any given time period.

<See Annexure 10 & 18>

Objective 1: What was the clinical condition of the client specially to rule out relapse?

- You should ask about the current symptoms of the client, if any. Did they (care giver) see symptoms similar to the times when the client was in bad condition in the past?
- Was the client regularly taking medicines as prescribed? If yes, then ok; if not, since when treatment had been interrupted (duration) and reason for same – was the treatment stopped on advice of the doctor or otherwise?
- When was the last review by psychiatrist / doctor?
- Information is given on nearby treatment facility (for mental illness)

Was the client employed in some productive work either at home or outside?

- Did the client work on his / her own or has to be instructed or prompted?
- Was the client participating or adjusted in the family or secluded and isolated?

If client is employed in an earning position inside or outside home, then following is enquired:

- Amount of money earned
- Amount of savings from this earning
- This information is maintained in an Employment Register of team

Scenario 1:

1. At times the care giver does not involve the client in any work - neither in household work or any gainful employment (inside / outside home). This is sometimes due to their concern for the client - ***(oh! (s)he is ill. How will (s)he work? (S)he should rest. There is no lack of resource in our house***.

2. At other times, they do not trust the client and are influenced by earlier behaviors (prior to treatment) of the client. This robs the client of any opportunity to work. If in future a situation arises when the client has to work, he/she is unable to do so due to loss of practice and is therefore ridiculed or receives unpleasant behavior.

If such a scenario is perceived by you, then provide the following key messages to encourage gainful employment of the client:

- Tell the care giver that their concern for the client was justified in providing rest and least stress to the client however, if in the future the client has to become as independent as possible. If on death of the care giver another person takes on the responsibility for the client, he / she might expect the client to be independent or perform some work. If the client is not allowed any opportunity to work then (s)he will lose her habit to work and, later will struggle to finish tasks. (S)he would then face unpleasant reaction from the new care giver.
- Participation in work is important for recovery of the client and lack of any goal directed activity is detrimental to her recovery
- The client is capable of working and should be allowed to do so. If the client cannot work completely independently, then provide her supervision to help complete the task

- The earnings of the client would support or supplement the family income thereby reducing family burden (since majority of clients and care givers are poor)

How was the personal hygiene, sleep, appetite of the client?

In addition to the above main queries supplementary information on following is also taken:

- Any physical complaints
- Inter Personal Relationships
- Any substance abuse

Utility of the phone follow up

The utility of the phone follow-up is as follows:

1. When you make the phone call, the family members of the reintegrated clients feel that there is someone who is concerned for the client. This influences their care giving. As the phone follow up enquires into several dimensions of the clients' life, the family members welcome this friendly advice. However, not all family members welcome or like the phone follow up and on request of family members, phone follow up could be discontinued. If you have been asked by a family member not to call again, make a noting of this request in the phone follow up register in the ear marked column and do not call them. Of course this decision is to be taken after discussion in the team and not unilaterally. Sometimes, families are angry and refuse on the surface but understand the importance of the call. At other teams, one of your colleagues is a better person to call, since rapport with the family might be just that good. Overall, NOT to call again should be the last decision to take

2. You should also inform the family members that you could sometime in the future come to their home to visit the client. The family believes that Sankalpa team would come for visit and that they therefore should take better care of the client

3. While making the call, you should enquires into challenges faced since the last call. Now, if the family had faced any situation in the past, they will share the same with you. Advise them on what actions should be taken by them in future. This builds their capacity as care giver to address different needs of the client including crisis or emergency. This is a very critical process. You should also make a note of the problem and your advice in the Phone follow up register.

If there is something that you do not know how to handle, then make note of it and inform the family that you would get back to them, ask them what is a convenient time to get back. Then discuss the problem internally and get back to the family.

Note all these in the register for any future reference.

4. The receiver of the phone call could be client, family members, and members of the Panchayat or other stake holders as per objective of the call. Make majority of calls to client / care giver, **preferably speak to client**.

Do not believe anything someone else is saying about the client since people have their prejudice about person with psychosocial disability even though the person has improved. Therefore validate everything with the client or the main care giver like parents, husband. In the phone follow up register, make a remark of who was saying what so that you know the prejudices floating around the client and she might support in handling those prejudices.

Also make a note on who you think is the **most reliable source of information** on the client.

A problem with family is that they provide medicine to the resident / client but do not talk with him / her leading to isolation. There is no current process to recognize this during follow up telephone or visit encounter and then a strategy to overcome it. While enquiring for inter personal relations, ask this specifically.

At other times, the family mentions that the client was in bad shape, on home visit the client is found to be symptomatically stable but it is the high burden of care which makes family complain

After completing the phone call, record all points of conversation in a register called the **Phone F/U register**. Here each client has a dedicated page. In the page of the client you have called enter details of conversation. Details are entered date wise.

You should fill information on each phone call in a format called **"Phone Follow Up log"** (exhibit below). This is a quick checklist of all phone calls made and quick categorization of status of each client contacted. This format provides structure to record status of client on four parameters:

1. Success of the phone call i.e. phone was received, validating this number;
2. Overall status of client – stable or relapsed;
3. the regularity of client towards treatment and drug intake and
4. Involvement of the client in activity.
5. A remarks column helps in noting any other information relevant to the activity.

<SEE ANNEXURE 11>

Having said all about phone call, it can be said that roughly 50% of the restored clients under phone call maintain treatment adherence due to the prodding of the phone call. They feel that there is some concern and respond to the kindness. They also know that in case of any trouble or difficulty there is help even though distant.

5.5.2 Home Visit Follow-Up

Home visits are generated after phone follow up calls. If client appears to have relapsed on phone enquiry, a home visit is planned. Home visit follow up is a selective service for which there is an **eligibility criterion**. It is defined as a visit by a member of the reintegration team to the destination of the reintegrated client with specific purpose to trouble shoot a problem that could compromise the well-being of the client.

Home visit process indicates that there is a higher level of support when there is a crisis or problem, this **escalation of support** is an outstanding feature of the service.

Resource constrain in making home visits especially outside the city of Kolkata make home visits a precious transaction. Rightly therefore in the recent LFA of the program, West Bengal and nearby districts are given higher priority for follow ups including home visits. However, current processes of home visit do not provide any mechanism to ensure a better rate of treatment adherence. Mechanisms therefore to increase the pool of people who could visit the home in addition to the visits by project staff should be explored.

Eligibility criterion for home visits

All restored clients are not eligible for a home visit. The eligibility criterion for home visit are:

1. If resident / client is unreachable over phone for past three months
2. If on phone enquiry, client appears to have relapsed
3. If on phone enquiry, a problem is identified – related to either family or community or both which could lead to rejection of the client or shows poor acceptance of the client (as indicated by statements such as – "*Please come here and take him / her away*")
4. If a client does not follow up at Sarbari follow up OPD for past three months

Random Visit: Random home visits are those where the team member while visiting another client who was eligible for the home visit additionally visits a nearby restored client. This is a checkup visit.

Hospital Visit: During home visit, the team visits the local facility from where the client was supposed to get follow up services (medicines and doctor review) and trouble shoot any issues. If the client had dropped out of treatment then you should reintroduce the client to the hospital to restart treatment.

Interaction with locals:

During home visit, you should interact with family and other local people to identify local resources to provide employment and support for the client. This is important to prevent homelessness and build support.

Do it even though it is difficult to ensure support or compliance since the results take time to come and there are no resources to go back again and again, however, take phone numbers of local people and see if they can be contacted later to remind them to involve the client for work. Send them some literature to keep them informed on recent events that are happening in mental health including case studies of someone like them who has helped person with psychosocial disability find work.

Assessment of current status of client:

The main objective of the home visit is to first hand assess the status of the client:

Client who does not follow up at Sarbari OPD:

Ask the client or the main care giver, do not ask anyone else to come to a conclusion about treatment adherence of the client.

If the client has been treatment non-adherent, then the client should be first reviewed and then started on treatment. If there is a nearby treatment facility, accompany the client and care giver to the location else see if it is possible to discuss the case with psychiatrist backs in Kolkata and restart treatment.

Motivate the family and impress upon them the need to restart and maintain treatment.

On the home visit record sheet, mark the client as treatment non-adherent as status on your arrival and note all actions taken by you

Client who follows up at Sarbari OPD:

If the client is a regular at the "Sarbari follow up OPD", then sort out issues identified over the phone follow up during clients' visit to OPD.

The remaining queries in home visit follows the same line as phone follow up. Your first impression on seeing the client should be noted down in the MSE (Mental Status Examination) format.

After you have done so, also estimate the risk of the client. Risk assessment is crucial and you should categorize clients into high, medium and low risk groups. You should discuss the objective criterion in your team, but even a guesstimate by the staff should be good enough as all are trained mental health professionals.

If the client falls in high risk group, certain mandatory actions should be taken:

1. Inform the care giver that the client is in high risk and that (s)he should take prompt action else situation might revert back to previous one or even worse. It is important that treatment be continued and that good affectionate behavior with client be the norm.

2. Create a daily schedule for the client to follow and explain the same to the care giver

3. If admission is required, see if financial help can be provided from the project

Similarly, devise a list of actions for clients in moderate and low risk categories. Thereafter in subsequent follow ups you should re-assess risk and if prescribed actions were followed or not

4. Leave your mobile number, give another one to the family. Tell them that you will call again in two days' time and do so. This client therefore should be prioritized in your call list.

5. Take a photo of the client, if there is consent. The photo can then be shown to the team back at Kolkata for them to conclude if the client appeared to be in good or worse state.

6. When you return home, ask care giver or some other close friend of the client to call him / her up and speak and motivate to continue treatment

Fill the data in the home visit format and file it in the case file. Set up the next date of the call of the client

5.5.3 Follow-Up OPD at Sarbari

The reintegration team operates a follow up clinic for restored clients who live in or near Kolkata and come back to Sarbari for follow up.

Organizing the clinic

The clinic is organized on a fixed day and usually the same psychiatrist is available for the clients. This maintains continuity.

As reintegration officer or member of the team, you should maintain a **due list or appointment list** of clients who are due for review. This list should be made available both to the psychiatrist as well as your colleagues. One of you should mark the presence of the clients when they come on this list.

The case records of the clients should be taken out in advance and studied by you. Further, you should have done a phone call follow up with the client prior to review date. The aim is to make a list of items on which the review should focus on. You should then discuss these points with the psychiatrist in presence of the client. In this manner the psychiatrist is also informed of different issues involved in the review and the client understands that all are working as a team.

Remind the client with a telephonic call, if the client requires a reminder otherwise do not introduce this habit.

When the client presents to the clinic, mark the attendance on the registration sheet and speak to the client how (s)he is doing before proceeding to the psychiatrist review. After the psychiatrist has seen the client, make a joint follow up plan focusing areas that need attention. You should mark items in the adopted recovery model where emphasis is required.

The client is supposed to purchase medicines from outside.

Record observations in the case file and then hand over it for filing.

You should take this opportunity to confirm address, telephone number and any other item of relevance for follow up

If the client needs psychological support, it is better to do it in this contact and not give another appointment to the client. To be able to do this, it is important to divide all clients scheduled for review in the team and then if required counsel the client. Since the event is held at Sarbari, other colleagues can also be requested to help

Inform the client of the next review date

<SEE ANNEXURE 12>

The utility of follow up is very high. It provides information on the status of client at time of follow up. The following table shows the proportion of clients who remain regular on treatment as disclosed during follow up. There is no clear cut difference between the destination location of the client since roughly 50% or less clients remain regular irrespective whether they were reintegrated outside or within the state of West Bengal, or even in the city of Kolkata. The regularity with treatment does not exceed 50%.

<SEE ANNEXURES 12a 12b>

5.5.4 Visit to a local hospital

For clients who have been reintegrated within city of Kolkata, you could take them for follow up to a local hospital's mental health service. You should introduce the client to the government doctor and explain the journey till date. This mediation on behalf of the client could compromise the agency of the client. So, if you have the time you could prepare the client to inform about him/her self to the doctor else if for any reason the client is hesitant do the initial introduction. However, tell the client that you would not speak on his/her behalf again with the doctor.

Once the client is reviewed, request the client to follow up at the hospital if satisfied with services. Tell the client that this was a free service and would always be there. If there are long queues, then the client has to find ways to overcome it, but not give up on the review.

It may so happen that the Caregiver of a client brings the client for review to the hospital. This is in addition to the caregiver spending money on the client for food, clothes, medicines, etc. Over time, Caregiver could start accompanying the resident / client to the government hospital and take medicines from there. The introduction of seeking care at the government hospital in the local community is an excellent process introduced by IS.

If you are making a home visit to the client, then you should accompany the client to the local hospital or service from which the client is taking follow up. Interact with the doctor and ask what his/her opinion about the client was. Introduce yourself and leave

your contact details with the doctor. Also ask the doctor what thinks he/she thinks are required for benefit of the client.

5.6 Scenarios Post reintegration of client

Scenario 1: Family complaints about client

At times after the family takes the resident / client home they bring them back to Sankalpa and thereafter don't take them back. Family withers under the burden of care; stops treatment and the person relapses. The person is then brought back to IS.

First speak to the family and the client, if possible to arrive at an understanding of the situation. Then, follow one of the two solutions below depending on if the family is just off loading the client or there are genuine interaction problems.

If the family is offloading the client:

In such scenario, you should call the family and ask them to visit the person at least once else you would forcibly stage a sit-in with the resident / client at the family's residence

If there are genuine interaction problems:

You should speak to the head of the family and advise him to allow the client to stay with them for a short duration (e.g. five days, a week, fifteen days or even three months) and then they could return the client back to shelter for a brief period (e.g. for one month).

Gradually, increase the duration of stay at family with final goal of permanent stay at home.

Scenario 2: Clients complain about difficulties

If reintegrated clients complain to you which they will; about difficulties faced at home - poor availability of water, no electricity, mosquitoes, etc. Advise them to stay put and not run away from the family. Offer them simple solutions, they are probably looking at someone familiar to talk to.

Ask them if anyone else in the family knows about these problems – *Have you told this to your mother?*

Make an assessment of what this complain is likely to reflect - Is this a reflection of dependence of the clients on certain facilities in the shelters? Is this a reflection of loneliness where not enough communication is done with family?

Cheer the client up, and tell them to look at the security, affection of the family and provide solutions to fight the problem as well.

Scenario 3: Complete Rejection by Family

For clients who are completely rejected by families, there is no alternative to the shelter. While the reintegration team identifies different resources in Kolkata city such as old age homes, other homes, it is always a challenge to create an alternative plan for this segment of clients / residents.

Sankalpa is trying to start group homes for women clients in which few of them could stay together outside the shelter in the community. Further, Sankalpa has also created independent living for clients in a place called Kashipur, outside Kolkata where clients live on their own in the community accessing work and other benefits from the community and taking care of themselves.

Scenario 4: Reintegrated become homeless again

This is a recurring issue and a problem area. Sometimes there is an underlying mental retardation that makes person very vulnerable to repeat homelessness; in other cases it is unavailability of parents or some other critical event that makes a person vulnerable.

Interruption of treatment is another major issue that exacerbates symptoms and the same phenomenon that led to first episode of homelessness repeats itself. Many a time's clients come back to Sankalpa but in quite a few cases there is no trace. There have been sporadic incidents where the client has retraced her path to Sankalpa. Readmission of previously discharged client is done at Sankalpa. Recently, a condition has been imposed wherein readmissions have to spend minimum three months at the shelters before discharge can be considered. This is to prevent rapid discharge of the person.

As member of the reintegration team, you have to be very sensitive of the possibility of repeat homelessness, if a client reports death of a parent, then increase frequency of follow-up and so on.

Scenario 5: Follow-Up by outreach team

Some residents who prior to admission to shelter were living at a particular location in the city wish to return back to the same spot post recovery, not to family. In such a case, the person goes back to the location of choice and is tagged with outreach team (if within the project area) for follow up. The reintegration team remains overall in charge but follow up is done by Naya Daur team.

5.7 Key Conclusion

The reintegration process introduces or rather reintroduces the clients to a new context and raises a huge demand from the client and the environment to adjust to each other. This is not an easy process and in which support is required. The reintegration team provides the support constrained by the factors it can influence. The maintained recovery of the client, the acceptance in the family is a result of many variables and it is hoped that at least maintenance of treatment and engagement of client in some

work with support by family are three things that can be focused in the follow up process.

5.8 Information Capture & tracking the process

The expected outcome or result of this follow up is very ambitious and shown below:

1. 35 % of the clients receive medical treatment from Government Hospitals after restoration
2. 90% of clients taking medicines as per prescription
3. 20% of restored clients engaged for 100 days in livelihood in a year after restoration
4. 100% of resettled clients are earning minimum of Rs1500/month

In addition to above there are process targets for reintegration, employment opportunities, stake holder engagements as well which the same team has to oversee making this a very ambitious target overall.

However, these targets also spell out the overall conceptual process of follow up. Clients who are discharged from any of the service need to take maintenance treatment and a substantial fraction of this should be from government hospital. Further, it is important for clients to be actively engaged in work, which should be remunerative. It is the combination of this that would maintain wellbeing and recovery.

Currently, the first indicator is limited by service provision in government hospitals and the service quality experience. Government hospitals have long queues and limited contact time which might be inadequate to understand the situation of the client and treat accordingly. Therefore a bridge process is required to make this a sustainable operation.

Treatment adherence at 90% is also ambitious and not seen in most cases. Therefore, toning down to around 60% would be more realistic

5.9 Internal Check & Balance

The program coordinator has to work closely with reintegration team to make a link between the therapeutic processes inside shelters and other program and the experience with the clients who have been reintegrated. Changes required should then be discussed separately with each team and worked out.

To oversee the reintegration processes, the program director should follow up on some key clients and ask for their follow up status at monthly interval. The criterion for selecting these client could be mutually discussed but clients who at the time of reintegration had best chance of success should be followed up as best case scenario along with others who constitute the more typical cases.

5.10 Evaluation / Audit of the process

At least once a year, an external audit of reintegrated clients should be done to understand following:

1. Process compliance

2. Link between process and outcome

A set of clients should be visited at home and their assessment should be done. Their recovery status should be measured and then linkages with what follow up support could have been provided should be assessed. This although resource intensive is an important task to be done

5.11 Gaps & Suggestions

Regularity of work during phone follow-up:

While enquiring into the work involvement of the reintegrated client during phone follow up, regularity of work should also be enquired. This is important since a yardstick set up for reintegrated client is to work 100 days in a year. Some information is required to make this judgment.

Adopt a formal recovery process framework

A formal recovery process needs to be adopted by the reintegration team and all parameters in that process regularly tracked during phone follow up or other follow up mechanism to make some meaningful conclusion.

For the Phone Follow Up, the process of dividing the clients amongst team members is unclear and not strictly followed.

Generate a due list of phone calls for each team member. Currently, phone follow up register is reviewed to identify clients who have not received follow up for notable time or those who have been irregular in their attendance at the Sarbari OPD.

How to select clients who should receive phone follow up call

Clients who have received follow up in recent past are not prioritized. Overall, it is the review of the register that decides which client would receive the phone follow up; it is not currently tailored to the needs and situation of the client.

Access to medical case file during phone call:

At the time of making the phone call, the team does not have access to the file of the client. They act by the notation of diagnosis in the MIS sheet and enquire into symptoms. Access to electronic medical record should help the reintegration team in asking more specific queries as well as better recording of the progress of the client in one place. The adoption of a recovery framework would also make at least 4-5 patterns that should be adopted for clients and follow up should be done on that.

Phone Follow-Up register:

Currently, in the Phone Follow Up Register only symptoms and work participation are recorded which is important but not sufficient. It is equally important to note the extent of loneliness, social isolation and self-esteem / self confidence that the person had at the time of contact. While employment is considered an important outcome, the status of the same is not recorded in the register.

Understanding adherence to medications during phone follow up call:

During post reintegration phone follow up, there should be some cues with the caller to understand that client is regularly taking medicines as prescribed and various

situations the client might face that need alteration in how the medicine has to be taken. This is also applicable for home visits. Otherwise there is no validation of this information.

Specific queries related to medicines that client is prescribed should be included to know that client is taking those medicines.

1. What to do if the regular dose is missed for a day, how to restart the medicine?
2. What to do if the client wants to conceive and is on treatment
3. What is the client is going for elective surgery like cataract
4. Is there any emergency such as Neuroleptic Malignant Syndrome associated with Risperidone and what to do in such situations

Adopting a yard stick for follow ups:

Currently, there is no yard stick for home visits or even phone follow up. These are considered as interactions to know about current status of clients. It might be important to set internal yard sticks such as how many clients who reported a relapse were provided with an escalated support? This will make the assessment of outcomes of home visit possible.

Targets for Reintegration: Since the reintegration team services all projects, the number of clients they have to keep a track is high. Roughly 250-275 clients were under follow up at the time of writing the document. This range is provided due to dynamic nature of services where discharge is continuous. The targets spelled in project action plan (LFA) are steep and with current staff strength it is difficult for follow up to be done well. It is therefore suggested that team strength be increased and some more instruments of action such as volunteer base be considered to augment follow up services. The volunteer base is an important element that needs to be developed in time to come for Sankalpa.

5.12 Training Requirements

The team needs to adopt a recovery framework and then along all dimensions of the framework, standard questions and assessment should be part of training.

6. General Notes / Gainful Involvement in Work

Work, the only thing one can do for eight hours a day, every day!

An important function of reintegration team is to find remunerative work or work opportunities for recovered residents and clients during their treatment phase. In Sankalpa's intervention design work participation is an integral part of the treatment and recovery process hence the need to find employment.

Remunerative work, not surprisingly fulfils serves many purpose:

1. Purposeful and remunerative work acts as an incentive.

2. It improves functionality.

Some clients who are not functional inside the shelter, become functional when they go for employment outside the shelter. Since work usually involves going outside shelter, it brings a sea change in the wellbeing of the person

3. Recovered Residents or Clients who do not have any scope of returning to family or any other community unit, for whatever reason, employment (self or wage employment) is a major support for them to regroup their life independently or with least dependence

What is the requirement from the reintegration team?

Important tasks for the reintegration team and also social workers in different projects are:

(i) To identify clients who are ready for employment (across projects) and

(ii) To identify opportunities for remunerative work in local community and even elsewhere outside.

Sometimes, employers are identified in close vicinity of the resident / client such as:

Who are the usual employers?

There are three usual employers:

1. Local small businesses provide an opportunity for work, to begin with such as tea shop owners who need someone to help them run errands, hotels that serve food and need help.

2. In addition, due to the networking of different project teams, work is also found inside homes and hospitals such as domestic help in houses, work assistants or maids in hospitals / nursing homes.

3. Small manufacturing units that need people who could do job work, etc. This depends if such units are available in the close vicinity of project area.

Sometimes, job work can also be found in large stores or with large units. This is usually around the time of festivals – Rakhi making, packaging food, etc.

Your task in the reintegration team is to find avenues of employment in the order given above. The process of finding the job is listed below.

What is the process of identifying a job?

You should identify a job or work opportunities, as Sankalpa calls it.

Many of these are in the local community and such employers are called **Community Employers**.

Refer to the **checklist** (see annexure 15) that has been developed for interaction with the employer. This has been done to safeguard the interest of both client and employer.

For residents of Sarbari who get a job and therefore commute from shelter to work place, the local Police Station is informed about their movement outside

The checklist:

1. Identify job requirements / prospective employer:
    a. Introducing the client to the employer:

i. It is a given that you yourself would be known to the employer as working for Sankalpa and therefore with people with psychosocial disability. However, if the employer is not directly known to you, your introduction

b. What does the job entail? Be very clear on both what work is to be done by the client. E.g. She has to cut the cloth material to size using hand held scissors sitting on the floor

c. How much has to be done? E.g. 100 pieces have to be cut every day

d. What are working hours and holidays? E.g. Work starts in the morning at 8:30 and closes at 6PM with half an hour break in between. Only Sundays are off. During Durga Poojo, 7 days are off

e. How the payment is made and is it linked with production targets? E.g. the payment will be done on 10th of a month after one months' work in cash. It will be Rs. 250/- per day only if 100 pieces are cut, for each piece less, Rs. 5 would be deducted

f. What is the working environment and the distance to the work place?

g. Is the employer ready to take some responsibility for the client especially in treatment regularity? E.g. would the employer allow the client to go for follow up at clinic / hospital? Would he / she inform if the client is showing signs of distress or unusual behavior?

2. Identify the client who matches job requirement

a. While the skills might not exactly match with the present skills of a client, identify the one who would have the best temperament to fit in the working environment

b. Discuss the work opportunity with the client and encourage her that she would be able to do it.

c. If needed, facilitate an initial visit to the working place

d. In the vocational centre in the shelter, arrange for her to gain some skills or practice under guidance of the trainer

3. **Strike the match**

   a. Negotiate with employer for salary and other work conditions (usually this means small breaks from work)

   b. Disclosure of the status of the client, is a pragmatic choice and depends on the consent of the client and the sensitivity of the employer. The latter has to be judged while the former has to be obtained. Disclosure and non-disclosure both have their merits and demerits. Preferably, therefore disclose.

   c. Introduce the client to the employer and settle terms of work in front of them and then the client could start the job

   d. Some legal bindings are required to ensure safety. These are mentioned in the prospective employer's checklist (Annexure 15)

Support during work

The clients have to be supported during work. You would have to watch if you have disclosed the status of the client and that the client and the employer both you're your visit to the work place. This would decide if the follow up is at the workplace or somewhere else. You should judge this for yourself.

Try to visit each client work site at least once a month and only if required more often

What are the reasons for following up the client?

1. First reason is that Clients get de-motivated during work

Clients, at times, could withdraw from work for some days. While you try to understand reason for this and address it, remember to provide the employer a substitute, if it is agreeable to the employer.

You will have to provide **motivational counseling** during work. This is similar to the one provided when resident starts engaging in vocational activity inside the shelter.

The internal yardstick is to do minimum two counseling for each client in employment. This counseling is also asking them generally how things are at work. The overall objective of your interaction with the clients who are working is to understand how they are engaging with the workplace, work and what you see in the long term as their recovery with work as a central piece.

Presently, there is no **manual or check list** of the essential items in the counseling but here are the salient points you should keep in mind:

1. Understand how the client is communicating with others in the work place. Communication is central to performing social roles hence you should ask about communication and enquire into different scenarios from the client.

2. Ask in details about the work including about processes. This should help you understand the processes the client might struggle with. Link it back with training inside the shelter so that such issues become part of pre-reintegration capacity building.

3. Discuss with the person who overwhelmed she feels with work, does she get adequate rest?

These three things should be the basic enquiries and then subsequent enquiries will be guided by answers you get to these and then move on from there.

There is however a checklist to monitor the essential transactions during visit to each client who is working, who is referred to as Engaged Client and this check list is called – **Engaged Person's check list**

2. Second reason for follow up is to help client and employer both vent their emotions, if any. Look out for any conflict and address it immediately with mutual participation.

One of the biggest challenges of clients is to handle the emotional and inter personal issues at work. Many a times, employers prefer their older and more senior employee and behave preferentially towards them, this puts the clients ill at ease and they find this situation difficult to handle. It is therefore important that as part of vocational training or employment preparedness, clients should interact with

many different people to be able to handle difficult and different situations at workplace later.

3. Sometimes, the employers either do not pay the client on parity or place pre-conditions on payment such as – *I will pay you when you go to your village, why do you need the money here, I am giving you food and clothes.*

These are difficult situations since employer might feel they are on a higher moral ground by providing employment to a person with psychosocial difficulty whereas the person feels that he/she is earning an employment through regular work. You will then have to resolve this conflict and explain to the employer that the person is trying to seek a new beginning and having cash in hand will allow him / her to buy things of own choice. However, you will have also have to be open to the employer's feedback that the client was using cash for tobacco, etc. So, do your own fact finding and then help in conflict resolution.

4. Clients may have symptoms while at work and the employer does not know how to deal with it.

Remember that the goal is not to focus on symptoms but let clients retain work. Sometimes clients will not be completely symptom free, they may have symptoms but they are not disruptive to the functioning. The employer feels that the client was talking to him/herself and find all this strange, you will have to explain to the employer these things.

What is the impact of work?

Functionality is expected to improve with work. Members of SHG have shown remarkable improvement in function. A few members of SHG don't want to go home despite traced address because they feel settled in their work and fear loss of it at home. Work has built a sense of purpose to their lives.

<SEE ANNEXURES 15 & 16>

Challenges

There is link between the training process when clients are residents in shelter and their performance at work. In the initial phase of outside employment, clients repeat

what they have learnt inside the shelter, it is only later that they understand the requirements of work and adapt accordingly. Therefore the initial training process inside shelter is very important. Currently, the team that trains inside the shelter is not involved in finding and maintaining jobs outside. Some sort of discussion on requirements outside and training inside should be done to ensure that clients are better prepared when they go outside for employment. In UMHP, the vocational trainer and one finding outside employment is the same, there needs to be more awareness of job requirements but the process is perhaps more fluid here than in shelter due to obvious difference in their settings.

7. General Notes / Resettled Clients

Follow-Up as Outreach client: In more ways than one, an outreach client is a resettled client. More details on the processes therefore have been discussed in Outreach chapter however a few salient points are mentioned here. Clients of the outreach can be admitted to the shelter as per their need, and they often go back to same spot in the community if their families are either not traced or they or family don't want the reunion. The need is for care in shelter like setting if the outreach client is not taking treatment, is not taking care if his/her personal appearance, has left food for several days, etc.

If the reintegrated clients have been reintegrated into local community units, then they are followed up by the outreach team provided the location of community unit falls within the project area of outreach. In all other situations, follow up of reintegrated clients has to be done by the reintegration team.

The community unit in the local community could be a small shack made by the client herself / himself in a particular location in the city. Such a location could be anywhere as per wish of the client. Usually there are other people living nearby. Locations that have been seen include besides railways lines, inside by-lanes, under flyovers, in local places of worships. Many a times, there is no physical structure, just the belongings are tied together but the person sleeps at same spot and is allowed to do so. There is a remarkable affinity for the spots, this is after all their home.

The reintegration team passes on the details of the clients to outreach team who then follow them up as they do other clients in their work. These clients are visited by direct visits and provided with medicines and food.

Clients are motivated to find work, some do find regular work with local shops, other beg for alms.

Some resettled clients who work regularly for one establishment are often taken care of by the employer. This could mean client sleeping in the employer's house and commuting with him to work place. This is only possible for male resettled

clients. Female resettled clients do find work in local community but live on their own. Often they live where there are other people nearby.

You should also follow up with the employer as part of the once a month follow up with employer. In many cases, a relationship is established between the resettled client and the employer which has been detailed out in outreach chapter because it is similar to the one with outreach client.

You have to tag a **community care giver** to all resettled clients. This community care giver provides food and other necessities like clothing but above all keeps an eye out for the client especially for security and symptoms. The daily interference in life of the client however is minimal (cf. family).

You or your colleague in the outreach team whosoever is following up on the client should often follow up with the **community caregiver** to know of recent past behavior of the client.

Other shelters: Some clients qualify the criterion of old age homes or other long term facilities and are shifted there for long term stay. These are also followed up as per follow up norms for restored clients.

Independent Living, Kashipur: On the outskirts of Kolkata, Sankalpa has started an independent living facility inside a village

In this setting, recovered women, stay on their own. They have been trained to live independently, manage their daily living and take their own medicines. They seek employment in the community. They maintain a daily schedule, manage their food rations and other issues involved in living.

You have to provide follow up to these women as well. You should check if they are able to follow their daily schedule and manage resources. You should also check on any accidents.

They are reviewed regularly in Sarbari OPD and carry their supply of medicines.

This new experiment is rather new and processes are being developed hence this document is not detailing the involved processes.

Repatriation: No client has been repatriated thus far since the procedure is not known. There is a client in the shelter (for women) who is recovered and ready for restoration, but due to lack of clarity of procedure her reintegration is awaited.

8. General Suggestions

Processes in rehabilitation phase of stay in shelters need to be different than either the acute or stabilization phase. The focus should be to develop capacities that are required for independent or community existence. Only then certain continuity would be seen with the restoration / reintegration process. The restoration team and shelter team should together work in this third phase with the former taking control thereafter.

Some of the training elements that are currently used for preparing clients for Independent living in Kashipur should be adopted during the **rehab phase** in the shelter for all those who are identified for restoration during third phase of stay at shelter or community. The current residents of Kashipur could also serve as a good check to see if Fit for Restoration form has the correct items in it.

It is during this phase, that employment or income generation services of Sankalpa should work with the person and get her trained and other necessary requirements for getting into a possible income generating role.

The objectives of this rehabilitation phase could be:

1. To build insight into their condition and need for treatment in clients
2. To develop coping strategies
3. to inform on ills of substance abuse and build capacities to abstain from the
4. to instill habits that enhance cognitive performance

Further, treatment discussion with resident should be enhanced so that she / he understand reason why certain treatment choices are being made

These points have been suggested based on premise that these are important factors predicting symptom remission in schizophrenia which is the main diagnosis amongst clients.

A **robust model of rehabilitation** should be identified through literature review and discussion with the professionals so that the model is not idealistic but suited to the service that can be provided and to the context in which the person would land post restoration.

The therapies or interventions can then follow the selection of the rehabilitation model. Fit for restoration form or some other form should be developed which serves as common convergence for various information collected on the client via scales and other interactions and based on theoretical model progress should be seen.

Clear outcome or success parameters should be set and all data fed into software to provide clear picture of each client and domains that need attention from reintegration point of view.

A **risk ranking** should be done of those clients who are predicted to most likely stay functional.

While this is currently done to a limited extent, **a different follow up plan** should be formulated for them. The current process of classifying different follow up mode based on duration since restoration is incomplete and does not take into consideration the individual. Differential budget allocations should be done to provide higher care to those who have the best likelihood of success while alternative plans for those with least likelihood of survival outside. The current performance of following up approx. 50% of all active clients is a good achievement but this is an output indicator. An outcome indicator such as number and proportion of active clients in symptom remission for a period of >or = 6 months and for a period of >=2 years should be created and results tracked.

The Risk stratification approach would also help the follow up team to understand the risk posed to the resident / client of relapse, self-harm or whatever is identified as undesired outcomes. It is then possible to provide **specific interventions** to those who face a particular kind of risk such as if the parent has died, then the person is at grave risk of repeat homelessness, in this situation what is the provision to be made versus a situation in which a resident / client is contemplating marriage

or having a child or going back to stay with her husband where in the past this was reason that precipitated her illness. The specificity of approaches would improve follow up outcomes over time especially for clients within a fixed radius of Kolkata.

Care Giver Interaction Manual:

A manual for interaction with care giver especially family exists but it should be more structured to guide interaction with care givers.

Care giver and client inter relationship is important for wellbeing of both. In present processes, there is not enough **time** to build this relationship or rather help each other interpret the relationship.

Many residents behave very differently inside shelter versus outside it. Hence, it is difficult to gauge the level of functionality or other general mood by observation only during stay inside shelter. This poses a big challenge to the care team. There are instances when a client who previously had poor mobility and needed much assistance in doing daily chores inside shelter was transformed outside it when taken for reintegration and flashed a big smile and was very enthusiastic. However, on reaching home, the smile and excitement were lost. This means that family might not be the suitable or even desired destination for many residents. Therefore, the transitory nature of shelter stands in conflict when residents are not able to adjust in family and come back to shelter or are rendered homeless.

In the Urban Mental Health Program the project team has access to family members and they help analyze situations that could lead or actually do lead to conflicts. This opportunity is not available to reintegration team. The contact during reintegration is too short to even develop a rapport let alone any other transaction. Hence, for reintegration team different tools and messages are required to ensure that a healthy relationship emerges between client and care giver. A short term project to build this manual should be undertaken and repeated revision should be done in view of new issues seen by the team.

Incidence Reporting System:

Any adverse outcome of a reintegrated client should be reported in INCIDENCE REPORTING and discussed during case discussions to prevent or predict or preempt a repeat.

These are adverse events that are likely to happen in care and rehab. The rationale for this is:

This incidence has a bearing on the way processes were done so reconsideration is required based on the reported outcome, while there may or may not be linear linkage between outcome and process, it is important to note the poor outcome

The details otherwise get buried in the files, so it is better to report this separately

The incidences are **red flag items** and list of items should be a select few (to begin with) such as:

- Death of a client
- Adverse side effect of a drug which is life threatening
- Suicidal ideation / Attempted suicide / Suicide / Self harm: this would require that small red colored tags be made available in OPD so that they can be attached to file
- Relapse in a reintegrated client or repeat homelessness of a reintegrated client. Others worth considering are Readmission to Shelter

The related issue of re-admission, who are the people getting readmitted to shelters, reasons of readmission, should be examined. Currently, no such report is filed.

A new criterion recently adopted that makes three month stay mandatory for readmissions has been put into place to prevent rapid cycling of clients from shelter to outside.

In the MIS, these should be shown as **RED FLAGS** so that immediately they have to be addressed

Protocol to handle red flags: As one goes along, defined response systems to address red flag situations of crisis or emergency could be prepared and teams trained so that incidence of red flags are reduced.

We can keep an internal tolerance of red flags incidence randomly right now and later attempt to reduce them below a certain number as a measure of quality control

Cues to understand compliance with treatment:

During post reintegration phone follow up, there should be some cues with the caller to understand that client is regularly taking medicines as prescribed. Specific queries related to medicines that client is prescribed should be included to know that client is taking those medicines.

Further, there should be a protocol with the reintegration team to respond to various situations the client might face that need alteration in how the medicine has to be taken. This is also applicable for home visits. Situations such as the following:

- What to do if the regular dose is missed for a day, how to restart the medicine?
- What to do if the client wants to conceive and is on treatment?
- What is the client is going for elective surgery like cataract?
- Is there any emergency such as Neuroleptic Malignant Syndrome associated with Risperidone and what to do in such situations

Considering that majority of those receiving phone follow up would not have access to any other nearby service and this would be the only follow up service, the importance of phone follow up has to be increased.

Reintegration process serves as a check of some sorts on the care and discharge process adopted by the shelters. The main questions involving the processes are two:

1. Does the treatment in shelter or other projects prepare client for reintegration to destination?

2. Are skills taught inside shelter in line with requirement for living in community?

Example:

- Can the client / resident manage her own medicines?
- Can the client stay at home?
- What skills does it take to maintain social relations and perform roles expected in the family?
- Do they have self-initiative or self-directed behavior?
- Does the client have sustained motivation to work?

Is the Fit for Restoration parameter good enough to identify those fit to go back? Does the format include parameters that identify requirements for maintenance of recovery achieved inside the shelter or project?

Fit for Restoration Form

There are three issues with the Fit For Restoration Form:

1. **Sudden and late introduction of a different scale:**

In the "Fit for Restoration" form, a different scale than usually used in the care process inside shelter, is introduced. This selection is good but unrelated to scales administered usually during care. This does not provide an opportunity to work on concepts that are found lacking at point of assessment of restoration – such as concept of Insight which is queried by DAI.

The case intake form does not specifically enquire into insight neither do any of the other scales. Truly, PANSS has items that measure insight but it should be used in the required manner.

The feedback on Fit for Restoration form is already provided as comments on the form.

2. **Not a common instrument**:

However, the form is a creation of the reintegration team and not a common instrument of the therapeutic teams and reintegration team. Therefore, it appears that a client / resident deemed fit for discharge by the shelter or project teams is re-examined by reintegration team. This should not be done close to actual discharge since it gives little time for any corrections to happen. As earlier suggested that **a third phase be added during stay of a resident** in the shelter and that during this phase, FIT FOR RESTORATION form be applied by the therapeutic team and reintegration team and clients who qualify should then be allowed a process of actual reintegration.

3**. Independent assessment of clients by reintegration team:**

Reintegration team should do a direct assessment of residents in shelter / clients of other programs to see who it thinks is ready for reintegration.

Currently, the process is unidirectional in which the therapeutic team considers a client / resident fit and then invites the reintegration team who then administer a Fit for Restoration checklist. This invitation system while being continued should be supplemented with direct assessment as mentioned above.

Same method should be used to identify clients who would benefit from training or employment. The reintegration team itself should examine clients / residents and identify rather than acting on invitation. This is because the reintegration team knows the jobs available in market and is making assessment of who can fit into job.

Oversight on discharge process:

An oversight on discharge process is required to ensure that clients:

- Who are not working in shelter,
- Who do not show desired changes are not pushed out of the system while the ones who are more functional retained.

An independent interaction with clients is therefore suggested by those who are not directly involved with day to day care such as the Assistant Director or the organization head.

It is also quite possible that care takers might not give equal attention to 80 odd residents in Sarbari. Some might get ignored in this process, hence the process of review has to be tightened and a mechanism of oversight created. Such mechanism however should be non- intrusive to task of care takers.

Needs Assessment of Clients of different programs:

Sankalpa should introduce an annual exercise of Needs Assessment of clients in various projects. Careful articulation of the needs and summary of the needs should be captured in the Individual Plans for clients. Services to meet needs should be tailored. This is a difficult process and success will take time. Already services respond to need, but a formal assessment of needs and assessment of services meeting those needs would help in service improvement.

The terms residents or clients while being used to communicate to outside world should be totally abandoned by Sankalpa. The persons with psychosocial disability are often stigmatized and lose their self-confidence, self-esteem and self-respect because the psychosocial disability becomes their primary identity. The current terms resonate this and should therefore be given up.

Often, the term used in Sarbari by staff is "*ladkiyan*, girls in Hindi"; this is a good casual term and should be encouraged. This point is mentioned here since the stigma is more pertinent when people are reintegrated than when they stay inside shelter or other project.

Disclosure of information on treatment:

Majority of inhabitants of shelters are illiterate or poorly educated. Their cognitive ability to understand treatment might be limited unless there is a concerted effort to inform them on nature of their treatment. The information is crucial, it should not be restricted to just telling them the need to take medicines. This will also help in building insight. Currently, no process is in place to do so.

9. Conclusion

The reintegration process is an elaborate process and has more than one team involved in it. It is a very critical process handled by different professionals. Shelter team hands over the client to Reintegration team. The latter then follows up. Shelter team therefore does not know if the training imparted during stay at shelter helped in reintegration of client and beyond. Reintegration team observes this phase of work. Therefore, reintegration involves coordination and attention to each individual's needs.

In this process, professionals are guided by limited information about the client and destination. They interact and engage deeply with the person to build capacity of person and provide best chance of survival in the community.

The reintegration team provides a web of support and continued care to restored client. The trip to homes of different clients in different parts of the country is in itself a challenging task. Reintegration team has to deal with families of people in all these different settings across barriers of language, culture and custom. Follow-up care is provided to nearly half of all reintegrated clients. It speaks volumes of the initial relationship, commitment of these professionals to clients. If not for Sankalpa, clients back in their families or other places would not have access to any care.

List of Annexures

Annexure 1a: Meaning of "reintegration"

- পুনঃপ্রতিষ্ঠা
- Punaḥpratiṣṭhā
- पुन: एकीकरण
- pun: ekeekaran

• The action or process of integrating someone back into society.

"Soldiers are beginning the process of reintegration into civil society"

- The action or process of restoring elements regarded as disparate to unity.

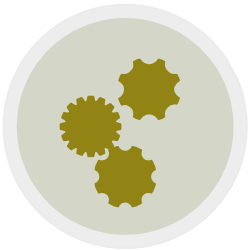
"The reintegration of art into everyday life"

- Burnt bridges with family!

Annexure 1b: Objectives of Reintegration

Objectives of Reintegration

Improve Functioning



Long term stable housing for homeless

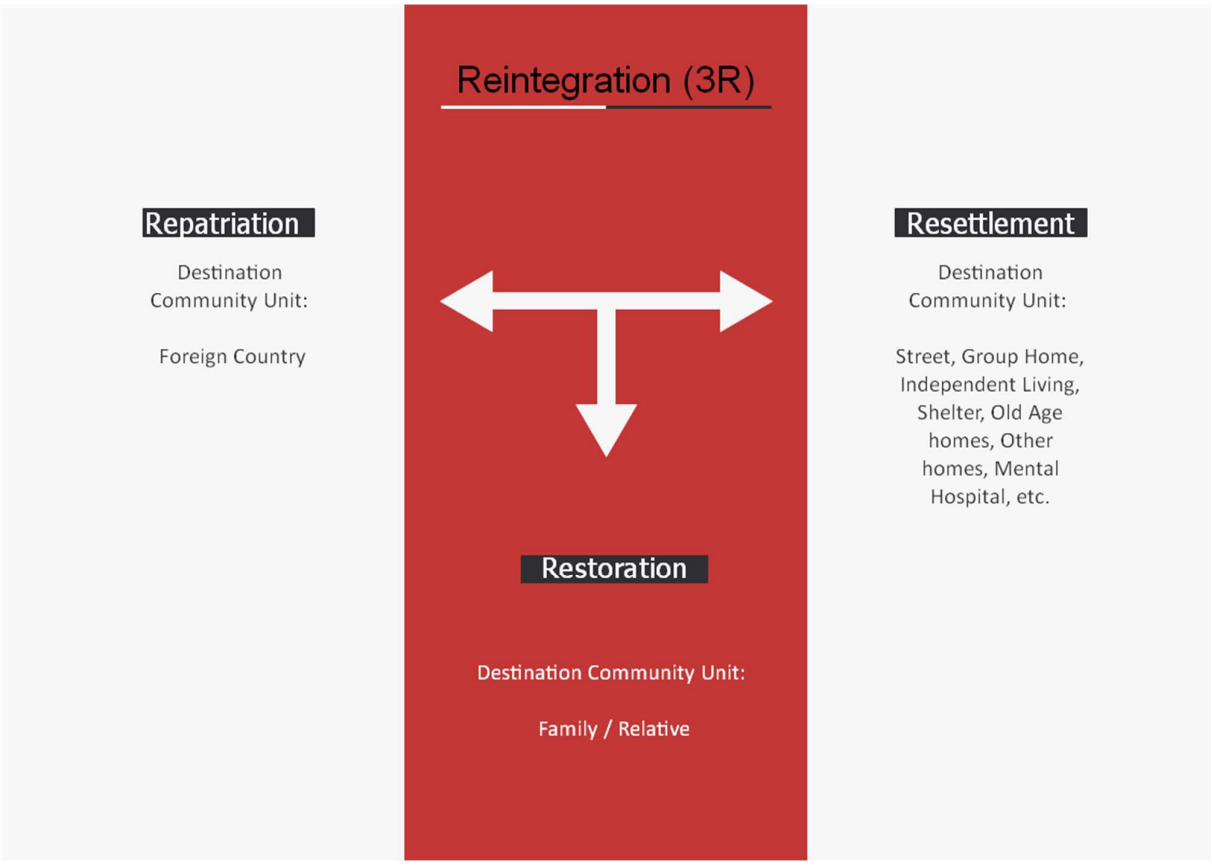
Improve Work Skills

Create Self-Employment

Healthy, Continued Community Living

Access to Work Opportunities

Annexure 2: 3R of Re-integration



Annexure 3: Pre reintegration Capacity Enhancement

Annexure 4: Restoration checklist

Iswar Sankalpa
Restoration Checklist

Client's Name: **ID No:** **Date:**

Scale	Total Score	Category (if any)	Criteria for Fit	Yes	No
IDEAS			Mild or Moderate		
DAI			Score > +10		
LSP			6 ≤ Score ≤ 13		
PFBS			Avg. Score < 2		
PANSS(P)			7 ≤ Score ≤11		
PANSS(N)			7 ≤ Score ≤11		

Followed by your impression, please mark (✓) your subjective assessment of client's fitness for restoration on the respective 10 point scales [where 1=Not Fit & 10=Fit]. The average score will be taken into consideration for final judgement.

Counsellor's Impression:

1 (Not Fit)	2	3	4	5	6	7	8	9	10 (Fit)

Sign:

Project Coordinator's Impression:

1 (Not Fit)	2	3	4	5	6	7	8	9	10 (Fit)

Sign:

Doctor's Impression:

1 (Not Fit)	2	3	4	5	6	7	8	9	10 (Fit)

Sign:

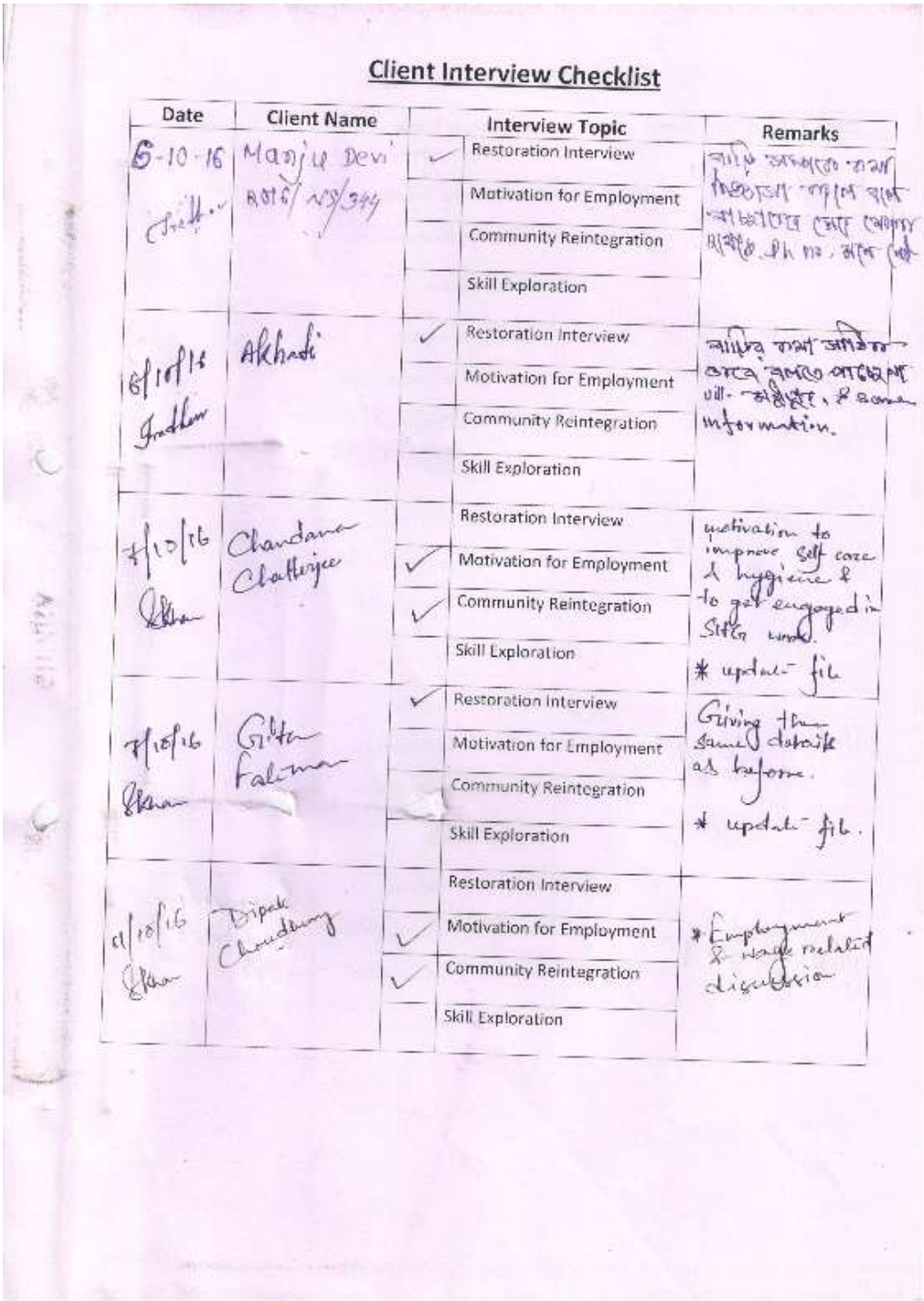
Reintegration Officer's Impression:

1 (Not Fit)	2	3	4	5	6	7	8	9	10 (Fit)

Sign:

Average Rating for Fitness	Criteria for Fitness	Fit for Restoration (put a mark)	
	Avg. Score ≥ 6	Yes	No

Annexure 5: Client Interview Checklist



Client Interview Checklist

Date	Client Name		Interview Topic	Remarks
6-10-16	Manju Devi	✓	Restoration Interview	
			Motivation for Employment	
			Community Reintegration	
			Skill Exploration	
6/10/16	Akhadi	✓	Restoration Interview	
			Motivation for Employment	
			Community Reintegration	
			Skill Exploration	
7/10/16	Chandana Chatterjee		Restoration Interview	motivation to improve self care & hygiene & to get engaged in skills work. * update file
		✓	Motivation for Employment	
		✓	Community Reintegration	
			Skill Exploration	
7/10/16	Gita Fakirma	✓	Restoration Interview	Giving the same details as before. * update file.
			Motivation for Employment	
			Community Reintegration	
			Skill Exploration	
11/10/16	Dipak Choudhury		Restoration Interview	* Employment & wage related discussion
		✓	Motivation for Employment	
		✓	Community Reintegration	
			Skill Exploration	

Annexure 6: Restoration visit key actions

Annexure 7: Restoration Visit Check List

RESTORATION VISIT CHECK LIST

CLIENT NAME: _____

CLIENT UID NO: _____

ADDRESS OF HOME: _____

DATE OF VISIT: _____

DURATION OF VISIT: _____

SERIAL NO	ACTIVITY	STATUS	REMARKS
1	Handover of client to the family member		
2	Official work with Police Station		
3	Family Counselling		
4	Meeting panchayat		
5	Meeting local police officials		
6	Meeting hospital officials		
7	Awareness with family and community		
8	Tagging client with local medical facilities		
9	Meeting prospective employers		

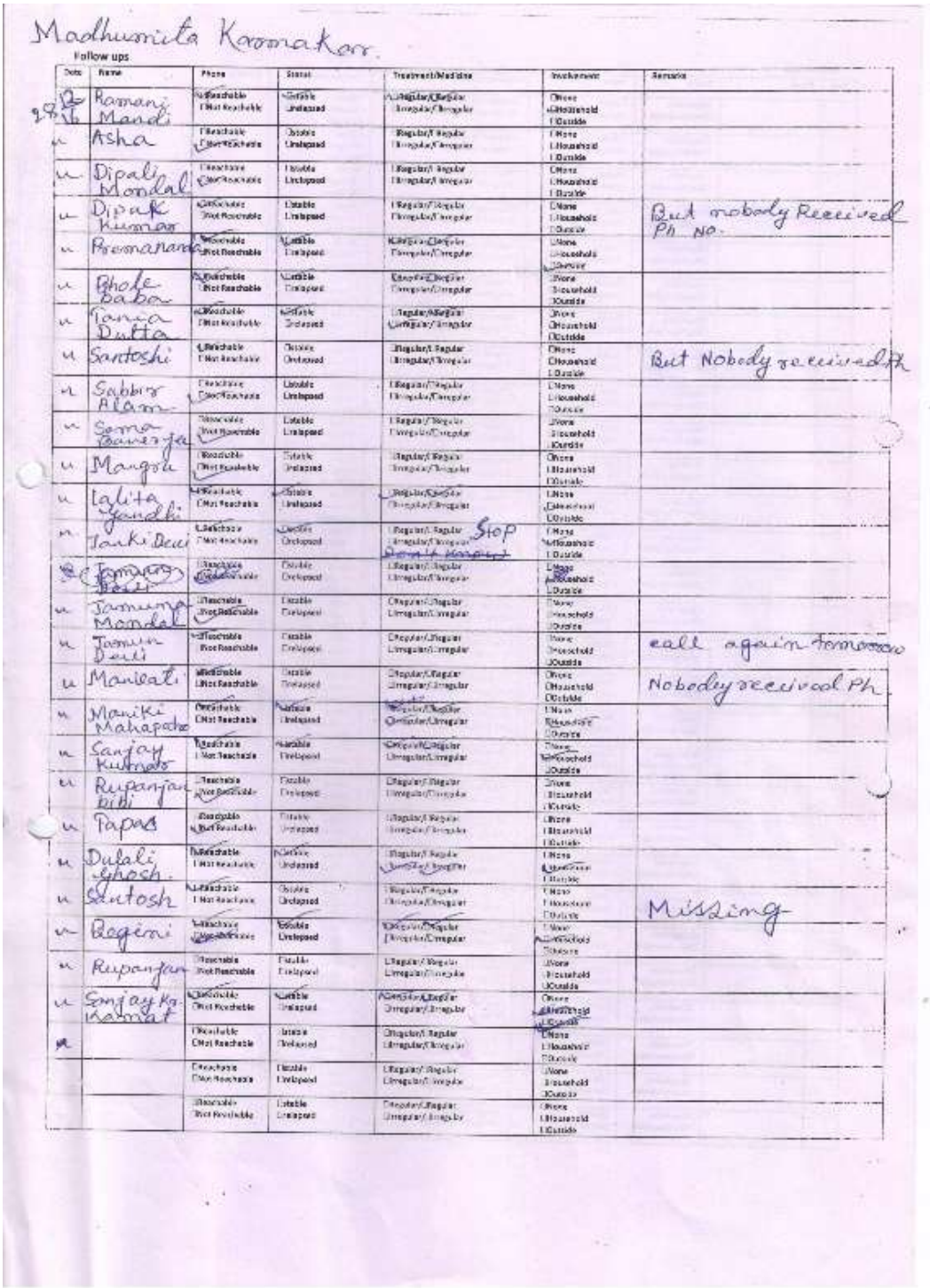
VISIT DONE BY (Name and Signature):

Annexure 8: Post Restoration Follow-Up key actions

Annexure 9: Table 1: Post Reintegration Follow-Up services received by clients

	Phone Call Follow Up	**Home Visit Follow Up**	**Follow Up OPD @ Sarbari**	**Postal Medicine**
Location of reintegrated client				
Outside West Bengal	Routine	Occasionally		If required
Inside West Bengal	Routine	Routine	Occasionally	
Inside Kolkata	Routine	Routine	Routine	

Annexure 10: Phone Follow Up Log Format

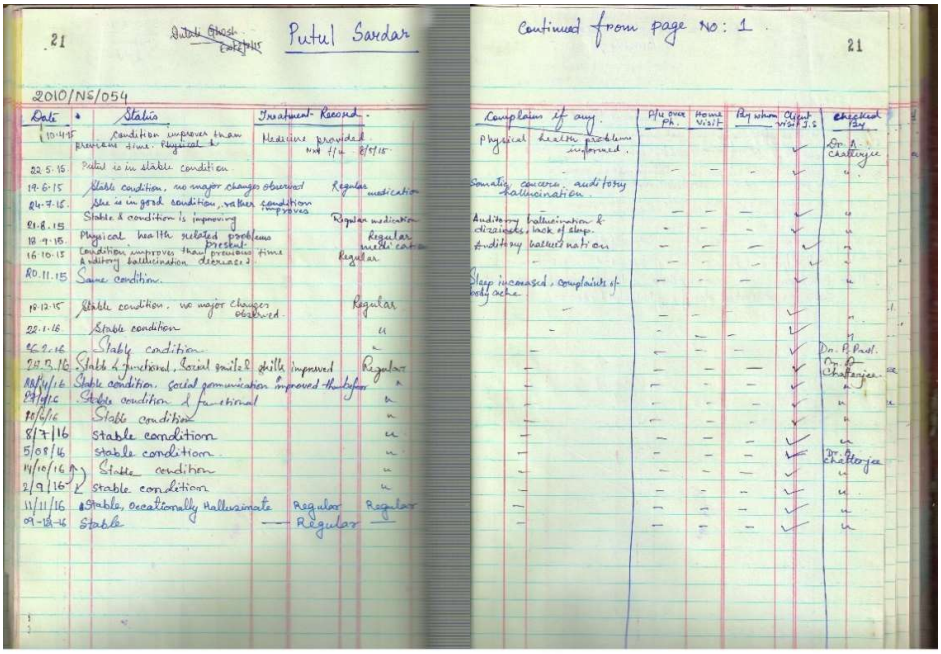


Madhusmita Karmakar.

Follow ups

Date	Name	Phone	Status	Treatment/Medicine	Involvement	Remarks
29/5	Ramanj Mandi	Reachable / Not Reachable	Stable / Unstable / Unlapsed	Regular/Irregular	None / Household / Outside	
〃	Asha	Reachable / Not Reachable	Stable / Unstable / Unlapsed	Regular/Irregular	None / Household / Outside	
〃	Dipali Mondal	Reachable / Not Reachable	Stable / Unstable / Unlapsed	Regular/Irregular	None / Household / Outside	
〃	Dipak Kumar	Reachable / Not Reachable	Stable / Unstable / Unlapsed	Regular/Irregular	None / Household / Outside	But nobody Received Ph no.
〃	Premananda	Reachable / Not Reachable	Stable / Unstable / Unlapsed	Regular/Irregular	None / Household / Outside	
〃	Bhole Baba	Reachable / Not Reachable	Stable / Unstable / Unlapsed	Regular/Irregular	None / Household / Outside	
〃	Tania Dutta	Reachable / Not Reachable	Stable / Unstable / Unlapsed	Regular/Irregular	None / Household / Outside	
〃	Santoshi	Reachable / Not Reachable	Stable / Unstable / Unlapsed	Regular/Irregular	None / Household / Outside	But Nobody received Ph
〃	Sabbir Alam	Reachable / Not Reachable	Stable / Unstable / Unlapsed	Regular/Irregular	None / Household / Outside	
〃	Sona Banerjee	Reachable / Not Reachable	Stable / Unstable / Unlapsed	Regular/Irregular	None / Household / Outside	
〃	Mangru	Reachable / Not Reachable	Stable / Unstable / Unlapsed	Regular/Irregular	None / Household / Outside	
〃	Lalita Yandki	Reachable / Not Reachable	Stable / Unstable / Unlapsed	Regular/Irregular	None / Household / Outside	
〃	Tanki Devi	Reachable / Not Reachable	Stable / Unstable / Unlapsed	Regular/Irregular	None / Household / Outside	Stop
〃	Tamanna Bedi	Reachable / Not Reachable	Stable / Unstable / Unlapsed	Regular/Irregular	None / Household / Outside	
〃	Tamuna Mondal	Reachable / Not Reachable	Stable / Unstable / Unlapsed	Regular/Irregular	None / Household / Outside	
〃	Tamim Bedi	Reachable / Not Reachable	Stable / Unstable / Unlapsed	Regular/Irregular	None / Household / Outside	call again tomorrow
〃	Manisali	Reachable / Not Reachable	Stable / Unstable / Unlapsed	Regular/Irregular	None / Household / Outside	Nobody received Ph
〃	Maniki Mahapatra	Reachable / Not Reachable	Stable / Unstable / Unlapsed	Regular/Irregular	None / Household / Outside	
〃	Sanjay Kumar	Reachable / Not Reachable	Stable / Unstable / Unlapsed	Regular/Irregular	None / Household / Outside	
〃	Ranjan Bibi	Reachable / Not Reachable	Stable / Unstable / Unlapsed	Regular/Irregular	None / Household / Outside	
〃	Papas	Reachable / Not Reachable	Stable / Unstable / Unlapsed	Regular/Irregular	None / Household / Outside	
〃	Dulali Ghosh	Reachable / Not Reachable	Stable / Unstable / Unlapsed	Regular/Irregular	None / Household / Outside	
〃	Santosh	Reachable / Not Reachable	Stable / Unstable / Unlapsed	Regular/Irregular	None / Household / Outside	Missing
〃	Begiroi	Reachable / Not Reachable	Stable / Unstable / Unlapsed	Regular/Irregular	None / Household / Outside	
〃	Ranjan	Reachable / Not Reachable	Stable / Unstable / Unlapsed	Regular/Irregular	None / Household / Outside	
〃	Sanjay Ka. Kamat	Reachable / Not Reachable	Stable / Unstable / Unlapsed	Regular/Irregular	None / Household / Outside	
〃		Reachable / Not Reachable	Stable / Unstable / Unlapsed	Regular/Irregular	None / Household / Outside	
		Reachable / Not Reachable	Stable / Unstable / Unlapsed	Regular/Irregular	None / Household / Outside	
		Reachable / Not Reachable	Stable / Unstable / Unlapsed	Regular/Irregular	None / Household / Outside	

Annexure 11: Phone Follow up log register



Putul Sardar

Continued from page no: 1

2010/NS/054

Date	Status	Treatment Record		Complaints if any	Phone Ph.	Home Visit	Psychiatrist	Clinic Visit	Checked by
10-4-15	Condition improves than previous time. Physical &	Medicine provided.		Physical health problems informed.				✓	Dr. A Chatterjee
22.5.15	Putul is in stable condition				–	–	–	✓	"
19.6.15	Stable condition, no major changes observed	Regular	medication	Somatic concern, auditory hallucination				✓	"
24.7.15	She is in good condition, rather condition improves				–	–	–	✓	"
21.8.15	Stable & condition is improving	Regular medication		Auditory hallucination & dizziness, lack of sleep.	–	–	–	✓	"
18.9.15	Physical health related problems present.	Regular medication		Auditory hallucination	–	–	–	✓	"
16.10.15	Condition improves than previous time & auditory hallucination decreased	Regular			–	–	–	✓	"
R0.11.15	Same condition.			Sleep increased, complaints of body ache	–	–	–	✓	"
10.12.15	Stable condition, no major changes observed	Regular			–	–	–	✓	"
22.1.16	Stable condition	"			–	–	–	✓	"
26.2.16	Stably condition	"			–	–	–	✓	Dr. A Paul.
28.3.16	Stable & functional, Social smile & skills improved	Regular			–	–	–	✓	Dr. A Chatterjee
28/4/16	Stable condition. Social communication improved than before	"			–	–	–	✓	"
29/5/16	Stable condition & functional	"			–	–	–	✓	"
28/6/16	Stable condition	"			–	–	–	✓	"
8/7/16	Stable condition	"			–	–	–	✓	"
5/08/16	Stable condition	"			–	–	–	✓	Dr. A Chatterjee
14/10/16	Stable condition	"			–	–	–	✓	"
2/9/16	Stable condition	"			–	–	–	✓	"
11/11/16	Stable, occationally Hallucinate	Regular	Regular		–	–	–	✓	"
09-12-16	Stable	Regular			–	–	–	✓	"

Annexure 12a: Frequency of follow-up

Duration since Reintegration (Community tenure)	**Minimum frequency of follow up by phone call**
One year or less	Monthly once
More than 1 year but less than 3 years	Quarterly once
More than 3 years but less than 5 years	Annually once
More than 5 years	No follow up / Stop follow up to those who reach this milestone

Annexure 12b: Results of regularity

All Diagnosis

	FY 2015-16			FY 2014-15			FY 2013-14		
Status (Row)	India	West Bengal	Kolkata	India	West Bengal	Kolkata	India	West Bengal	Kolkata
Regular	15	9	0	19	13	3	21	19	7
Discontinued	3			7			10		
Irregular	6			3			2		
Not Applicable	2			3			3		
Next Month F/U*	1								
No F/U will be done	3								
Information N/A#	2			2			4		
Grand Total	32	18	1	34	21	7	40	29	10

Diagnosis Grouping	Psychotic Disorder								
Discharge Year	FY 2015-16			FY 2014-15			FY 2013-14		
	All India	West Bengal	Kolkata	All India	West Bengal	Kolkata	All India	West Bengal	Kolkata
Regular	15	9	0	16	10	2	15	14	5
Grand Total	31	16	0	28	15	6	31	23	8

*F/U: Follow Up

#N/A: Not Available

Annexure 13: Targets for follow-up

Follow-Up Type	Location	Client	Frequency	Percentage (Numbers)
Home Visits	Within West Bengal	Clients to be visited	Once a year	40% (40)
	Outside West Bengal		No clear basis	
Phone Calls		Active Clients to be called	Every Month	50% (95)
Review at IS OPD		40% of restored clients should visit	once in three month	40% (39)
Follow-Up Hospital Visit	Within West Bengal	Number of restored clients to be visited and taken to a local hospital for check up by the doctor	Once a year	50% (56)
	Outside West Bengal	Number of restored clients to be visited and taken to a local hospital for check up by the doctor	Once a year	30% (16)
Resettled Clients		Follow up	Monthly once	All (7)

Annexure 14: Key Terms Used in Reintegration Process

S.No.	Key Term
1	Activity Plan
2	Motivational Counseling
3	Vocational Training Module
4	Enlisted clients
5	Baseline data of Client's Capacity
6	Work Opportunities
7	Positive Engagement in Productive Work
8	Established Set Ups
9	Supportive Employment
10	Monthly Follow up of employers and Employed clients
11	Engaged Clients
12	Employed Clients
13	Self Help Group (SHG)
14	Business Plan for SHG
15	Community Units
16	Resettlement in Community
17	Prospective Group Homes for Female Clients
18	Active Clients
19	Community Tenure
20	Reintegration
21	Resettlement

Annexure 15: Prospective Employer Checklist

PROSPECTIVE EMPLOYER CHECK LIST

CLIENT NAME: _____

CLIENT UID NO: _____

ADDRESS OF HOME: _____

EMPLOYER'S NAME: _____

EMPLOYER'S ADDRESS: _____

SERIAL NO	ACTIVITY	STATUS	REMARKS
1	Filing GD at their local PS with necessary information		
2	submit their ID proof with a letter that s/he is hiring our client from IS office		
3	IS staff will inform the employer about the level of functionality and amount of productivity the client will be able to provide.		
4	Taking detailed job description i.e. hours of work, nature of work, remuneration, safety measures		
5	Psycho education employer sharing some basic knowledge about mental health, how to motivate them in engaging in work, how to behave with them, e.g. Show less negative expressed emotion if the client is unable to perform of their level of expectation, importance of regular medication and check up.		
6	If they find anything different in the client (any kind of behaviour the client doesn't show usually) immediately inform IS over the phone or bring her/him to IS		

VISIT DONE BY (Name and Signature):

Annexure 16: Restoration Visit Checklist for Employer follow up

RESTORATION VISIT CHECK LIST

CLIENT NAME: _____

CLIENT UID NO: _____

ADDRESS OF WORK PLACE: _____

DATE OF VISIT: _____

SERIAL NO	ACTIVITY	STATUS	REMARKS
1	Monthly visit by IS staff		
2	Motivating the client		
3	Assessing job satisfaction		
4	Feedback from employer		
5	Employer counselling		
6			
7			
8			
9			

VISIT DONE BY (Name and Signature):

Annexure 17: MIS of Reintegration

	Table for Items Forms, Manuals, Policies, Handouts, Auto reports, Flags	
	Reintegration	Create / Modify
	Forms	
1	Fit for restoration form (Assessment)	Modify
2	Checklist for follow-up	Modify
3	Phone follow-up log	Modify
4	Phone follow-up register	Modify
5	Home visit - log	Use
6	Home visit - form	Use
7	Sarbari OPD follow up log	Create
8	Sarbari OPD follow up register	Create
9	Incidence Reporting Form	Create
10	Prospective Employer Checklist	Use
11	Work Place follow up form	Use
	Manuals	
1	Caregiver Interaction Manual	Create
2	Essential information on medicines during phone follow up	Create
	Policy	
1	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 those clients who qualify for reintegration	Create
2	Due list of clients to be followed-up	Create
3	Reintegration Atlas (details of all clients who have been reintegrated including details of community units)	Create
4	Frequency of follow up of any kind for different clients	Create
5	Average length of follow up of different clients	Create
	Lists / Data bases	
1	Volunteer data base	Create
	Flags	
1	Incidence reporting	Create
2	Default on follow up	Create

Annexure 18: Phone Follow-Up Process Flow

(Provided separately)

IS_Reintegration_A
nnexure 18_PhoneF

Annexure 19: Reintegration Process Flow Chart (Centre Spread)

(Provided separately)

IS_Reintegration_A
nneure 19_Reintegr