SARBARI – SHELTER FOR WOMEN

STANDARD OPERATING PROCESSES

SARBARI – SHELTER FOR WOMEN

Standard Operating Processes

DR. VIKRAM GUPTA

ISWAR SANKALPA

Copyright

Acknowledgments

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

The Sarbari team is doing a splendid job and this document is a tribute to their hard work.

Preface

This document documents key processes and activities of the treatment, care and support of homeless women with psychosocial disability who come into Sarbari. It aims to set up protocols for care processes to ensure sustainability and fidelity to philosophy of Sarbari over time. The document maps the current practices including their objectives, key activities that express the care, exceptional scenarios and safeguards put in place to ensure that Sarbari meets its objective and ultimately the goal.

This document could be useful to others, who either run or plan to run a similar facility, in understanding how the work in Sarbari is organized for the people it caters to. The appeal of the document is universal and is applicable to other facilities that care for people with psychosocial problems. This document could help family members understand how to care of their affected members at home. It gives a view of the world inside Sarbari for those who do not know what transpires behind the four walls, may they be benefactors, well-wishers, common people, mental health professionals, municipal corporation employees, police makers, administrators or any other stake holder in mental health. Lastly, this document should be used by new staff joining Sarbari in understanding how work is organized and find his/ her role in this intricate, rewarding process of care.

Methodology

The air smells, the walls whisper, the floor resounds with the stories that abound in this space that I call my home! Sarbari is home to staff and some of its residents. The author was allowed to observe its daily routine, speak to all the staff and with some of the women who receive services called residents. The author also met visitors, spoke to clients who had left Sarbari for their home, sat with the doctors seeing clients, poured through case files and had informal talks with assistant directors of the organisation.

All notes were taken in hard copy, discussed and validated with staff to ascertain if the record captured in true essence what happens at Sarbari. Over many such deliberations with staff, many shortcomings were overcome. Staff, residents and others shared their thoughts with an implicit trust and faith that makes their information authentic and places a responsibility on the author to present it accurately to the reader.

Scientific literature was referenced to the extent applicable to Sarbari from PubMed and Google Scholar using different key words. All relevant references are presented in the text. This is not a scientific publication therefore only limited referencing has been done and the language does not claim to be scientific at all.

Processes as termed in the document are designed by the author to provide reader a structure to understand the work at Sarbari. Inside Sarbari, work flows seamlessly like shuttle of the weft weaving through the warp in the loom. The write up on processes has been supplemented with process maps, drawn in a licensed version of Edraw Max version 8.6

This document has been through several drafts and many corrections and alterations. Gunjan C Khemka, one of the assistant directors has provided feedback that helped finalise the document. Photographs of activities inside Sarbari were taken but not included in the document on advice of Sarbani, the secretary of Iswar Sankalpa.

Originally, the assignment was scheduled to finish in a shorter time, but mother nature and indefiniteness of the author to include more stories delayed it. The author is thankful to Sankalpa to retain their faith and affection during this task.

Interaction with residents, staff and observations at Sarbari were emotionally taxing, soul stirring and brought one back in touch with the frailties of human life. No wonder there is an emotional overtone to the work in Sarbari and the way staff and residents relate to it. Strength to all those who engage day in and day out in this task.

Table of Contents

A person with psychosocial disability should survive and lead a life with all Rights, liberty and security

Introduction

If you have recently joined the Sarbari team or are currently working in it, then you know that the project is unique in its ambition and implementation. Perhaps nowhere else or not in many places is there similar work. Providing treatment and care to homeless women with psychosocial disability in a shelter in collaboration with local municipal corporation is an example in itself. It is both an interesting and a challenging task. At this juncture, you should read and familiarize yourself with the values of this work – what does the organization believe in while starting this work. It will allow you to interpret the processes instead of reading them as to do list or something you have to do being staff.

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

You should be conscious of Quality of intervention and of outcome in your work. Hence processes that influence quality have been outlined in different places. The transactions of Sarbari are held behind the walls and you the staff are the main flag bearers of quality and rights of all those who work in Sarbari.

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

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

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

1. PROGRAM OVERVIEW

1.1 About Project

The name Sarbari means "Beacon in the Night Sky" and rightly so! Sarbari is both the name of a project and the night shelter for Urban Homeless Women with psychosocial disabilities in the city of Kolkata. Sarbari night shelter is located at 19B Chetla Hat Road, Kolkata - 27.

It is a night shelter for homeless women operated by Iswar Sankalpa in Kolkata. Kolkata Municipal Corporation (KMC) has collaborated with Iswar Sankalpa to operate the night shelter. This is a night shelter with a difference though!

The goal of Sarbari is to provide a safe space for homeless persons with psychosocial disability for restoring health and improving functionality[1]

Sankalpa has transformed the 'night' shelter into a round the clock shelter for homeless women with psychosocial problems. These women find refuge, treatment and rehabilitation here. It is a place to ensure dignity of people who are psychosocially disabled and who are currently homeless.

In its neighbourhood, there is an Urban Health Centre, Chetla; one of the subordinate units of All India Institute of Hygiene & Public Health, Kolkata, a RNTCP clinic and a hostel. It is situated amidst the community of Chetla Hat and is

[1] Source: LFA for Shelter

close to Chetla Central Park. To the outsiders Sarbari might be a lunatic asylum (Pagal khana) where women of unsound mind are kept.

Sarbari, the shelter is located on the ground floor of a building owned by Kolkata Municipal Corporation that has been renovated post it's commissioning. KMC is responsible for the upkeep of the shelter.

Sarbari has two separate facilities inside – a night shelter for homeless women with psychosocial disability with a bed capacity of 80 and a smaller licensed mental health facility with a capacity of 4 beds.

It is open round the clock throughout the year and provides residential care for homeless women with psychosocial disability. Sarbari is a shelter and not a mental hospital.

1.2 Problem Statement

A homeless woman with psychosocial disability faces a myriad of problems - malnourishment, abuse, disregard, disrespect and at risk of losing her possessions and perhaps the most cherished possession her life! She finds her own way to survive on the streets or rather the streets find their ways to help her survive. She begs; bides her time; communicates in her own way, somehow she lives! There is little sense of time, regularity of schedule, the givens of life, and the certainty of things become fluid in this existence. She moves around or stays at same place, always on the watch out! There is no place to bathe (safely!), she hangs on to her belongings, wrapping them many a times around her, only having herself for company.

When others like Sankalpa approach her because she appears to have some psychosocial problem and is homeless; there is confusion and suspicion in her mind. She at that moment, does not share a common frame of thought or circumstances. She does not know what Sankalpa intends to offer her; similarly Sankalpa does not know who she is and what she wants. Does she know what she needs; has she eaten for past few days; has she been mistreated; is she ready to interact at this time; many a questions that need to be resolved and trust established before any offer of support can be made or accepted.

No wonder she is isolated from the community or people around her. This isolation is the problem. Community is also habituated to this isolation. They say "*she is mad,*

take her away". But where to? Should she not stay in the community and recover in front of them? Could she? An already isolated person can be doubly isolated by taking her away, to an unseen place. People ask to take away the mad person because they don't like the sight of him / her and feel uneasy, others are repulsed by lack of hygiene of the person, in all the overall attitude is to get rid of the person. This is a reality!

Community Engagement – Out in the street

The journey of Sankalpa to the shelter is an interesting one. Sankalpa started its work with homeless person with psychosocial disability in the community; identifying community resources for their treatment and rehabilitation. Sankalpa believes that psychosocial disability and homelessness are in themselves isolating for the affected person. Admitting the person in an institution, like a mental hospital or a shelter, in this condition away from the eyes of the community would reinforce the isolation. Hence, Sankalpa staff would befriend the homeless person on the street and with the help of community members treat them (the psychiatrist from Sankalpa plans treatment and one of the community members provides medicine and care to the person). Food and clothing in any case was provided by the community. The process of community engagement in itself is an interesting journey discussed in the chapter on Naya Daur - the program of Sankalpa that caters to homeless person with psychosocial problem on the streets in the community. Such community engagement took place in different localities / areas of Kolkata city.

Interaction with homeless person with psychosocial disability on streets with aid of community was a time consuming yet a rewarding process. With regular treatment and care, people showed significant signs of improvement. Sankalpa arranged for their regular bathing and personal upkeep. However, this improvement in personal appearance brought with it a new, unknown and unanticipated danger. Young women, recovering from psychosocial disability appeared cleaner; in better health and were now targets of sexual harassment on the street. This threatened their safety and security. Even though the community around was vigilant towards any potential abuse, threat, it was impossible to look after the young women all the time especially in the nights when the girls slept wherever they found a place.

On one such cruel night, one of the women with who Sankalpa worked, who had recovered very well, had found a job within the community and was going on with her new life was brutally raped and murdered. Her body was untraceable for many days. Her care taker, a community member who had provided her with a job during the day was distraught as was the Sankalpa team. This incident left everyone shell shocked. This is also a reality!

What could prevent recurrence of such an event? How vulnerable is the life on the streets? The foremost concern is therefore of protection, safety and security. A place where at least these primary concerns are addressed. Treatment and other programs could follow later. However, this meant admission in safe places - double isolation, as discussed above. Faced with a difficult choice, Sankalpa went ahead to create a place where homeless women could be provided safety especially in night. Thus was born – "Sarbari", a shelter for homeless women with psychosocial disability, a place foremost for their safety and security.

Sankalpa is well aware of the risk of isolation of homeless women with psychosocial disability inside the four walls; hidden away from eyes of the community. To minimise this risk, Sarbari was conceptualized as a Short-stay facility i.e. homeless women with psychosocial disability would stay here for a short duration when they would be treated, cared and supported in a safe and secure environment but then would leave Sarbari and not be dependent on it.

Services and processes were designed to ensure that resident women themselves and staff understand that this was not a destination but only a transit point. This was not home, but a stop in the journey back to home.

The continuous balance between security, safety and independence of resident women is therefore a daily battle at Sarbari and the one that keeps the place the way it is. The risk of losing skills of independent living in Sarbari is real; a threat to which staff and management is aware of.

Sarbari is a night shelter or at the most a short stay facility. However, at least a third, if not more, of the women coming into Sarbari suffer from treatment resistant Schizophrenia with poor prognosis. They have a poor chance of recovery and returning back to their families. What needs to be done to improve their chances is

a constant challenge not only for Sarbari but also for medical research into schizophrenia.

1.3 Philosophy of shelter

Sarbari is a space for women with psychosocial problems to heal their wounds inflicted by family, state and society; to find power within them to raise their heads as empowered human beings[2]. In this shelter, women with psychosocial disability redefine their identity, discover new skills and start rebuilding their life. A long journey from "Nowhere" from "No one" to "somewhere" and "someone" – perhaps a citizen of the State, but most of all a human being with hope and a future to look forward to!

1.4 Goal statement of the project

The goal of Sarbari is to enable homeless women with psychosocial disability lead a productive life and get reintegrated into mainstream society.

1.5 Objectives of the project

It's objectives are:

- to provide safe shelter for homeless women with psychosocial disabilities and
- to care for them to enable recovery

1.6 Components of the service at Sarbari

Homeless women with psychosocial problems are brought into Sarbari and provided with treatment, care and support. Sarbari provides psychiatric treatment, psychological therapies, pre-vocational training and employment opportunities, functional literacy during the stay. Post discharge, another team of Sankalpa called the Reintegration team continues to follow up the client for continued support during the course of the illness.

Characteristic features of service provision at Sarbari are:

[2] Iswar Sankalpa, Annual Report 2012-13

- continuous negotiation with the beneficiary
- a space of love and empathy and
- a belief in the empowerment of residents

Women admitted into Sarbari are referred to as residents in the document. They are otherwise called ladki (Hindi for girl) in the shelter. On their recovery, some women are reintegrated back to their families or another suitable destination; others who do not recover or don't have a place to go to continue to stay at Sarbari.

Staff consists of caregivers who are resident and responsible for day to day working of the shelter. Professionals (Psychologists, psychiatrists, vocational trainers, educators) help in treatment planning and training. The Shelter supervisor is overall responsible for Sarbari. Assistant Director is at hand for any clinical or administrative guidance. Sarbari also houses the pharmacy for Sankalpa manned by inventory manager who coordinates supply of medicines for all Sankalpa projects from Sarbari and has other roles as well. A shelter committee with representatives from KMC and other stake holders keeps on oversight on the shelter. Sarbari houses the kitchen of Sankalpa that cooks for its residents, outreach clients and for special occasions. It also serves as canteen for staff.

All residents follow a daily schedule overseen by caregivers who are the pivot of Sarbari. Medicines are given under direct observation by the caregivers. Residents are trained in social skills and initiated into employment (sheltered employment, facilitated employment & self-employment).

1.7 Stakeholders of the project

The project works at the intersection of homelessness and psychosocial disability. The departments of health, social justice, and social welfare are direct stake holders as the problem and work have a direct bearing on their remit. The organization of mental health services and the extensions to other services of rehabilitation is the remit of no one department and calls for collaboration between different departments and ministries. All those are stake holders. The agencies involved in urban planning who face the challenge of providing safe places to its inhabitants including homeless are an important stake holder as is police and other agencies responsible for helping citizens in distress.

Not for profit organizations, the judiciary of the country which has constantly focused attention on the issues of homeless and therefore are relevant to the

homeless with psychosocial disability are an important stake holder of the project. The families who lose their loved ones to the psychosocial disability are an important stake holder and need to perhaps raise their voices in provision of care and support when such a devastating incident happens in their lives.

Funders who support such cause and are looking at solutions that are scalable are an important stake holder as is academia and researchers or police makers who are looking at different solutions to the problem of homelessness and psychosocial disability in cities of different countries.

1.8 Information parameters of the project

The project deals with an incognito homeless woman with psychosocial disability to begin with and then traces her response to different interventions of the care package. From her condition at admission to that at discharge, she is assessed by psychometric scales and other observations. All these parameters that are captured come together to inform progress (as expected) of the person. Therefore, the project collects several individual progress parameters. In addition, as a shelter the project works on different parameters that keep the service ready and efficient for serving the client or beneficiaries. The parameters should in the future bring out a report card of the status of the shelter and its residents on the two axes of status of residents and status of shelter

1.9 Challenges

The number of homeless women with psychosocial disability on the streets of a city like Kolkata far outnumbers the beds available. There is also inadequate allocation of resources to service this need. Overall, an ecosystem for serving this client is lacking. Due to lack of ecosystem funding, trained human resource, follow up mechanisms, legal hurdles are faced by Sarbari on a day to day basis. Although much has changed on all fronts, the funding is inconsistent and unpredictable. The involvement of Sankalpa into different forums would help identify these challenges and mount a methodical response such that the future has some concrete solutions for the ecosystem rather than individual work by organizations

1.10 Evaluation / Audit of the project

External and Internal evaluations are conducted for the project as part of funder requirements as well as part of the new approach adopted by Sankalpa which is driving it towards measurement of its results for the resources spent. Since to a

large extent Sarbari is a closed institution, the audit needs to be more stringent and currently the Shelter Monitoring Committee is mandated with the task. Internally, work is reviewed for each quarter which forms the basis for improvement and identification of gaps.

1.11 Overall Process Map

After admission into Sarbari, the treatment team works on three main areas or domains - activities of daily living, socialization and work.

Assessment, treatment planning and review of residents is done by the different professionals together at a joint meeting keeping residents' medical, psychological and social needs in view.

Psychosocial support is given an equal emphasis as drug treatment. The cost effectiveness and importance of these measures in treatment of schizophrenia is notable[3]. Further, the services are tailor made for homeless women where there is no immediate availability of family for support and varying levels of trauma, neglect and abuse that client has had experienced.

Resources to run Sarbari are primarily raised by Sankalpa while KMC provides some budgetary support in addition to the building and cooperation

Since April, 2010, Sarbari has been one of the few safe locations for women with psychosocial problems who are rendered homeless. It is not only a service location, but a living experience in the worlds of these women and their care and support. During its evolution, Sarbari has inspired those who have ignored the human amongst us, especially those with a psychosocial problem, be it state or its citizens.

A process map showing in an overview the main service components is attached as **annexure 2**

The following sections deals with the processes followed at Sarbari

[3]Burton, Neel; Psychiatry Second Edition, pp. 70; Wiley-Blackwell Publishers

2. Sarbari Framework

As you begin your work in Sarbari you would soon realise that the journey of a current resident of Sarbari – a homeless woman with psychosocial problem, begins from the street of Kolkata.

Each resident of Sarbari has a story to tell and you as staff of Sarbari should know the story. The chapter provides a framework which will allow you a structure to understand the story and also the care processes inside Sarbari. The care processes are divided into four phases, starting from entry into the shelter to exit from it. The fourth phase might not be applicable to all residents since they do not fulfil the conditions for discharge.

Each phase has several milestones which marks significant achievement in that phase and signify progression of the client along the recovery pathway

Four phases are thus identified:

Phase 1:

In this phase, you will admit an eligible candidate into Sarbari from the streets of Kolkata. This is simply the ENTRY

Phase 2:

In this phase, you will plan and provide initial treatment, care and support to the new resident in Sarbari. This is the period of acute care

Phase 3:

In this phase, you continue to care for the resident who has now been put on a stable treatment plan and appears to be settled. This is the period of stabilization

Phase 4:

In this phase, you will discharge the resident from Sarbari and pass on the care to the Reintegration team. This phase marks the EXIT from Sarbari

After Phase 4, Reintegration team of Sankalpa will provide follow up treatment services to the client if the client is restored to family and the outreach team will

follow up if the client is reintegrated to some other spot in the field area of the outreach program. These processes are described in the Chapter on Reintegration

Milestones

To indicate progression of a resident during each of the phase, milestones have been developed. It is possible to develop several more milestones depending on the ability of the project to measure them and each milestone indicating significant change from the previous state.

Since the project undertakes regular measurement of certain parameters of client care, it should be possible to measure milestone at a set frequency.

For special scenarios such as pregnant women or women with young children separate milestones may be developed. These have not been mentioned here since their applicability is not universal to all women in the shelter.

Table of milestones
AXIS = FOR RESIDENT OUTCOME

Phases	Key Term	Brief Description
Phase 1:	**Admission**	**Providing entry to the person in Sarbari**
Milestone 1	Complete admission	All processes of admission process completed as per SOPs
Milestone 2	Crisis Resolved	Optional – If the person presented with physical or psychological crisis, the same has been resolved
Phase 2:	**Acute Care**	**Care during first few days after admission**
Milestone 3	Initial assessment	The resident has been assessed to be able to draw an intervention plan
Milestone 4	Initial Management Plan	An initial management plan has been developed for the resident and she has been initiated on it

Milestone 5	Stabilization of symptoms	The resident responds to initial management plan and her symptoms respond (true for positive symptoms, physical ailments, injuries)
Phase 3:	**Stabilization Phase**	**The client has responded to acute care, showing early signs of recovery and is now marching towards recovery**
Milestone 6	Stable treatment plan	Resident is on a treatment plan that is more or less stable with no or few changes expected. This is likely to be her long term treatment
Milestone 7	Consistent Work Participation	The resident shows consistent work participation in at least one or more vocational activities that could serve as a potential source of income for her or occupy her time
Milestone 8	Social Participation	The resident shows good social relationships with at least people of her choosing
Milestone 9	Self-Initiative	The resident shows self-initiative in work, enthusiasm and good comprehension of requirements
Milestone 10	Found Employment outside Sarbari	The resident has found a job outside Sarbari
Milestone 11	Sustain employment outside Sarbari	The resident has been able to sustain job outside Sarbari for at least 6 months
Milestone 12	Episode free period	The resident has shown smooth recovery with no relapse or deterioration in condition for at least a period of 6 months
Phase 4	**Discharge**	**The resident is discharged from Sarbari**

Milestone 13	Destination Unit = Acceptable	The resident has an identified destination unit which shows acceptance of the recipient, resident and environment
Milestone 14	Discharge Process	The discharge process has been done as per SOPs

Each residents could be separately assessed on the checklist and data put on a graph to see how many milestones have been achieved relative to other peers. Over time, time in which milestones should be achieved can be estimated and time delay of achievement of a milestone can be plotted.

A separate checklist has been added in the annexure for shelter's functioning

Sarbari Format – Exhibit

				Phase 3	Stabilisation Phase		
				Milestone 12	Episode free period		
				Milestone 11	Sustain employment outside Sarbari		
				Milestone 10	Found Employment outside Sarbari		
		Phase 2	Acute Care	Milestone 9	Self-Initiative		
Phase 1	Admission	Milestone 5	Stabilisation of symptoms	Milestone 8	Social Participation	Phase 4	Discharge
Milestone 2	Crisis Resolved	Milestone 4	Initial Management Plan	Milestone 7	Consistent Work Participation	Milestone 14	Discharge Process
Milestone 1	Complete admission	Milestone 3	Initial assessment	Milestone 6	Stable treatment plan	Milestone 13	Destination Unit = Acceptable
	AXIS = FOR RESIDENT OUTCOME						

3. Phase 1 / Admission into Sarbari (Relocation / Registration)

A homeless woman with mental illness from any location in the city of Kolkata could be admitted into Sarbari. This process of bringing in a homeless person from street to Sarbari is called "Relocation / Registration".

3.1 Sources of Admission:

You could receive the new admission from any one of the following sources:

1. Police

2. Staff of Sankalpa or a member of the community as part of community engagement

3. Medical Camps organized by Sankalpa

4. Other NGOs or other organisations

A homeless woman with mental illness on streets of Kolkata is identified either by the police or by staff of Iswar Sankalpa. Sometimes, people from community could inform either of the above two about a homeless person.

It is important to separate the sources of admission since the process you will follow in case of relocation / registration by police and relocation / registration by staff of Iswar Sankalpa is different.

Let's start by describing the process most commonly seen:

3.1.1 Admission by Police

When the police takes custody of a homeless person with psychosocial problem, they first bring her to police station of that area. They call this rescue. Here they record the details of the rescue and make note of details and provide this a reference which is called General Diary Extract (GDE). This is the official entry of the rescue record of the person in police records.

With the GDE entry, they then take the woman to Sarbari for admission. The police is usually informed by community members about the person or they could also do it on their own in different circumstances.

At times the vagrancy department undertakes drives in the city and evacuate the homeless people from their locations and take them to shelter homes. Homeless person are produced in front of a magistrate who then allows custody of the person to one of several homeless shelter across the state of West Bengal. These special drives pose a tough challenge to both homeless people and those taking care of them either in community or organizations like Sankalpa because suddenly one day the person you have been working with has disappeared without a trace. This process is opaque, unpredictable and custodial. No assessment of mental health status of the person is done and homeless person with mental illness could be locked in a homeless shelter of the state without appropriate treatment and care for a long time.

However, the police will only approach Sarbari with the GDE which is the relevant point here. The police does not distinguish a homeless woman with psychosocial disability from another who does not have it. They rescue a homeless woman and will bring it to Sarbari. Later we shall discuss how you will have to negotiate with the police to identify the suitable candidate for admission into Sarbari.

3.1.2 Admission from community outreach program of Sankalpa

The second source of admission if by the Iswar Sankalpa staff who identify homeless women with mental illness as part of their Outreach program called “Naya Daur”.

In Naya Daur, the usual process is to work with this person on the streets itself with help of community resources. However, in face of following conditions, the woman could be offered choice of admission in Sarbari:

- If her illness is severe and she is in a poor condition
- if she does not have a safe place to sleep in the night and her security is threatened

In above circumstances, Naya Daur staff will refer the woman to Sarbari for admission.

3.1.3 Admission from a Medical Camp:

As a part of the outreach program, Sankalpa organises medical camps where psychiatrist are available for consultation. These camps are organised in field areas of both programs. The local people seek advice from the doctors. In addition, homeless person (men and women) with psychosocial disability are brought to the camps for medical consult, attending to their personal hygiene. They see a doctor, take bath, change into new pair of clothes, eat a full meal and then decide if they want to go back to the street where they would be followed up by outreach team or to the shelter.

< SEE ANNEXURE 3a, 3b: Processes involved in admission and admission by police specifically>

3.1.4 Admission by another NGOs / organisation

Sometimes, new client may be brought to Sarbari from another organisation that runs homes for homeless women but are not geared to take care of those with psychosocial disability. They therefore bring these women to Sarbari. At times, other organisations working with street children could bring in mothers of such children who appear to have a psychosocial disability.

3.2 What is the benefit of admission into Sarbari

Sarbari is a short stay facility, but it is a closed system nevertheless. Women coming off the streets have to adjust to this new world. Admission is not always voluntary as in the case of police admission. Staff and a few of the residents who were residing at the time of writing the document when interviewed provided the following rationale for admission to Sarbari:

1. Sarbari prevented exploitation of a woman with psychosocial disability. Out on the street even though many women are in community care, their security cannot be guaranteed; real life experience has proven so. Strangers feel that this woman is mentally ill, she would not be able to speak anything and none values her therefore she is a safe target to exploit. Anything can be done to her. Sarbari puts a protective boundary around the woman which although symbolized through locked doors and four walls protects her from exploitation.

2. Sarbari provided a location where treatment can be done instead of aimless wandering on the streets. Wandering around makes treatment very difficult. At one location such as Sarbari, the focus is entirely on the resident and her needs. This initiates and hastens her recovery or at least gives recovery the best chance.

3. The woman gets a chance at resettlement – either back to her family, if traced or some other option

4. She also gets a meaning or purpose to her life. The support services and relations she builds at Sarbari provides her both an insight into her own present condition and a purpose to what she is doing or would like to do.

If she liked dancing, she gets an opportunity to dance during energizers and Dance Movement Therapy (DMT) sessions; she could participate in the Annual Event of Iswar Sankalpa. These options provide her an outlet from her present predicament and make her happy. During all these activities she receives much appreciation and encouragement. Importance of appreciation and affection cannot be overstated as we shall see in the document throughout.

3.3 Admission Criterion:

I have described the sources of admission to Sarbari, but there are certain admission criteria which must be fulfilled before you admit someone in Sarbari. These are:

- The woman should be currently Homeless or a resident of another shelter
- She should be an adult (between 18 years and 45 years); Sarbari is not meant for children or juveniles
- She should have a psychosocial problem

Disqualifiers:

At the same time, there are some disqualifiers, conditions that do not permit admission in Sarbari because of the way services inside Sarbari are organised. These disqualifiers are:

- a woman less than 18 years of age or on another hand an elderly woman

- a woman with a serious or severe physical illness. In this case, the woman is not admitted since Sarbari is not geared up to attend to difficult physical problems

- a woman with Intellectual Disability (Intellectual Developmental Disorder) alone

3.4 Exceptions to Criterion based admission:

In some situations, however, police might request you (Sarbari staff) to admit a person for a short time (say for the night). It could be due to poor condition of the person (usually poor physical condition). Since there are many women who would qualify this exception, it is important to follow the admission criterions to provide beds for women who are homeless with psychosocial disability. In exceptional situations, as a shelter for homeless women, you could permit short term stay for a homeless woman even if she does not have a psychosocial disability.

3.5 Why is there an admission criterion

The facility is specifically suited for recovery of homeless women with psychosocial disability and not for any homeless woman. Admission to any homeless woman would not be the optimum utilization of the set up and would reduce chances of recovery of a homeless woman with psychosocial disability on the streets. Hence, you should ensure that admission criterion is strictly followed at Sarbari. As staff, you should negotiate with police and others when a new client is brought in by them and if it does not fulfil the admission criterion. Only in view of the gravity of the situation, you should allow for short term admissions even if the criterion is compromised. The process map captures the pathways of such a process.

So the women who benefit the most from the set up at Sarbari are those who are / were:

- highly symptomatic for psychosocial disability

- young

- speak and understand either Bengali or Hindi

- have a shorter duration of homelessness
- responding to treatment on the street but were irregular with treatment
- responding to treatment on the street but safety was threatened

It should be made clear that these characteristics do not profile that you should select for admission and deny others. Women of all ages are admitted here. However, it is an observation of the staff that older women who have spent several years on the street lack confidence even after recovery. There is somewhere a gap that is difficult to overcome and they take long time to recover.

Similarly, the issue of language is only because staff is well versed in Bengali and Hindi. For residents who speak some other language, interpreters are asked to help, but regular transactions, therapy cannot be held in any other language however this is not a disqualification criterion and you will find women of different languages here

3.6 Processes in admitting an eligible client

Now you will be able to appreciate that If police brings a person for admission at Sarbari, an additional process is performed which is not required for any other source of admission. This is the process of negotiating with the police after judging the suitability of the woman for new admission

3.6.1 First, Admit based only on criterion:

Negotiation with police / any other party who brings in a new person:

When police brings a woman to Sarbari, you should admit based on admission criterion. Police often does not seem to understand this. You will have to negotiate with police and impress on them the reason of refusal of admission to the woman they brought. Exceptions are made however as stated above. This is what you should do.

Scenario 1

If the woman meets the admission criterion and it is day time, you should request the police to first take the woman for an opinion of a psychiatrist at a government hospital / government mental hospital.

If you impress upon the police the need for this, the police will do so. After assessment, the person is brought back with a prescription to Sarbari and admitted.

Scenario 2

If the woman is ineligible for admission, then she is either returned with the police who are informed of a suitable location for her or kept at Sarbari for a brief duration to find a suitable location for her.

Police is an important stake holder of Sarbari and enjoys a good working relationship. All the above tasks are done by the caregivers at Sarbari

3.6.2 Second, talking to the person & taking care of her

1. As soon as you receive the new resident, take her to a room along with the person who brought her and speak to her and ask her identification details – name, where she was from, is she hungry, is she thirsty?

2. Give her something to eat and water to drink. She is very likely to be hungry and thirsty. If she looks of old age, ensure she has something to eat. Do not worry if she refuses. She might want to drink from her own vessel, in such case pour the water in her vessel.

3. Take her Blood pressure, check her pulse, temperature

4. Screen her for any obvious physical injury, wound, and accompanying child or visible pregnancy. Give her a head to toe examination and first attend to any obvious physical complaint. Most commonly you would find – maggot infestation in wounds; open wounds. If it is day time you should request the accompanying police or another person to take her to a government hospital for care, but if there is no such opportunity attend to her.

5. Give her a bed roll and direct her to a space to sleep. One does not know how long she has been on the streets. Now that she has found a secure place let her sleep undisturbed.

6. Then complete the admission formalities which are the following:

1. Open a new client file and fill in the case intake sheet with whatever name she is giving or the accompanying person has told you. You don't need to undertake a detailed case history; that would be done later. For now, the main objective is to put the person at ease and let her settle first

2. Mark the time and date of admission and make an entry into the admission register

3. If the police has brought in, note the GDE and receive the letter that police station in-charge writes to Secretary, Sankalpa requesting admission for the homeless person.

4. Receive the signature of the person who has brought the new resident on a write up that he/she has brought in the person and is admitting to Sarbari

7. Intimate the doctor

Within a short time of a new admission, you as the caregiver should inform the psychiatrist associated with Sarbari about the condition of the person over phone. In case the police takes the woman for an opinion in a government mental hospital, treatment is started on her return as per prescription. Care giver should start the treatment and inform the psychiatrist. Later, the in-house psychiatrist should examine her and if required, the treatment could be modified.

As the caregiver, in all other cases and as a default process, you should inform the psychiatrist of the new admission. You should explains the condition of the client and the psychiatrist would inform you the initial temporary treatment plan over the phone, till the psychiatrist is able to examine the client in person. If the psychiatrist is able to visit and assess the resident there and then the treatment is chalked out else the doctor advices the initial treatment over telephone.

As caregiver start the treatment.

Preferably, as caregivers you should be trained in basic nursing and should be able to administer both intravenous and intramuscular medicines if prescribed by the doctors.

3.6.3 Third, Intimating the Police about the new admission

General Diary Entry (GDE):

On admission of a homeless woman with mental illness irrespective of source of admission, you (the caregiver / shelter supervisor) should inform your local police station. This information is registered by the police as a General Diary Extract (GDE). You should write a letter (in duplicate) in prescribed format describing the person, when (date and time) she was brought it, who brought her and from where and submit it to the police station. The letter would be received in the police and based on this they would then make a GDE entry. You have to note the GDE and bring it back on a copy of the letter. If possible, add a photograph of the person. Usually, by the time of admission, photograph is not ready, so you could provide this later to the police.

The GDE is very important since it is a legal reference which is used in the scenario of residents running away from Sarbari; retracing the family; in times of death of the resident, etc. Irrespective of the source of admission, the above process of recording GDE is a standard procedure which is followed in all cases.

The adoption of GDE based process in contrast to the Reception Order issued by a Judicial Magistrate is an administrative convenience which makes taking care of homeless person with mental illness easier for following reasons:

1. In the event of death of a resident either at Sarbari or at a hospital, last rites are done as per government procedures for homeless person instead of Sankalpa having to perform last rites

2. GDE is a regular procedure for police and does not involve much time and effort from their side, this makes it convenient for homeless person to be addressed by police

Caveat: Legitimacy of the above procedure should be clarified. As far as being standard procedure, this is currently adopted at Sankalpa and is working well at Sarbari and as you will see even in Men's Shelter (Marudyan).

3.6.4 Fourth, Photograph at admission

Within 2-3 days of admission, a photograph of the resident is taken. This is kept in the case record. It is a baseline photo and would be compared to another photo take later at discharge. The differences in the two show the changes during care at Sarbari. If a resident leaves Sarbari on her own without informing anyone, the photo is used to inform police and trace the resident, bring her back to Sarbari.

These processes culminate the admission process or Phase 1 of the treatment, care process in Sarbari. Before we proceed to Phase 2 processes, a short mention on the Client Case file is presented below.

Creation of a file

When a homeless woman with mental illness comes into Sarbari for the first time she is a "New Admission" and is given a new file number. This file number is **unique** to a client at Sarbari and overall at Sankalpa. No two residents across the organization can have the same file number. The homeless woman with psychosocial disability is hereafter called a **resident**.

Residents who were earlier part of the Outreach program and were referred from it may already have a file number. Same is continued at Sarbari. You may not know their file number so just open a file and note in it that this client is from an ongoing program. Later, you can find out and place the file number on the file. They are admitted here for in-house care.

Any other person coming into the service network of Sankalpa for the first time is issued a new file number which then stays with the client irrespective of which project or team she is located under.

File is an important instrument at Sarbari. It is a repository of all transactions with the client. It is also the archive of information that resident gives from time to time. The file has 9 sections. All sections are shown in **Annexure 1**

4. Phase 2 / Initial Care of the New Admission (Acute Care)

Phase 2 starts with taking care of the now "resident" of Sarbari during initial few days of her stay at Sarbari. This is when formal professional care starts. The processes involved in acute care are:

1. Initial assessment of the resident and

2. Preparation of an initial management plan

4.1 Initial Assessment of the resident

As soon as you receive the new resident, begin her initial care. We will call it Initial treatment, because it is part of the overall care process. Overall, the objectives of this phase are:

1. to form an understanding about the new admission (who is the person, what is her story till date?);

2. to initiate treatment and

3. to attend to any crisis or severe condition the person might have.

During this phase, you should initiate drug therapy for the psychiatric condition and any other physical illness and attend to personal hygiene of the resident.

The first impression on the new person is very important. There is the **technical initial treatment process** and the **soft or the human care process**, both are equally important. Phase 1 care only dealt with initial shelter to the resident. In Phase 2 she will start engaging with you and your colleagues hence there are some behaviour characteristics that have to be kept in mind while taking the initial care of the resident.

However, before you initiate treatment, there are two scenarios you could encounter:

Scenario 1: If a woman is pregnant at admission, you as the care giver should take her to a government hospital for antenatal care and continue to do so at required intervals till her delivery.

On delivery, you should hand over her child to an agency that is mandated by law to take custody and provide shelter to orphan children under the oversight of Child Welfare Committee. The process adopted is detailed later.

Scenario 2: If a woman has a young child with her at admission, then you should have over the child to the same agency as mentioned above.

4.1.1 Processes that express the human or softer part of care:

1 Individual Attention and a flexible routine

First few days of admission are critical for the resident. She is often angry or withdrawn or both. She would often get into a fight and spend time all by herself. You and your colleagues (Care givers and other staff) have to allow her some time on her own; allow her to follow her own routine to settle down in the shelter. As a Care giver, your role would be critical in the initial phase.

During her first few days, if the resident is violent, allow her to sleep in a location different from other residents. Give individual attention and focus on basic activities of daily living such as sleeping, eating, bathing, etc. You should expect her to sleep a lot. She has perhaps found a place to let her guard down and rest. The medicines that you would have started also cause sedation (see later).

So let the 1st two weeks be as per the residents' own pace.

If she is not violent, let her sleep anywhere in the complex which would usually be the case. Allow her to wake up whenever she wants, take bath. Exert no force to ensure that bath is as per schedule of other residents. Whenever she wakes up request her to brush her teeth and she could go back to sleep again.

During this period, emotional outbursts are frequent. Provide emotional support to the resident. You should address her by her name or ***'didi'*** or some other connotation and call out softly to her. Ask her for food and water. If she expresses a desire to sleep, tell her it is ok, sleep as much as you want. Always keep some food

for her, in case she gets up at odd hours and is hungry. Bear with her anger, continue to speak softly.

There is no practice that counsellors alone will address emotional issues, anyone available at hand answers the call of duty. In retrospect, residents share that initially they found it difficult to adjust to the shelter where many women stayed. This initial phase of maladjustment could persist forever with some residents largely due to a longing for family or a place they can call their own home. The desire to go home is very strong in most if not all residents.

The initial stage therefore is very important. Many a times, address is revealed during this stage however tracing the address is not started since the client has not recovered. Remember you don't ask for address, you simply ask the resident her story, if she seems to engage in conversation, ask about her, who she is, what is her name and who is in her family? Do not mention anything about illness or her stay in the streets. Tell her where she is and who are all of you.

2 Fellow shelter residents or Peer Volunteers:

Older residents who have recovered help the new resident during this period including helping her perform Activities of Daily Living (ADL). The help extends from helping in taking bath and other ADL activities to eating meals. Central point is to leave the woman to her own schedule and let her settle down.

As Care giver or counsellor, you should speak to the peer residents what the new resident has revealed to them. At the same time you should oversee that the peer residents do not treat her harshly. Despite your best effort, this would happen sometimes, immediately counsel both the parties and restore peace.

4.1.2 Processes involved in the technical initial treatment process

1 Initial Case Interview & Intake Form / Case History

If you are one of the Mental Health professional (counsellor, psychiatrist, social worker), you should assess the client as soon as you are informed about the new admission. The care giver will inform you and in any case you should have the habit to check the visitor's register at entrance gate to see if any new admission came the night before.

You should attend to new admissions during previous night the next day while those during your presence in the day time are assessed on arrival. It depends if the resident is in a condition to respond, if she is not, she is left alone for a few days before she is revisited for assessment.

Elicit her history as per the guidelines of the intake form or **a case history form**. This case history form is a detailed form however not all information is retrievable at first contact with the resident. You will have to speak to her several times and continue to populate this form. If there is lack of space in the form, then add a plain paper and enter information there.

As psychologist, your first case interview with the resident should be more of a rapport building exercise. This activity is critical to the psychologist's role since it introduces her to the resident and helps in understanding her. Repeated interviews and discussions with the resident help build an understanding about her. Your impression as the psychologist is captured in the Psychologist's format filed in the client file.

2 Psychometric Scales at Admission by Psychologist

In addition to the initial case interview, you as counsellor / psychologist should administer a battery of Psychometric scales. The findings of these tests are recorded as baseline or admission finding.

The set of selected scales to be administered are:

- Positive and Negative Symptom Scale (PANSS)
- Global Assessment of Functioning (GAF)

- Indian Disability Evaluation Assessment (IDEAS)
- Life Skills Profile (LSP). This scale should be administered by the Social Worker and not by Psychologist.

As Psychologist / Counsellor you should fill in all scale, if required, support from the Psychiatrist should be taken. Record the scales on their paper formats and file them in the relevant section of the resident file. The different sections of the files have been shown in annexure. These scales are an important objective record of the progress of the beneficiary (discussed later).

3 Initial assessment by the psychiatrist

As discussed earlier, the psychiatrist initiates the treatment of the resident and during the acute phase the treatment is new for the client. She could sleep a lot under the sedating influence of the drugs.

The psychiatrist visits Sarbari on fixed days but is available in between as well and over the phone. Whenever is the earliest, the new resident is reviewed by the psychiatrist. If this is in person, then you as care giver and counsellor should be available during the first interaction. You should preferably introduce the resident to the doctor as "

this is sushmita and she came to us yesterday! Sushmita, this is Dr. Abir. He takes care of the other didi here. You can tell him whatever he asks you. I will also be sitting her, so don't be afraid.

4. Laboratory Tests

All clients are not subjected to a list of routine laboratory tests. The lab tests are based on an initial assessment by the doctor. This is a good process and in line with current recommendations.

Earlier, a general physician used to visit Sarbari but of late this has been discontinued. If there is any physical health need, a beneficiary is taken for assessment to the Urban Health Centre in the adjacent building.

After the assessments are over, the management plan is prepared to provide care to the resident during acute phase.

4.2 Initial Management Plan

The treatment process is handled by the Psychiatrist and the Counsellors. The occupational activities are handled by the Vocational Training department. A separate team provides training on literacy. All participate in leisure activities. Care givers assisted by Peer Volunteers play a pivotal role in all these processes.

After assessment of the resident, an initial management plan is prepared which consists of three parts:

(i) Pharmacological therapy as prescribed by the psychiatrist

(ii) Non pharmacological intervention by counselor / psychologist

(iii) Participation in daily activities of the shelter overseen by the caregiver

4.2.1 Pharmacological Intervention:

During acute phase of treatment, the drug treatment is started after the initial assessment by the psychiatrist. The medicine is given under direct observation by the care giver. This is the dominant form of treatment during acute phase of illness. The prescription is written down by the doctor and placed in the personal file of the resident. The medicine is provided from the drug store of Sarbari. This process is described in more details during the next phase.

With the introduction of antipsychotic medications, positive symptoms of residents are controlled to an extent. This allows residents to participate in different therapeutic and skill building activities. The treatment approach at Sarbari is to ensure drug compliance and provide a number of psychosocial measures including psychological supportive therapies and rehabilitation. Rehabilitation involves supporting in activities of daily living, occupational activities, leisure activities and social skills. This requires a multidisciplinary team which is available at Sarbari (see staff structure).

4.2.2 Non Pharmacological Intervention:

The non-pharmacological intervention is non dominant during acute phase. As the counselor your main emphasis is to build rapport and to attend to any acute crisis

in the client otherwise you should serve as the patient ear for the resident. Both the drug and non-drug intervention in acute phase are as per their technical protocol.

Develop a technical protocol for therapy during acute phase of treatment

4.2.3 Involvement in activities of the shelter:

The initial treatment consists of medicines and involvement in activities. If the client takes only medicine and is left on her own, she would get isolated, involved in her own thoughts, hence involvement in activities is essential. Hence you as caregiver and counsellor should introduce the resident to the schedule of the shelter. Leave it on the resident to participate or not, but continue to encourage her to participate.

As Caregiver you should encourage the resident to come for the activities as they happen. She should be made to sit in the common area from where she is able to observe other residents working. Peer Volunteers should also encourage her to get involved. Usually she would participate but if she is not keen let her involve at her own pace.

Endpoint

When the new resident adopts the routine of the shelter, it marks the end point of the initial phase of acute stay. This phase might last from a few days to a few weeks.

Gaps

1. Mental State Examination

A Mental State Examination (MSE) is not done at this stage. However, MSE could provide baseline value of "Insight" which is assessed later during discharge by the Drug Attitudes Inventory in Fit for restoration form.

Scenario: Admission to a hospital:

If any beneficiary has a serious medical problem, you as care giver should shift her for inpatient care to one of the hospitals with which Iswar Sankalpa has a tie up. The assessment of this situation can be made by the doctor but also the care givers. The

final decision to shift has to be made in consult with the doctor and shelter coordinator.

If hospital admission if required, then following process is followed:

1. The care giver takes the resident to the hospital and admits her there. The ambulance of Sankalpa can be used for transportation. If unavailable, another ambulance is requested to come.

2. The care giver takes responsibility for the resident and Sarbari is provided as address of the resident in the hospital.

3. Care giver continues to visit the resident in the hospital regularly. Another resident could stay with the resident in the hospital.

4. All expenses are paid by Sankalpa.

Suggestion:

It is suggested that a group health insurance policy such as ones offered by New India Assurance Co. Ltd should be taken to cover such hospital expenses.

5. Phase 3 / Period of Stabilization

After the initial period of stay of the client at the shelter, the period of stabilization starts. The characteristic of this period is that the resident settles down in the shelter i.e. in its activities. The treatment plan of the resident is more or less settled and she is on a longer term treatment with medicines not changed for some time and same for other interventions. This period lasts till the client is fit or suitable for discharge. During this phase, the multi-disciplinary team of Sarbari comes to fore and a rainbow of different activities unfold which keeps residents busy and inculcates different skills in residents.

5.1 Phases of care

This phase has been described in four different sections that each capture the different dimensions of the work. These sections are:

Section 1	The quality attributes of the service delivery	This section details how the service is delivered, the values and behaviour of staff who delivers different services
Section 2	Management instruments	This section explains the key management instruments that keep the entire range of activities in sync
Section 3	The Package of Services	This section describes the different activities that happen daily in Sarbari, how they are organised and their different dimensions
Section 4	Miscellaneous Information	This section describes different things that are not cleanly captured in any of the above three sections

An outline of different sections and their contents is provided in **Annexure 2** <**SEE ANNEXURE 2**>

5.2 Signs of Recovery

According to different staff, signs of recovery are very visible and it is easy to discern that the person is recovering. Following are some signs that indicate improvement in residents:

- Improved personal appearance& personal hygiene
- A sense of time e.g. a normal sleep cycle
- Eating food herself
- Talking normally
- Come on her own to take medicines
- No visible strange behaviour
- Wear her own clothes properly
- Understand communication
- Interact with other residents and is able to stay in shelter
- Not react angrily when someone says something
- Show self-initiative in activities
- Improvement in work performance – if she was earlier making a necklace of random beads and now is able to follow instructions to make a necklace of same coloured beads. Later she is able to replicate a design in her art work
- She required repeated monitoring and now does not need reminding for a task
- If she is involved in cooking, does her part of the job complete
- Develops Confidence
- Socialises with others; establishes and maintains inter personal relationships
- Wears a smile

- knows how to approach someone
- Knows "Who Am I"? (Initially, at admission a client is asked her name, she does not give any answer, however on recovery she gives her name)
- Has some Insight about her illness

Earlier, my brain was not working properly hence could not remember anything, could not work, I was beaten. So, how did you recover now? I recovered because you give me much love, it has healed me. How do you know I love you? You give me medicine! Love is essential! If one explains with love, the other person listens[4].

Studies have shown that it is very important for people with psychosocial disability (mental illness to be precise) in recovery to feel they are cared for[5]

5.3 Time to Recovery:

On a daily basis, you as care giver, counsellor, vocational team member should observe residents for signs of recovery. You should remark about this sign to the resident, congratulate her and also relay this information to doctors during their review.

As discussed later, the multi team review at Sarbari is a best practice. It integrates information from daily observation into treatment planning. As caregivers you should share your observations with the counsellors and vice versa since this team largely manages residents on a day to day basis. The usual time to recovery of a resident is 3-6 months since admission. Early signs of recovery such as improvement in self-care and personal hygiene could be seen sometimes even after 2 weeks; improvement in functionality however takes up to 3 months. To take initiative, move and mix around with other people, speak with them however takes around 3 months and readiness for discharge although depends on each case is usually around 6 months.

---

[4] Extracts of a conversation between a resident and a caregiver as heard by the author

[5]Svavarsdottir SJ, Lindqvist R & Juliusdattir S (2014) Mental Health Services and Quality of Life. International Journal of Psychosocial Rehabilitation. Vol 18(2) 72-88

5.4 Section 1: Values in delivering care

5.4.1. No use of force

Allow the residents to settle in at their own pace, do not use any force of any kind. Once residents start improving, they exhibit anxiety about their future, there is also a longing to go back home to family. There is hope that at least one day, she would be able to go home. This hope might not be fulfilled ever or within the time frame the client expects hence anxiety, despondency and failures have to be tackled at the shelter. This situation results in conflicts which could frustrate the care givers and therapists however, no force is used at Sarbari.

In the past, there have been rare instances where the residents confided in a staff that physical force was used, senior members of the staff intervened to ensure no repeat in future. However, an oversight is required to ensure there is no use of force at all.

As Shelter Supervisor / Coordinator, you should personally engage with all residents and notice their behaviour. If you find strange deviation from routine, then you should call in the person on pretext of some work and ask if all was ok. It is possible, that the resident might have been threatened with dire consequences if she disclosed to someone else, hence your observation is most critical to notice changes in behaviours.

For Shelter Coordinator:
There is not much information in literature how to guide your services to ensure there is no act of violence against residents behind your back. You could consider developing resource on this.

Gap:

There is no separate mechanism to ensure Human Rights for the people involved – residents as well as staff. As shelter supervisor, counsellor you should encourage residents to speak with yourself or Shelter Supervisor / Counsellor if they face any problem or have any complaint. If they complain of being hit by someone then it is the duty of Shelter supervisor or Counsellor to redress the problem by hearing out both sides. However, it is made clear to Care givers that use of physical force is a not tolerated at all.

More for the staff and visitors I suggest you put up a board or a charter that clearly states what the resident is entitled to in this place

At the same time, be aware to the violence that the staff could be themselves subjected to. Hence, more often it is the need to maintain an environment of mutual trust and calmness than get into fault finding; but when required do not hesitate to plug the leak.

Sarbari does not have a Board of Visitors. Shelter Management Committee also does not involve itself in Human Rights issues of residents and staff. It is advised that as a process some oversight be created by the senior management to address possible human rights violation at Sarbari.

5.4.2 Residential Staff:

Care givers are residential and stay with residents albeit in a separate room. They are available round the clock. They are involved in cooking, serving meals and entire set of activities at Sarbari.

Residential staff sleeps in a separate room than residents. They cook their own meal and are available all the time. They take few days off to visit family. The staff does not wear any uniform; they are dressed plainly. The rationale is to distinguish Sarbari from a hospital. The uniform could act as a barrier to interaction. Many residents have had past experience with mental health facilities, and it is important for them to feel they are in a home like setting. That helps in the therapeutic process and ability of the resident to build relationships, a skill they might have lost out on the streets. For a 24 hour facility where residents know who is responsible for what uniform is not important hence this is a good process.

What you need to do as a residential caregiver?

As a residential care giver you would have been informed of your duties and responsibilities by the HR. However, you should read the following section to understand the spirit of the service. Your role is captured in Annexure 3.

1. You should learn to perform the Life Skills Profile (LSP) which you and social worker would be performing on the resident. It is a scale which your seniors will teach you. The profile is to be recorded on a paper format and you should then file it in the case file of the resident. It tells you how the resident is doing on different dimensions.

2. You will work the closest with the Counselor, so it is important to have a good rapport with her.

3. Knowing your residents is very important both as a client but more importantly as a person. So ask her what is her story, read her file as well, if you come to know something new, then record such observation in your section of the file, in the report you have to write in Bengali.

4. Also bring up this new information and relay it to the person who would need it most – counselor or reintegration team member if it is related to address or anyone else. Bring such information also in the monthly shelter meetings, tell the meeting that you have found this new piece of information. Do not hold it within you. To prevent forgetting information, record it in your register or best the case file of the resident in your section, as I have already mentioned.

5. When you take leave, inform in advance so that your colleague knows in advance

6. When dealing with residents try not to be partial towards anyone. All residents are different and some may express themselves more and shower affection on you, it is only human for you to feel affection towards them, but remember the client who needs you most is the one who is withdrawn, who has restricted her life to herself, does not talk, does not perform activity. This is the person who would most benefit by your care.

7. There could be occasions when you would be subjected to violence, you should be trained on how to handle violence. Here is a resource you could use or ask one of your colleagues to work on it together (Tisher, Gordon, & Landry-Meyer, 2000).

5.4.3 Attitude of Staff

The common belief amongst staff is that the residents have lost their family support; have lost their way in life consequent to psychosocial problem and other life circumstances and are shattered within.

There is an inherent belief in individual capability and therefore much emphasis is on development of skills of each individual so that they are able to live a life of independence and dignity.

Inherent to above approach is to treat the residents with respect. When residents were homeless on the streets, they received food and clothing from the community, but not respect. They were isolated and lived a life all by themselves.

Many have suffered abuse (physical violence) inside families. Most of the women recall **a critical traumatic event** that either triggered their situation or worsened it. Therefore the overwhelming feeling amongst Sarbari staff is to provide a loving and caring environment where residents can forget past trauma and reconstruct their lives.

The kind of treatment received by residents at shelter is important for their recovery. Many residents have had past experience of ill treatment. They refer to it while being treated here by others. The more painful the past the more important present treatment becomes. Therefore there should be a constant proactive enquiry into how residents feel they are treated here by others.

It is not necessary for residents to return to their families. They could earn their livelihood and live anywhere, but they need to have self-esteem, feel accepted, loved and be safe. Most of the staff regard "Sarbari" their second home and the other staff members as their own family. A few have a special bonding with different residents; this sets Sarbari apart from any other care taking centre. This is a reflection of good mental health of the organization. This is seen in increased attendance, well-being and productivity of staff

Staff receives affection from residents. Residents ask if they have had lunch, they prompt them to go and eat and not work so hard. This show of affection and concern is an important process in human interactions.

A few staff feels that this work is service to God, while others regard Sarbari as a mental hospital where clients with mental illness are brought for treatment. This is also the explanation they give when others in family or friends ask them about their place of work and what they do. But this might be an explanation for others who do not fully understand the concept of a home like shelter for homeless mentally ill women, a fall out of the isolation phenomenon described above.

5.5 Section 2: Management Processes

5.5.1 Quarterly Treatment or Management Plan:

During stabilization phase, a Quarterly Treatment Plan is prepared for each resident. Salient features of the treatment plan are:

1. It has an objective or goal for the quarter

2. It has role of each kind of treatment – pharmacological and non-pharmacological, vocational put in one place

3. Residents are reviewed monthly to check on their progress on the treatment plan. Any modification required is noted in the plan.

As the Counsellor, you would be responsible for this plan. The organisation of services is that half of the clients are entrusted to one counsellor and the other half to another. You as the counsellor are therefore the case manager for your half of the clients. So, you hold the quarterly treatment plan for the residents of your set.

The treatment plan for the initial acute phase differs from the stabilization phase. During stabilization phase there is higher transaction with the resident, the key mechanism of which is the Individual Session.

5.5.2 Multi-professional team review of the client

Psychiatrists, care givers, counsellors and inventory manager together as a team review a resident. The caregivers share their observation on day to day behaviour of the resident; the counsellor shares her findings from different sessions with the resident. The doctor interviews the resident. The latest treatment plan is opened on the computer by the inventory manager. After interviewing the client and exchanging notes, the doctor notes his observation in the file and drug treatment separately on a prescription pad. The inventory manager then makes a note of the drug prescription plan and makes note of any revision in a word document she manages.

This team review allows the entire team to have a similar understanding on the status of the resident. Having similar understanding on the client and having a uniform, singular plan of action is paramount to team work and client recovery.

Rehabilitation of resident is team work

Selection of residents for monthly review is random. A few residents are randomly selected for review by care giver and counsellor with the guidance that all residents should be reviewed once a month. Any with a problem is reviewed on priority.

How, as a Counsellor, you could improve on this process?

As the counsellor, you can further improve the process by inviting the client / resident to participate in treatment design. This proactive invitation to participate

by the more powerful professionals would increase her self-confidence and self-esteem.

The treatment designed with the participation of the resident would also help you and your other colleagues in identifying her needs and incorporate them as far as possible.

The needs of the person under treatment should be seen in line with the cognitive understanding of the professional disciplines as well as the objective of the organization.

Also, remember it is not easy for a resident to speak in front of the powerful professionals she meets in the review, so you have to give her the strength to speak and understand her treatment.

During stabilization phase, residents get involved in vocational activities that provide them another therapeutic space to explore their own thoughts and another set of professional to engage with. During these activities, the residents reveal information about their past. This provides more information on the client.

Two Psychiatrists between them visit Sarbari 4 times a week. Another psychiatrist comes on another day but only to review the follow up residents. The psychiatrists are also available on phone call. They come to see New Admission as early as possible else communicate with staff over phone.

Days	**Psychiatrist**	**Counsellor**	**Care Giver**
Monday & Wednesday (except last Wednesday) & one Friday of the month	Psychiatrist 1	Counsellor 1	Care giver 1
Tuesday & Friday	Psychiatrist 2	Counsellor 2	Care giver 2
Thursday	If there is an emergency, one of three psychiatrists come to attend		

5.5.3 Psychometric Scales (Quarterly):

In line with the quarterly treatment plan, residents are evaluated for their progress by administering a set of psychometric scales each quarter. Psychometric scales are administered by the counsellor once a quarter every quarter from admission till discharge. The forms are then filed into individual files. Data is also entered into a spreadsheet called the Vital Indicator Tracking System (VITS) every quarter.

The VITS is a spreadsheet that has each resident's score on all the scales each time it is done. An improvement in the serial scale data indicates improvement in the condition of the resident. These supplement the above mentioned review process and provides an all-round review of the resident.

Suggestion

Currently, there is neither an analysis plan for this data nor its utilization in treatment planning. A protocol should be adopted which sets out the rationale for selection of scales and recording of data on them and present analysed data periodically to clinical team of Sarbari.

5.5.4 Directly Observed Services

An important management process is to ensure that residents take their medicine in front of the caregiver.

Pharmacological therapy is planned by the psychiatrist. One of the two care givers is responsible for giving medicines to residents.

If you are the caregiver who is allotted this responsibility, undertake the following steps to complete the process:

1. Dedicated one drug box for one client. Stick their name on it

2. Stick the latest prescription for the resident, written on a small piece of paper on the inside of the cover / lid of the box so you know which medicines the box should contain

3. Fill up one week's medicines in the box

4. Prepare the boxes for all residents on one day of the week. You could split it up depending on the review of the residents.

5. With help of peer residents, organise the residents in a line the room where the case files are kept and your store the medicine box. Ensure that residents come with water.

6. Call out their names and give them the medicine in their hand and then ask them to swallow it. Inspects their mouth to see if the medicine has been swallowed.

The direct observation of medicines is an important control mechanism.

Limitation:

The shelter caters to nearly 70 women all of who have to be given medicines as part of their daily treatment. To achieve this objective, the above process is efficient.

However, recovered residents are also subjected to same process hence they do not know their own medicines and are not responsible for it. This creates dependence on someone else for their own medicine. The general feeling is that residents should not be handed their medicine due to fear of misuse or no use. When some of these residents get discharged and go home, they continue to be dependent on a family member to give them medicine and sometimes medications are discontinued due to this dependence.

Same issue is with providing personal articles like combs to residents or allowing them take their own food. A few residents do not have control on their appetite and eat beyond their hunger; a few take a lot but leave the food to waste. A few residents have metabolic disorders hence food restriction is part of their medical management. At times, those with diabetes mellitus are seated separately looking away from other residents so they cannot see the quantity of food in the plate of others. Further, when officials from Vagrancy department come for inspection, they specifically point at residents who are obese, have blood pressure or are diabetic or at risk of these. Due to all these reasons, food is served to residents by fellow residents.

The challenge faced by Sarbari care givers is where to draw the line. A few residents have a tendency to hoard and take things for granted, while others know how to set limits. This leads to wastage or misuse. Therefore, food servings are restricted and monitored.

5.6 Section 3: Package of Services

A set of five different services are provided to the resident during her stay at Sarbari that helps her recover from her state at admission and achieve the cut off for reintegration i.e. discharge. These services are:

1. Daily Activity Schedule
2. Physical Activities
3. Psychological Services
4. Vocational Services
5. Functional Literacy

5.6.1 Daily Activities at Sarbari

It is important to follow a routine in the shelter. Women coming in from streets have lost a sense of time and predictability in their lives. A regular routine brings some discipline in their lives and a focus.

Every day residents follow a daily activity schedule **(see facing page)**. The objective of the schedule is to perform activities of daily living, socialization and involvement in work.

You as the care giver are the main person responsible for these activities. **Kitchen in charge** oversees cooking activities.

1 Activities of Daily Living / Personal Grooming

Across Sankalpa's programs for homeless, personal appearance is an important feature of self-care and self-discovery. There is an emphasis on adopting a routine of personal hygiene & grooming, wearing appropriate clean clothes and keeping one's surroundings clean.

Shared bathrooms and toilets are available for women residents in Sarbari. Each Morning, residents are supposed to take bath. Fellow residents (Peers) help those residents who find it difficult to bathe by themselves (initial stage of admission, elderly, unfit).

You as a Care giver along with Peer volunteers should oversee and ensure that all residents take their bath, brush their teeth and groom themselves.

Prompt those who do not do out of their own initiative, show them the directions, and encourage them to take bath. As a process there is prompting for some to follow directions, but many others follow their routine independently.

Treatment of hairs is significant for a woman in our socio-cultural context. Many women who come in as new admissions have deep wounds in scalp or head lice which make it necessary at times to trim their hair. Earlier at Sarbari, the trimming was done by an untrained person. It was therefore crude. Many residents complained about it; a few were depressed seeing their poorly cut hair. Recently, this was changed.

One of the care givers who joined was a trained beautician. Hair cutting has now become proper. This was very important for the residents.

As the care givers and any other staff of Sarbari, it is important to pay significant attention to how the residents appear and carry themselves.

You should encourage and compliment residents on their personal appearance.

"Didi, today you are looking very beautiful", "today you have combed your hairs well, let me take a picture of us together"

During morning personal grooming session, as care giver, hand out combs to residents. Ensure that all of them have combed their hair properly. However, there is a flip side to this facilitation. This and similar other actions create dependence. While it is central to care givers observation routine and ensures all women have combed hairs it does take away their agency. Effort could be made with select batch to give them combs and prompt them to maintain their own hair. This is only to match with their conditions at home (post discharge) when they will have to claim the comb and dress their own hairs.

It is important at Sarbari to appear clean and wear clean clothes. The clothes for residents are donated by donors. They are altered to fit the residents. New set of clothes are bought during Durga Puja (October) each year.

At any point in time, as care giver ensure that each resident has 2-3 sets of clothes. If there is wear and tear, replace the clothes.

Residents clean their own clothes. Extra clothes are provided as per need. Ensure that clothes are changed daily. It is possible, that there are a few residents who

would change 3-4 sets of clothes daily. You will have to counsel them and ask reason for doing so and bring them down to using one set of clothes and keeping them clean through the day. A few residents, sometimes, select their own clothes to wear for the day.

In their initial days of stay at Sarbari, residents are unable to manage clothes and dirty them often. If brand new clothes are used, many sets would be required in a day hence it is better to alter donated clothes and use them. Later, residents who earn stipend or other income buy a few of their own clothes. Some receive clothes when family comes visiting them. Residents have to be provided with space to store their own clothes. This could be a closed locker for some or simple clothes line for others. You as the caregiver have to decide depending on the ability of the resident to maintain the locker.

Clothing is correlated with socialization. Women who go out of Sarbari wear better clothes than those who stay inside. This aspect though saddening is a reality. For those without family close by to visit them, and no friends from outside, how does one create social interactions for residents? Frequent visits by guests could make a difference in enthusiasm else there is little to cheer. Clothing is an important contributor to enthusiasm.

Encouragement and compliment play a significant role in motivating to wear good clothes.

Residents with Intellectual Disability (Intellectual Developmental Disorder) have to be provided extra care and both care givers and peer volunteers help them in all activities.

Residents who have recovered or are on their way to recovery may regard other residents with prominent symptoms as "mad" and do not befriend them easily. Although limited, there is communication or casual chit chat amongst the residents, sometimes a few of them become fast friends and are inseparable. Some people do not communicate with others.

Such clients are then on the advice of care giver involved in activities where they are grouped with a more vocal client. This decision is taken by the counsellor / shelter supervisor.

When engaged in activities, residents do not speak much but when free they indulge in casual conversations. Much of their conversation is with care givers and counsellors.

Power dynamics is also visible in the shelter. This is cause and effect of the relationship of the care givers and other staff with some residents.

2 Household Chores & Cooking

All household chores at Sarbari are performed by the resident staff and residents - cooking for all residents, cleaning the space, filling water, etc. is done by residents.

This is not only to make their current environment orderly but also to promote participation in household work once they return home or any other location. It is an expected social role from the women.

The staff knows that being a woman; family would expect them to participate in household chores hence it is important they work here.

Except for 7-8 people, all residents in Sarbari work. Those who don't work are either too old or too disabled.

As caregiver, delegate the activities to different residents as per schedule. The kitchen in-charge should delegate kitchen activities to a set of residents. Some residents could volunteer to do specific activities, welcome them.

This demonstration of self-interest is an important sign of recovery as well as an open environment in Sarbari.

Cooking is an important activity since fresh hot food is cooked two times daily for all residents, one time for the clients of the outreach program and for staff who want to eat from the canteen that kitchen doubles up for them.

Cooking for outreach program is done by the Self-Help Group of select women residents of Sarbari as a means of work options for homeless women with mental illness. This SHG also serves tea and snacks to non-resident staff that comes for the day and for any guests visiting Sarbari. Presently, two SHGs have been formed. One is active and the other is not in focus as of now.

One of the care givers is the kitchen-in-charge. The kitchen-in-charge is also responsible for ordering ingredients and keeping an account of same. Menu is fixed and has a liberal supply of nutritious food.

Sarbari serves both vegetarian and non-vegetarian food to its residents. If any resident has a special request then the same is entertained. At times well-wishers donate cooked food for residents. It is served to residents. Donors could also donate money to cover the cost of one time meal at Sarbari.

As mentioned earlier, staff cooks their own food separately.

Serving the food:

1. Food is served by residents who have been given this duty. The residents bring in the food from the kitchen and serve inside a room where all residents are made to sit.

2. The residents first clean up the eating area. The utensils with cooked food are then brought inside. The residents are provided with utensils which they rinse once more prior to eating and then come in line to take food which is served to them.

3. As care giver keep an eye on the process to ensure that a resident does not take more food than she can consume and directs the resident serving the food to reduce serving size for specific residents.

4. Residents are allowed to sit anywhere inside the room or in the corridor outside. They come back for repeat serving if required.

5. After the food, the area is cleaned up and the residents in charge for utensils take them away for washing. All residents wash their own utensils.

6. After having fed the residents, caregivers eat.

The evening tea and snacks is also served in similar fashion

No Monotony!

The daily schedule of activities is changed regularly driven by the need and interest of the group to prevent boredom. Energizers; Day Outs; television, etc. provides entertainment during break from the activity schedule.

Daily Activity Schedule (ON FACING PAGE, ONE FULL PAGE)

Time	Activity
06:00	Wake up time
	Brush teeth
	Prayer
	Medicines to be taken on empty stomach are dispensed
	Sample collection for laboratory test (if any)
07:30	Tea and Biscuit
	Bathing & Toilet
	Clean up dormitories, clean windows, doors, etc.
08:30	Morning Medicine
09:00	Breakfast
	Cleaning of breakfast room
	Personal grooming
10:30 – 11:00	Yoga / Energizer
11:30 - 13:00	Group 1: Vocational Activity groups Group 2: FLP Group 3: Client Review
13:00 – 15:00	Lunch & Afternoon Siesta
15:00 – 17:00	Vocational Activity groups & FLP
17:00 – 18:00	Evening tea and snacks

	Attendance of residents
18:00 – 20:00	TV time & time for Care Giver to document their daily work
20:00	Evening Medicines
21:00	Dinner, Cleaning dinner room
22:00	Set up Bed Rolls; Residents retire for the night
	Care givers' Dinner time
23 – 2330	Care givers retire to bed

5.6.2 Physical Health & Physical Activity

Physical health of person with serious mental illness is generally poor. Mortality levels remain about twice those of the general population. They are at greater risk of health problems such as heart disease, respiratory problems, and diabetes. The factors contributing to these health problems include higher levels of smoking, obesity, physical inactivity, and a nutritionally poor intake of food[6]. Of the three main risk factors – smoking, lack of exercise and poor dietary choices, Sarbari has prevented at least two (smoking and poor dietary choices)[7]. These are still seen in Naya Daur program but the risk factor of significance inside Sarbari is lack of exercise.

Physical Health of residents should be screened regularly. Since the general physician has discontinued visits, the onus is on the psychiatrist to be able to detect symptoms of physical illness. The close proximity of urban health centre is very helpful but maintaining good fitness levels is essential for residents and hence specific activities for the same are part of the daily schedule.

Another fact related with physical health is dietary advice and selection of menu. When the woman comes in as new admission, her nutritional status is compromised both due to neglect on the street and also due to preference for poor dietary choice by persons with schizophrenia. Their diet is compared to be close to that of Social Class V[6]. Good nutritious food at Sarbari helps client regain her body strength, however lack of activity poses a significant risk.

Further, persons with schizophrenia also face following threats to good physical health:

(i) weight gain and obesity are side effects of anti-psychotics;

(ii) deranged lipid profile, hyperglycaemia and diabetes are further complications in person with schizophrenia;

---

[6] Pearsall R, Thyarappa Praveen K, Pelosi A, Geddes J. Dietary advice for people with schizophrenia. Cochrane Database of Systematic Reviews 2016, Issue 3. Art. No.: CD009547. DOI: 10.1002/14651858.CD009547.pub2.

[7] Nadeem Mazi-Kotwal and Baljit Upadhyay. Physical Health in Schizophrenia. Accessed from the internet from the link - http://cepip.org/sites/default/files/CEPiP.2011.1.74-77.pdf

(iii) someone with predominant negative symptoms would find it difficult to participate in physical activity or take care of her physical health. Hence, care of physical health is essential. One way to do this is to exercise.

Since residents are restricted in their movement to the four walls of Sarbari except those who work outside or those who are active inside in different tasks, they could get very frustrated and this could induce lethargy and a lack of stamina.

Activities that are physical in nature are therefore much required - Energizer, Dance Movement Therapy and Yoga are three activities that are done with the residents. Vocational activities like gardening and block printing also have some amount of physicality to them.

1 Energizer:

Energizer is a large group session conducted in the morning **twice a week**. It involves following activities:

- Dance to popular music
- Ball Games
- Free hand movement

Energizer is very important. The movement and related activity enthuses the residents. In some case help their memory as well; many residents have recalled their past after the activity.

All staff is involved in organizing the energizer. It also helps everyone vent their feelings. Energizer infuses energy, enthusiasm and excitement amongst participants who otherwise could feel burdened by the predictable monotony of daily schedule.

As Counsellor you should play support role as there is other staff to help organize the activity.

2 Dance Movement Therapy (DMT)

DMT is a recognized form of art based therapy that residents of the shelter participate in. Residents participate in dance sequences along with trainers who lead them in the dance. DMT trainers come from another organization and staff and residents from Sarbari participate in it. Dance has been very therapeutic for the women and the staff. It is done **once a week**.

3 Yoga

Three times in a week, residents perform yoga for 15-30 minutes under supervision of a qualified Yoga trainer. First session is held for staff and later for residents. Staff is required to help in residents' session.

In the same room where food is served, since it is big enough to allow for yoga, the staff first undergoes the session.

It is the duty of the shelter supervisor to ensure that sessions are held as per schedule. You as supervisor should allocate duties such that by rotation all your staff participates in yoga

The caregiver and counsellor would help identify residents who could participate in yoga session. As caregiver and counsellor you should be available when the session is in progress to help residents perform the exercises and communicate instructions. Not all residents are able to participate in yoga or in all exercises, but those who can, encourage them to participate.

If possible, you as care giver should take 10 minutes of yoga classes for all residents and staff each morning

4 Day Out

All residents in batches go out of the shelter for a full day; this is called their Day Out. **Every month**, a group of 10 residents go out of shelter for their day out. If for any reason, day out is not possible, then a movie is shown.

Day out is an important activity and resident get to be with the outside world. It provides leisure and entertainment. It also helps in understanding how markets are organized, how money transaction is done, how to take buses, cross roads, etc. Residents look forward to their Day out.

As Caregiver and counsellor, you are mainly responsible for organising the day out and then accompanying and taking care of the residents during their day. The activities involve organising the venue of day out, logistics, sanction of budget and the actual day.

Socialization for homeless women is a difficult area, some thought is required in understanding if risk can be taken and some residents can be exposed to increasing levels of independence by perhaps organizing their Day out themselves. The

dependence on the staff would be reduced which would be confidence boosting for the residents. Moreover, the decision of the venue, activities should involve residents as well which would make them feel party to the decision. Currently, the decision is taken by staff. The process of involving residents more in the care and service right from planning and execution would help them develop independence.

5.6.3 Psychological therapy

A part of the daily schedule are the treatment services. While the drug therapy, as was discussed earlier, is planned by the psychiatrists, psychological therapy is planned and delivered by a team of psychologists called counsellors at Sarbari. They work under the supervision and guidance of Assistant Director.

The psychological therapies plan an important role in Sarbari.

1. Objectives of psychological therapies are:

1. to explore thoughts and emotions of the residents and subject them to reality testing

2. to provide emotional support

3. to develop social skills

4. to motivate the residents and keep their self-esteem high and

5. to provide residents an insight into their condition and the importance of treatment adherence

6. Crisis management

2. Who provides the psychological care?

There are two female counsellors or psychologists at Sarbari. All residents (70-80) are divided equally amongst the two.

3. What is your role as counsellor in Sarbari?

As a psychologist or counsellor, you have five main responsibilities:

1. Assist in diagnosing the resident and her treatment planning

2. Provide psychological therapies to residents as per treatment plan

3. Review progress against treatment plan and make necessary modifications to treatment plan

4. Administer psychometric scales

5. Work with the family of the resident when they visit the shelter primarily psycho-education of family when they come to the shelter for restoration of resident

The psychological therapies are provided as an integral part of treatment. Therefore, they are reflected in the treatment plan and like the other items in the treatment plan are constantly reviewed for achievement of the treatment goals and revised accordingly.

4. How do you as a counsellor go about the therapies?

You have to start by identifying the overall goal of the treatment as part of the treatment team. Then you must break down this overall goal into quarterly goals. You will be guided by your interaction with the resident as also your discussion with your other colleague, assistant director and discussion during review. You should identify the domains or dimensions in which you will work with the client. The psychometric scales will, each quarter, give you an idea of the progress made by the resident on different domains. You should summarise the progress made with the resident on the path to recovery in your notes.

The case file has an entire section for you. You should make succinct notes in that section. Documentation is as important as the work itself since it forms the basis of learning for your colleagues and some of the remarkable achievements could be documented and archived. You could even aim for publication of stellar cases.

5. Goal of treatment:

Create or set a goal in the treatment plan for each quarter based on the problems faced by the client during the review period and the overall treatment goal.

This will allow you as the psychologist to identify the problem areas of the client and focus on it in your work with the resident (treatment plan).

6. Monthly review:

As the psychologist, you should your set of residents at least once a month. Their progress against the goal for the quarter should be noted in their case file. You have a separate section in the case file where you have to write your observation, your

treatment. This can then be reviewed by your senior at the shelter (Assistant Director) and the review team during the multi professional team review.

For individual counselling, each psychologist has a daily target of 5 residents.

The observations or information received from the individual sessions are recorded in the case file in the section for Psychologist observations. You are advised to note progress against plan and if there is some outstanding item that was not achieved in one month, then carry it over to the next month's plan of action. Do not let go of a goal till it is achieved or achieved the best it can be.

7. Quarterly scales:

Besides, you also have to administer the psychometric scales, each quarter. You should add in your client description the data from the previous reading of the scale, what is the information that the data gathered from the scale is telling you. You should also note the improvement you desire to see or expect to see. It is against this backdrop, you should administer the subsequent scale. You should then match if your desired result is reflected in the scales score. Ideally, you should ask your colleague psychologist to do the scales on your set of clients and vice versa. This would be very objective. You should then discuss why progress was or was not seen as per expectation. As has already been mentioned, each scale has a paper format in which data is filled in and then transferred onto an excel sheet called Vital Indicator Tracking System (VITS).

Below are the questions you should ask while working on scales:

1. What is the previous scale data telling me about the resident?

2. I have worked with the resident on x and y issues and I expect to see an improvement in these dimensions on the scales

3 Let me ask my colleague to administer the scale, let me see the scale result. Does it match with the result I expected or not? What are the reasons for the same? Shall I need to review the treatment for the quarter or continue with my plan and give more time for achievement of the target? I need to perhaps discuss with the review team

Most residents should receive a minimum of one counselling per month however the number of counselling sessions is determined by issues identified and strategies

decided to address those issues. Since each psychologist has 40 residents, residents cannot get more than 2 counselling sessions a month.

Suggestion:

Counsellors should adopt a protocol of counselling or therapeutic framework. Many issues that are identified are not worked upon and continue to linger on. Attention is taken by daily emergent issues and the underlying problems are often ignored. A list of issues identified should be developed and their status measured end of each month on a checklist. This would prevent earlier identified issues being un-addressed at cost of new ones.

At regular intervals, to gauge progress the psychologist administers psychometric scales on residents. However, this data is not analysed and used in treatment planning. If there is any confusion in a scale, psychologists seek counsel of the psychiatrist

8. Individual Session & Group Work

The main instruments of psychological therapy are Individual counselling and Group Work. Counsellors work with residents either in one to one sessions (Individual Sessions) or in groups (Group Sessions). It depends on the objective of the session whether first or latter would be done.

As discussed before, treatment plan is made for one quarter after which it is reviewed and if required, revised.

I. Individual Session

One to one session with the resident is the backbone of the therapeutic relationship between counsellor and the resident. It is the main activity. Since Sarbari has trained professionals, the technical aspects of individual session is not being discussed. Some other aspects that are equally relevant to the set up are however mentioned:

1. As the counsellor, you should do an Individual session only when a resident is willing; at a location of her preference – need not be an office session and could be held at a location mutually suitable to both resident and therapist; at work site or in a secluded space.

2. Hold a session for 20-25 minutes but it could last longer up to 40-45 min if needed.

3. The resident is encouraged to come to the counsellor's cabin and speak with her if she prefers so, this provides her privacy. The beneficiary also value this – *"if I go to didi's cabin, I can speak with her with no one around."*

4. The sessions are need based. In a session, you as counsellor should note the following, besides other things, about the resident:

- External Appearance of the resident;
- Emotions / Thoughts of the resident

As counsellor, your initial sessions would be rapport building sessions with the resident. Gradually, counselling is done, in rounds. Although each client should be counselled at least once a month, a schedule, tailor made to needs of individuals, is prepared.

Commonly, a counsellor targets 5-6 individual sessions with different residents every day.

What is the main objective of the session?

One of the main objectives that you as counsellor should have is to help resident improve her **participation** in different activities of the shelter.

You should give her feedback during individual sessions. This helps residents modulate their behaviour in the shelter. Suggest actions if there are any problems faced by residents. Try to retrieve details, including address of the family from the resident.

Hold support sessions (Individual or group) for residents who have been victims of domestic violence. Provide motivational counselling for those who need it especially those engaged in vocational training or employment.

Documentation

Record the details of the counselling session in a tailor made format. There are separate formats for individual session and small group work.

File the notes of the individual session in individual file of the clients while record the notes of the small group session in a separate dedicated register. You could even record this data in the client's file.

Team work

As counsellor, you should periodically enquire from Vocational trainers if they were facing any issue with residents. You should then address such issues in small group work.

During their stay in the shelter, residents come to know the role of different staff members. At times they might not listen to your advice since you might not be directly involved in the task related to which the beneficiary has a problem. In such a case, you should seek out the help of relevant staff including psychiatrist to advice the resident.

Bring all such observations of the client and her response to treatment together at the multi-professional team review once a month.

CASE STUDY OF MINA

"Mina was doing well in the shelter. She had shown remarkable progress since her arrival in the centre 9 months ago. She had learnt cooking and was able to cook lunch on her own with little oversight. She took her own medicines and participated merrily in the energisers. The reintegration team had been able to find her a job outside Sarbari, but there was one problem. Mina was convinced if she left Sarbari for the job, the police will arrest her and put her behind bars. She conveyed this to the vocational trainer. The vocational trainer counselled her that no such thing would happen but thought it prudent to check with the counsellor if there was any other issue. The counsellor checked Mina's file for any history of past experience with police but found nothing, her fears did not appear to have any rational basis. She counselled Mina that there was no such possibility and she should feel free to go for work. Meanwhile the employers were pressurising to join. The counsellor mentioned this issue during the shelter staff meeting. One of the members of the reintegration team then told Mina later that he would ensure that police does not arrest her. He took out his mobile phone and fictitiously dialled the police station and pretended to speak to the police officer in charge and told him not to arrest Mina at all. Mina's anxiety was reduced but she was not fully convinced. So the same reintegration staff, took out a paper and wrote an application on it and then placed a signature on it. He then showed the letter to Mina as proof that police had confirmed they would not arrest her. This worked and Mina was now satisfied and started going out to work. She came back and told the reintegration staff that she saw a police man on the way to work but he did not say anything to her so she was sure that the letter had worked its way through all the police.

Treatment Plan

As psychologist prepare your own treatment plan detailing out core activities. You could or could not inform the doctor completely of her treatment plan. While the psychological therapies treatment plan is documented in the file, this is not reviewed by the doctor during the team review.

It might be suitable to either follow a **standard therapeutic framework** which entire team understands specially the counsellor and the psychiatrist or hold a discussion with the psychiatrist on the therapies being offered to the client. In doctor's prescription there is seldom any mention of the need for any psychological therapy. Further, there is no comparison of progress of a client on a quarterly basis. This makes the quarterly treatment planning exercise sub-optimum.

During stabilization phase, many events happen with the resident. In addition to pharmacological therapy she also receives non pharmacological therapy. She is involved in several activities in the shelter and starts speaking with several people around her. While it is easy to assess progress she is making during this period from her behaviour, appearance, work involvement, etc. it is difficult to show on paper. Although it is not necessary do so, and encouragement of the client that she is doing well is an important enough message that she was doing well, still there is a felt need in the project to see progress of client as per records. This is largely to prove to outsiders that stay in shelter is resulting in positive change for the client, which is significant enough. Only to this end, it is suggested that a **face sheet or report card** of client summarizing the status of client be prepared as she traverses through stabilization phase. If the course of stay could be **plotted on a tool** that on a single glance could capture major issues, milestones and it would inform the outsider on the progress made by resident. It could also make treatment more focused, perhaps.

Residents need to be trained on Social skills; ability to divide complex tasks into simpler ones, communication skills; all of which would help in her reintegration and post discharge stay at destination.

As Counsellors, you maintain regular contact with residents and are therefore best positioned to do the above. It would be ideal if you are able to capture the rich interaction between resident and yourself in a summary in the case file. It would allow a better conceptualization of the case resulting in perhaps a better client outcome.

II. Group Work

The group work activities are done only during the stabilization phase. Two types of group work are done: Small Group Session and Focus Group Discussion. Generally, 4 small group sessions and one Focus Group Discussion (FGD) are held each month. Each small group session involves 7-8 residents while FGD involves 10-12 residents. The sessions are scheduled a month in advance during the shelter team meeting (on this later).

These sessions are organized for the following reasons:

- to resolve an issue that residents face
- to resolve a situation involving a few residents

Group sessions are need based and are scheduled in response to identified problems. These problems could be issues faced during work, inter personal problems, information about a new product delivery order received by Vocational team and its execution, it could also discuss other issues such as a new rule at shelter, etc.

A Small Group Session could be held when residents do not have motivation to work. In this session both motivated and de-motivated residents participate. A comparison of their situations and reactions are done. Motivated residents explain how they maintain their motivation. Demotivated residents are informed that if they earn more money they would be able to buy beauty products of their own choice. People who are earning well are asked to explain how they feel with their enhanced earning.

The decision to hold a small group around work related issues is taken by Assistant Vocational Coordinator or one of the vocational trainers. If de-motivation persists even after a small group session, counsellor is approached by the vocational team (usually verbally informed) and then counsellor takes over and handles the situation. The counsellor usually has a rapport with clients largely due to her individual counselling session and helps the client identify and resolve the issue to renew work. She could organize an individual counselling session to resolve the problem or provide an on-spot support during vocational activity or even hold a small group session if many residents are similarly involved.

Small group sessions are not held with all residents of the shelter. These are usually limited to the more active ones. Group discussion is a critical activity to know what

the residents are thinking. For example, a few residents like to be involved in activities at shelter but not like taking medicines. They would say – *"Don't give me medicine; I like to work"*.

Group sessions, also inform on inter personal issues and what things offend shelter residents.

While group sessions are held, it is not clear how they contribute in resolving a problem that they were supposed to resolve. It is of course difficult to definitively say that a problem has been resolved, when it could resurface later. For residents residing in the shelter, there is little scope of disagreement due to dependence and fear. There is no clear mechanism to overcome this.

The sessions help residents ventilate their emotions, those who are emotionally withdrawn feel relaxed as if accumulated thoughts and emotions have been released. This helps improve their socialization in shelter.

In further refining this process, shelter team could think of using group sessions to improve the agency of the person in the group or the group in general. When residents are discharge and face a situation in family or elsewhere they are able to put their points across in a small group setting. This is important for their survival post discharge.

Would I be able to make my point in front of my family?

III. Crisis Management:

The first few days of stay of a person at Sarbari is very critical and differs substantially from her later stay.

Crisis with residents is a way of life at Sarbari since admission is a rolling process. Staff is trained in crisis management. At least two of the current resident care givers have worked as nurses before. If there is a medical crisis and if the doctor is available then he sees the resident and advises treatment; else telephonic advice is taken which the nurses implement.

At times, residents are angry, aggressive, etc. Even then, the resident listens to the care giver and or other staff member and could agree to emergency use of medicines including injections. Injections are administered by care givers. After the crisis is over, the staff sits down with the resident and tries to identify triggers for the crisis. She is also supported to overcome the unpleasant experience. She is reassured that her progress towards recovery would continue despite this setback. This is an important process and is usually done by care givers or counsellors. Other residents also come and console, reassure the resident. They share their own personal experience of similar situations in the past. Some residents rub water on the back of the affected resident and console – "*don't worry, you will be ok*".

At times, doctor and counsellor forewarn of an impending relapse. All measures are instituted to prevent the crisis and everyone is prepared to handle the situation.

5.6.4 Vocational Activities:

1. Introduction

Work is treatment. Mental Illness compromises both functional and working capacity of an individual[8]. At Iswar Sankalpa, vocational activities were earlier referred to as vocational therapy and more recently as vocational training and skills development. Vocational activities or rather pre-vocational activities which they are really are an important part of the process of recovery and rehabilitation. Involvement in activities is enriching for the staff and residents, much so for the latter. There is much energy and focus in the activities.

During the stabilization phase, the objective of the vocational activities is to contribute towards improving both the functional and working capacity of the residents. Involvement in activities earns residents a stipend. It is seen that with medicines alone, a few residents would not be functional; however, with involvement in activities residents starting participating and were functional. Further, Sankalpa has learnt from experience that a person with mental illness can live in the family if she is productive i.e. can take care of herself; can take her own medicine and earn a small income to share the expenditure of the family.

2. Objectives:

Activities are goal directed. According to the various staff, the objectives of participation in goal directed, purposeful activities are:

- to train / skill residents in appropriate vocations that would enable them earn an income both during their stay at Sarbari and post discharge from Sarbari when residents are at their homes or some other locations;
- to help residents forget their painful past including abuses, if any
- to assess response of residents to treatment. The improvement in residents' work performance and her interest / initiative in work are important signs of her improvement

[8] Mental Health and Work: Impact, Issues and Good Practices: WHO, 2000

- to improve self-confidence, self-respect, self-esteem and dignity. A client receives incentive / honorarium related with each activity. She can then use this earned money in whichever way she wants (purchase of personal toiletries, jewellery, etc.).

Vocational activities are held in two sessions – the first session is post breakfast from 11 AM to 1 PM and the second session is post lunch from 3 PM to 5 PM. New admissions and elderly residents do not come for VT activities.

3. Structure of the Vocational Unit

The hub or the Vocational Unit of Sankalpa at Sarbari has a **Production Unit** and a **Training Unit**. The Training Unit trains residents in one or the other vocational skills and the Production Unit is responsible for preparing products that are sold by Sankalpa at exhibitions or counter sales.

Vocational Unit has 9 team members. Overall, the Vocational Coordinator is in-charge, supported by an Assistant Vocational Coordinator.

The Training unit has four trainers. The Production Unit has an in-charge; one full time staff and another on retainer basis. Two of the trainers also double up in the production team. Together they are responsible for a range of vocational activities mentioned below.

Production Unit organizes its operations as a separate unit. It has reached maturity in some processes such as:

- It has understood how to work with a mix of residents and vocational trainers to deliver orders
- To maintain a range of activities at Sarbari and few other project locations of Sankalpa via part time visit of one of the trainers to sites outside Sarbari
- Product Design, purchase of raw materials; organization of work, distribution of work load, maintaining inventory of raw material & finished products, product coding, pricing, sale promotions, sale events, sales, billing, work logs, incentive payments, accounts and quality control is also done by vocational team with help from professionals of Sankalpa as required.
- They have identified a process holder for conflict resolution amongst members during work;

Other staff of Sarbari - counsellors, care givers, reintegration team members, inventory manager all participate in vocational activities yet perform their own professional roles. These professionals are process holders of their respective processes and allows vocational team to focus on their core tasks, this is a great process

The Vocational Unit is nearly independent and should be considered as a separate entity working inside Sankalpa. It is perhaps required for the vocational team to regard other project locations as its branches and make specific focused program from those locations as well. The orders for products are received and mostly executed from Sarbari location. Other project locations should also be involved in this work. There need to be rethinking on this line.

The pressure and demand of fulfilling product orders is a driving force for Vocational Unit. Similar approach should be taken to other project locations. At Urban Drop-in-centres and Marudyan, vocational work should be made more focused and product sale oriented. At the present moment, the work there is at no level close to Sarbari. Further, the link to outside employment, employment post restoration should also be thought. The development plan for vocational unit is an exercise which should be taken without delay. It is possible to think of it as a separate company or entity within Sankalpa.

4. Range of Vocational Activities (The Activity Circles)

The Training Unit at Sarbari offers training in the following categories / types:

- Jewellery Making
- Arts and Craft (greeting cards, earthen lamps, etc.)
- Stitching
- Preparation of Food (Snacks)
- Preparation of Food for residents (Kitchen group)
- Block Printing
- Gardening (twice a week): Ideally Sarbari staff would like to engage residents in agricultural activities that are more similar to what residents practice at home. Gardening is done inside Sarbari on a small piece of land.

Each of them is called an **Activity Circle** because while working residents sit in a circle performing similar activity.

The rationale of providing a range of activities under vocational activities is to serve a wider resident population who has different interest areas. Some are interested in stitching; others in gardening, a few in cooking and some others in studying, etc. Residents usually prefer one activity over the other hence a range of activities is provided. Same activities also lead to monotony and boredom. A range of activities prevents this.

The activities introduce the residents to a range of colours, materials, designs, shapes. It ensures physical work for residents. Activities like block printing, stitching are good physical exercises

Vocational trainers use both **individual and group training approach**. While they work with a group of residents, they also identify the ones who are showing keen interest and learning faster than others, these women are given more time by the trainer. This woman has the potential to work and earn more.

Rotation of residents within different groups:

As Vocational trainer, rotate the Residents across different activities. Those who are involved in cooking should be later moved to Arts and Craft.

They could also be doing both depending on their time schedule.

Case Study of Jhilmil

Jhilmil was not friendly towards anyone, in fact she was violent. She threw utensils and cursed if any of the staff tried to get near to her. Most of the times therefore she was all by herself. The staff was perplexed how to deal with this situation. During one of the days when she was being asked from a distance to participate in the vocational activities, she went towards the work station where material for craft activities was kept. She immediately picked up the red paper and started cutting it into shapes. The vocational trainer approached her and asked what she was making and she quietly replied, just something she would like to use. She cut the papers in no particular shape, and returned to her own space after a while. But thereafter each day, she would go to the red paper and start cutting it into shape. Slowly she even accepted the help of vocational trainer who was trying to teach her how to cut proper shapes. Her

behaviour towards others had undergone a dramatic change, she was no longer violent, she would not talk much but violence had disappeared. Over time, Jhilmil started talking and the counsellors could have their first ever sessions with her. She continued to cut the read paper into shapes, she did not work on anything else, no other material, and no other colour paper, only red. The vocational trainer and Jhilmil became good friends and most of the details of her past were revealed to the vocational coordinator who would then inform the counsellor. One day, Jhilmil took the block prints from the hands of the vocational trainer and started block printing, she printed randomly but kept on printing. Seeing this new interest, the vocational trainer who she was now friendly with told her how to print, she quickly grasped the instructions and improved her block printing. In a few days, she printed herself a T-shirt, this was finally something she could use. The red colour paper and the block print changed Jhilmil's life and calmed her down and she settled into the normal routine of the shelter like other residents.

5. Initiation or Introduction of a client to a vocational activity:

During acute phase, a resident observes other participants in different activities.

First thing in the morning

As vocational staff in the morning, you should open the work place. Then you should call out to the residents and ask them to come to work.

You should divide the residents into groups. In this, you would be helped by all other staff – vocational trainers, care givers, kitchen in-charge, and counsellors. All of you together should collect residents and make them participate in activities.

Usually, residents are divided into three groups:

(i) One group attends Functional Literacy Program Session (more on this later);

(ii) Second group gets involved in vocational activity and

(iii) the third group goes for treatment review.

Arranging women in groups is a challenge and requires support of all staff.

How do you initiate or introduce a client to vocational activity?

As the vocational trainer and counsellor ask the newly admitted client what her interest areas are and accordingly make her part of a group of residents undertaking that activity. The initiation is therefore totally interest based. A few residents who don't opt themselves are offered – "*would you want to paint earthen lamps*?" and

based on their response they are initiated into the activity. This is an excellent process.

Ensure that the Care Giver is present. This is important and essential to instil confidence in the resident since for her both the place and activity are new and the presence of caregiver could be reassuring. The presence of care giver makes learning easier and better. All understand that adoption of any activity by a resident is essential. If trained, she could take up this activity back home, it will keep her occupied and earn her a livelihood as well.

Involving new clients in execution of an order

As Vocational trainer, in the production unit sometimes you will get orders for manufacturing products to specifications. One such order could be painted earthen lamps for the festival of Diwali or something else. In such a case, ask the new client to participate in the task. She is however free to participate or opt out.

Keep the open and fluid with participants coming and leaving. Ensure that a typical session of intense focused activity lasts at least 25-30 minutes after which a few residents would leave. As the trainer however you would continue to perform the activity.

6. Graded levels of difficulty:

As Vocational trainer, structure the activities in each category of vocational activity, from a level of low difficulty to high difficulty.

Typically, **initiate the new resident** from a simple or first level in any one or more than one category. As the resident's interest and performance improves, migrate her to a higher difficulty level. The final level is where a woman can complete a significant part of a product herself, example stitch parts of a bag or a piece of cloth to specifications on a foot operated stitching machine. Only a few residents manage to reach this stage.

Beading a necklace

The first activity that a client is usually engaged is Beading a necklace. This activity involves stringing together a string of beads of different colours. This requires hand-eye coordination, focus on a task and no complicated skills. Initially, residents could just sit and observe what others do; they are not forced into any work.

As Vocational trainer and other staff, prompt the resident to take on the work, tell her – "*make a necklace and wear it yourself, it would look nice on you*".

If a client refuses and does not want to perform one activity offer her another.

Taking it one level higher

As Vocational trainer, make the beading exercise a little more difficult by asking the resident to make a string of beads of same colour and shape and later to make a necklace looking at a design.

Make the residents work together in a group under your supervision. You should constantly monitor, support, encourage and assess progress of task and each resident.

Continuous motivation during task and presence of vocational trainer, counsellor is important during the tasks.

As discussed earlier, performance in these activities are an important information to assess response to treatment.

Following Instructions to make a difficult design, baby steps!

As Vocational trainer, you will note that residents start work by first using random beads of different shapes and sizes as they do not have real sense of what they are doing and they could be in acute phase of illness.

As their condition improves you will note that they start following instructions of making a necklace of **singular colour or a specific design**.

Similarly, in stitching, ask them to initially practice stitches on a piece of cloth where lines are drawn as guides. Then ask them to do stitches without the guide lines and finally to make a small design like a flower.

The residents who you plan to migrate to the sewing machine, call them first to practice running machine using their feet alone and later only use of hands are taught. In nut shell, all activities are **taught in steps**.

The main people involved in this are the vocational trainers and care givers.

Able to complete tasks on their own

Once the client attains speed & proficiency in a task; is able to identify and use colours, upgrade her from beading to another activity like stitching. As mentioned, this again starts with simple stitches on a piece of cloth and then moves to stitching on sewing machine (foot operated) and later to embroidery.

This process takes residents to a level where they are able to execute tasks on their own. Not all residents make it and till date however around 15 residents have reached a level where they can independently be part of production.

What is the motivation for residents to migrate higher up

Production Target

The vocational activities are almost always driven by production target. Every month the Vocational Coordinator schedules two product exhibitions. Products have to be prepared for exhibition, therefore. If the production target is steep, staff and members of the Self Help Group (SHG, more on this later) help execute the orders. All the women cannot be involved in production. In the scenario where there is no order (rarely so), then also training continues for residents.

Money

Target means more work, and more work in stitching means more money. A strong motivation to migrate to higher level of activity is money. As Vocational trainer and care giver, tell the residents that if they work in stitching they would earn more money by producing more products. Participating in cooking earns higher stipend that stitching or any other activity.

The residents are paid an incentive for their work. Earlier, a flat 30% of the total sales amount was distributed among residents involved in making products (labour cost). However, recently an amendment to this is being considered. The incentive or payment norm is discussed later.

Caution in some activities

Several activities are involved in block printing; few of them are done only by the vocational trainer while others are allowed for residents. Typically, those not allowed are ones where there is chance of self-injury due to sharp scissors. Hence, the trainer cuts boards, paper while residents are allowed use of scissors on cloth and paper. 10-12 people are involved in block printing, in shifts.

7. Maintenance of a client in a Vocational Activity:

Residents typically have their ups and downs and therefore need to be supported during their downs to continue working. A resident could come regularly to work for a week and then drop out for a week or more. Therefore, one of the most critical processes in vocational activities is to maintain a resident consistently in vocational activity.

Here the role of assistant vocational coordinator is to ensure that all work is done smoothly. Vocational trainers are involved in training the residents and supervising them at the same time ensuring that operations proceed smoothly.

What you need to do?

Prompting the start

In the morning when the session starts, you as assistant vocational coordinator, vocational trainer, caregiver, counsellor should prompt the residents into joining the different activity circles.

You have to do this more prominently for a few residents than others. However, it should be noted that each woman has an interest in one or the other activity.

Involve all the staff in prompting residents to start activity, but once it starts then prompting is not required for most.

Take a break! Contact Counsellor

Residents who are inconsistent and / or complain of lethargy, disinterest, sleep, apathy; can't sit for work; do not enjoy work or wish to go home saying they don't like it here are asked to take a break from the activity and restart later.

As the vocational trainer, speak to the resident and put her at ease.

1. All women long to go back to their families, even those whose address is yet not traced. When the thought of going back home comes to their mind, they lose motivation to work and it becomes difficult to motivate them back to work. It is difficult to explain to people who have no traceable address why their family could not be found and where do they belong.

2. Sometimes a resident has a physical illness or a condition that interferes with her work participation. It is then addressed

3. Residents sometimes have problem interacting in the group. You as the Vocational trainer should ask the counsellor to address this and the latter would undertake group activities to identify and sort such problems.

4. Switching from one activity circle to another is a challenge:

Residents follow a daily activity schedule at the shelter. They follow a cycle where one activity of one kind leads to another perhaps of a different kind say from stitching a piece of cloth shift to Functional Literacy Program for English classes. Each activity is usually 1 – 1.5 hours; FLP sessions are 45 minutes long. This shifting from one activity to another **is not easy for residents**. While it breaks monotony it

also is stressful. Residents who go out for employment work at a stretch with periods of rest but in the shelter the cycle causes them to change activities from one kind to another. This shifting needs a closer review.

Chronic absentee

However, if the resident is chronically complaining or is **consistently absent** from work, or suffering from depression then take the help of counsellor. **This is also informed during review of the client.**

What about someone who is genuinely not interested in activities?

A client who is not interested in VT activities is advised to go and participate in Household chores (House-keeping) or FLP or she is asked what her interest areas are? Presence of care giver is important and helps in motivating the beneficiary to work.

8. Supervision and its link with rehabilitation

The vocational trainers and other related staff have to supervise the work of the residents to impart skills, ensure quality of products and to keep an eye out for emerging issues amongst residents and addresses them during regular vocational activity.

If there is any issue that vocational team cannot handle, then counsellor / shelter supervisor or the assistant director should be called in to help. This is the **Escalation Protocol.** One of the members of the vocational team keeps an eye on smooth flow of work else things could get disrupted.

When women return home, even though in the shelter they would have participated in cooking or other household activities, they have done so under supervision (some residents do cook independently), some supervision might be necessary. This supervision if it is supportive, then the resident is able to perform tasks else if it is not then the resident could lose interest in work and spiral down rapidly into lethargy, disinterest and further ridicule by family. This issue has been identified and has been addressed in details in the chapter on reintegration as to what the families need to do to allow participation of the residents in work at home.

Suggestion

It might be better if some residents pursue only stitching till they reach at a level where they are performing at a decent level in stitching and then only a new activity is introduced. Then perhaps some other activity like cooking snacks may be added. Same is the issue with FLP. Could residents only do FLP classes in a particular subject

till they reach a milestone and then new activity may be added? To maintain continuity brief sessions of previously learnt activity might be repeated. In a set up like Sarbari this will pose several operational challenges to change the process, therefore much has to be thought and planned before the switch is considered.

When resident reintegrates with her family, she is expected to perform several different activities. Though she may know how to do those activities, she could on particular days not have the motivation or energy to complete the activity. This behaviour could repeat. In the absence of an insight into this mood swings families have a lot of anger, frustration against the client which unsettles the person further. Hence this need to engage in different activities and ability to switch on and off from one activity to another needs to be carefully looked at.

Case Study of Mamta

Mamta had recovered significantly during her stay in the shelter. She was eager to go out and start working in the house where she was working prior to her admission in Sarbari. She had wandered out of her employer's home and was relocated from the streets by the police and brought to Sarbari. Her employer had registered a missing person's complaint and soon enough they were traced by Sarbari reintegration team with help of city police. They came to meet Mamta and agreed to take her back after her recovery. They would send her clothes while she was at the shelter. After she was discharged, Mamta went back to the employer's house where she would cook and take care of the house and stay in the accommodation provided by the employer. She would come for her follow up care in the Sarbari OPD regularly. Her employer would give her money for the journey. She would review with the doctor and the counsellor, purchase the medicines from outside and go back to her own life.

This time her employer had accompanied her in the OPD. He shared with the doctor that he had seen some changes in the Mamta, similar to what he had seen earlier when she had gone away from the house – she was getting angry on trivial issues and had no motivation whatsoever to do any of the household tasks. He worried if Mamta was relapsing. Earlier, when Mamta had become similarly angry, with outbursts a common occurrence he did not understand that these could be signs of psychosocial problem. The doctor reviews the case and effected a change in medicine.

He then continued to come to the OPD for next two months and also followed up over phone with the reintegration team. Mamta had improved significantly and had

overcome the sudden exacerbation of symptoms. It was the vigil of the employer that conveyed to the treatment team changes in Mamta's condition and helped tailor the treatment accordingly. Such support of care givers is crucial to the well-being of person with psychosocial problems.

Small issues that matter a lot!

Practice material and products that are not finished properly are stored but not reused. Earlier, the practice was to reuse the incomplete or improperly finished products for practice. However, retained stitching lines on these materials was apparent and residents soon realized it was their own work that was being reused. They thought their effort was wasted. To avoid this situation now the material is not reused and all previous work of residents is retained.

Quality in work

A few residents exhibit excellent quality in their work. It is visible even in the small pieces they make or small part jobs they do.

9. Success measures of Vocational Training

The vocational training helps residents learn skills that would make them independent to an extent. However, this goal would be achieved for some and not for other residents. Therefore, the success of vocational training is in providing a purposeful set of activities to the residents that keep them busy, learn new skills, improve self-esteem and earn money for themselves, with little or no monitoring. Long stay in a place is very demanding and for the Sarbari staff to maintain consistency of operation, enthusiasm and create income is an exemplary achievement. The FLP is an important addition, which when it matures would be a value add.

10. Organizing the work place

You in the vocational team should give considerable attention in organizing the work space.

The work space should allow free movement of resident from one work station to another. It should allow them to demonstrate their interest and self-initiation.

Example, colours for arts and design, block printing material, etc. are should be kept at a slightly distant location which the client has to get up and fetch.

If the client knows what the next step of the activity is she will have to go and get material required for it. Once amidst colours, residents select colours to their liking and then uses them in the work. The clients will then walk to this location and decide which of the material she has to select and then bring it back. If she is not interested she might forego even the small walk to the station or randomly bring any material

The work place is a place for continued learning. The resident learns counting while finished products are being packed and counted. The trainer therefore as a matter of fact passes on related skills to the client.

Gardening

Gardening is once a week and involves watering & tending to plants within campus of the shelter. Residents love gardening. Those from rural areas recollect their memories of tending to vegetables and crops in fields back home. Due to lack of space, gardening is restricted to once a day in a week. However, plans are to make this more frequent including growing vegetables. This activity is the one that residents can easily get involved when they return home.

11. The process of paying out the incentive / stipend

Recording the output

Record of the work done by each resident is maintained by one of the trainers in a register. This is then made available to the inventory manager who calculates the due amount for each resident. They are then paid as per the applicable rate. There is a flat rate for basic work and additional payment for good / regular work and extra work.

If a beneficiary is involved in stipend oriented work either inside or outside Sarbari then also recording is made in a register of the amount of work done and she is paid at the applicable rate.

Increment as an incentive on certain conditions

If a resident is regular in work for two months then the counsellor, care giver and inventory manager can decide to give her an increment.

Steps involved in making the payment

1. The calculation of total payment due to the resident is done by the inventory manager each month based on the work output recorded in the register.

2. Once a month, the payment is made to the residents by the Inventory Manager. She will seek cash advance from the office for this purpose.

3. The inventory manager should call out the name of the resident, explain her the entry in the work output register and explain to her how the amount of incentive was calculated

4. Then the resident should be requested to sign / thumb print against her name and amount in a register. She is explained how much money she has earned in her account.

5. Do not hand over the cash to the resident unless she needs it for some purpose. There is a possibility of it getting misplaced, stolen hence it is better that it not handed over unless there is a need.

6. Bank accounts:

All beneficiaries do not have a bank account, yet, though a few have.

7. The money in the name of each resident is kept with the organization. Each beneficiary is conveyed how much amount is balance against her name.

Scenario 1:

If, the resident plans to make a big ticket purchase like jewelry she is asked what she wants to buy and often the care giver helps her in making a choice from the market. An estimate is first taken of the item and then money is paid against bill.

Scenario 2:

Some recovered residents are in Supportive Employment i.e. they stay at Sarbari because their families have refused to accept them, but they work outside Sarbari and earn an income. They deposit their cash with Sarbari and take money for travel allowance and personal purchases.

12. Residents who pay for their stay at Sarbari

Residents who have lived in Sarbari for more than three years (excluding those who are elderly) pay a sum of Rs. 200/- per head per month (Rs. 50/- towards expenditure on health & hygiene and Rs. 150/- towards medicine expenses). A receipt is issued in their name by the Inventory Manager. This amount is deducted from each person's account and balance communicated to them. Signature of each resident is taken against her name in a register maintained for this purpose.

The aim of this exercise is to inculcate a sense of relationship with Sarbari where not everything is free, taken for granted and not to support any real costs.

13. Sales

There are two major source of sale of products – (i) Exhibitions and (ii) Counter sales.

1. Scheduling Exhibitions:

Exhibitions are scheduled by the Vocational coordinator and a calendar for the same is prepared. In addition to exhibitions in different locations, few exhibitions are set up in local colleges as well. While the exhibitions have more or less a fixed schedule the college exhibitions happen on a random basis.

2. Selection of products:

Festivals provide a good opportunity for orders and recently the vocational team got a large order for painted earthen lamps for Diwali festival. The selection of products that would sell in these exhibitions is done by the team under guidance of the Vocational coordinator.

3. Preparing the products:

Almost all the time, there are orders which vocational team's production unit is busy executing. This provides a goal oriented work for the team as well as residents. There are a few products that only trainers make, a few residents make parts of it, however, trainers are required to do the major work.

Large orders: If and when a large order is received then trainers have to pitch in to complete it.

4. Quality Control of the products:

Since products are sold it is important to ensure quality control of the products.

To ensure good quality involvement of those working on the product is essential along with their skills. Therefore the above process of continued motivation, prompting, problem solving is an essential process done by different people available at Sarbari. Final finishing of the products is done only by trainers.

14. Limitations of vocational activity

The products produced by the Production Unit and sold in exhibitions are targeted at a specific customer base. While the skills used in production are useful for the residents and would help them earn a living when reintegrated back with their families, they would not be able to make same products. These products are expensive to manufacture and in rural areas even the raw material would not be available. The items that residents could make on their return home are regular clothing items like Petticoat, blouse, pyjama and so on.

Residents on their return home could either work under supervision of a tailor or get a job in a company involved in garment manufacturing to earn income. There has to be some set-up to aid them in working and not be a burden on the family, at least their cost of medicines can be borne through this. ***It must be realized that only with family support residents at home can become independent and not on their own.***

At the same time, if reintegrated women in their homes do not get opportunities to practice their learned skills, they would be soon forgotten.

Walking the thin line!

Vocational Activities is a balancing act between need to train residents, sale products and earn an income to be self-sustainable. This is not an easy act to do. A few trade-offs have to be therefore done. The stress on training residents could be at times under pressure from making products for an order.

Residents who show consistent work retention should be studied and supported further to develop a vocational training program for them. This program should explore permanent or similar work options for them and then train them on it. Such a training program including prevocational training and support during work would have a wider application to other organisations working in a similar field. One thing is clear that vocational training department focuses on skills and ability of the beneficiary which is very important for her self-esteem and confidence. It is

therefore required to include a scale that measures **self-esteem and confidence** of residents along with the other scales currently used.

15. Employment outside Sarbari

Residents working outside Sarbari as their main occupation are allowed to stay at Sarbari yet work outside. Such opportunities present for a few residents, usually during festivals. In recent past, during festival of Raksha bandhan, 6 residents were provided job work to pack Rakhi threads. This is facilitated by Sarbari team members or members of reintegration team.

Those who find work outside are escorted by the Care Giver to their work place. Once residents are familiar with route and mode of transport, they travel on their own to and fro. A resident who was a teacher earlier in her life was provided an opportunity to teach again in a nearby school. The care giver accompanied her to the school in the morning and then in the afternoon brings her back. Such support allows residents to find opportunities outside. If a vehicle is required, Sankalpa makes arrangement for the same.

These jobs are found by several different people – the reintegration team, the shelter supervisor, social worker of shelter. In fact it is this aspect which is growing at Sarbari with new options opening up – including domestic work, help as maid in local hospitals, etc. The challenges faced during work are a completely different dimension which is starting to get addressed by the staff. More thought and processes are required for it to mature. Details on this process have been mentioned in the chapter on reintegration.

Women going out for employment should be trained to meet the challenges involved specially identification of any exploitation and methods of addressing them. This should be built into part of training them for outside employment.

One side effect of ideal care giving in Sarbari could be to create **an atmosphere of comfort** for residents that are in disagreement with the reality that exists outside. It is necessary to prepare residents to work outside where they would be faced with different challenges which are to be overcome. It is necessary to encourage outside employment despite initial discomfort or problems faced. Staff supports and insists that residents continue to engage with challenges faced outside, this is important.

The process currently is a little weak and many times residents leave outside job citing one trouble or the other. **The continuity in a job is difficult**. The consistency with an outside job is an important outcome indicator that should be used in each

quarterly treatment plan and strictly followed up. Reasons for quitting jobs should be explored and addressed, if possible

For person with mental illness, of the several barriers to employment, **social exclusion** is most difficult to overcome and is usually associated with shame, fear and rejection. Therefore the work of counsellors and care givers to continue to discuss with the resident their experience in working outside would keep their self-confidence, self-esteem high. As the FLP matures residents would gain literacy skills. Interventions that build insight, communication skills are currently missing and need to be added.

Counsellors provide support to residents employed outside similar to their work with internal residents. At times however they have to meet the employer to resolve potential or actual conflict situations. This negotiation can also be done by the reintegration team. Counsellors and reintegration teams have to monitor essentially two things in the resident:

(i) performance at work and

(ii) fair treatment of the resident at work place

Expressed emotion at work place, past memories and desire to meet near and dear ones, worries of future, performance anxiety, etc. at times de-motivate residents at work. The psychologist is called in by the process anchor (reintegration team, outreach team or social worker) and counsellor then helps resolve the situation. The counsellor could organize an individual session with client at shelter, at work place or a meeting with employer alone or a face to face with client and employer.

Recently, a format was introduced that spelled conditions for employment of residents which employers have to fulfil:

(i) employer would be responsible for safety of the woman specially that she is lost again

(ii) employer would be responsible for treatment to the extent of regular doctor review (giving leave to attend doctor review) and purchase medicine;

(iii) if there is any other inter current illness, employer shall be responsible for due management and shall not abandon the woman at Sarbari.

(iv) payment to be done as per mutual agreement.

However, it is not easy for women to work outside Sarbari and this is an area that needs more work; indeed it is very challenging.

Work provides different psychological experiences that promote mental wellbeing. It provides time structure, social contact, collective effort and purpose, social identity and regular activity[9]. If a resident works inside Sarbari, many of these experiences are provided barring social contact that is reserved for those who work outside Sarbari. For most residents inside Sarbari social contact is restricted to the staff and their day out where again it is limited. How could social contact be promoted? How could collective effort and purpose be promoted is an area of enquiry that should be actively looked into?

In the context in which Iswar Sankalpa operates, the biggest challenge is that most jobs are in the unorganized sector where regular job benefits are absent. The attitude of employers in this sector is perhaps more accommodating towards person with mental illness but the stress on work absenteeism, role performance and adequate payment may not be so rigid. Employment is a major goal for adults in productive age group. For a person with mental illness it is difficult to find and retain a job. The rates of unemployment amongst the mentally ill are nearly 90% and women fare worse than men hence even one successful employment is of immense value and ensuring that person stays in employment through intensive efforts is translating rights of the person into a reality. Hence the call to look into this aspect of work and develop more processes around it.

The new economy might provide different work opportunities for residents such as hospitals, retail shops, tourism, IT, care for elderly and children, etc.

Training programs should be developed to simulate work opportunities in the market and train residents (few of them) towards more permanent work. Small work stations set up inside the first or second dormitories at Sarbari could be used to train residents in roles such as hospital attendant; help in retail store, etc. Partnerships with Skills Development Centres should be sought to mature this. Some of the other services that can be looked if supported by donor or state are cleaning services in schools (interiors + exteriors), offices, maintenance of parks, gardens, etc. It is therefore required that closer attention is paid to both structure and function of employment related work at Sankalpa

[9] Mental Health and Work: Impact, Issues and Good Practices: WHO, 2000

Iswar Sankalpa is already experimenting with self-help groups; however, it could look into the idea of social firm and study it for a long term perspective. The website link provides more information on it - http://socialfirmseurope.org/

5.6.5 Functional Literacy Program (FLP)

The Functional Literacy Program is a relatively new addition to Sarbari. The need was felt because many residents were either illiterate or had forgotten their past literacy skills. Literacy skills are required to manage money, keep accounts if women are to be employed outside. Many who were working in vocational activities could not even count their money, sign their names. Hence, FLP was started and has emerged as an important activity of skill building in Sarbari. Some women residents who were in their earlier life academically inclined and did not show any inclination towards vocational activities in the shelter, find this new activity of great interest.

The process of FLP involves following main sub processes

1. Building Rapport:

The FLP coordinator is given a list of all residents and she then speaks to them during DMT or energizer session to build rapport.

2. Assessment and Classification:

Based on their past education history, she divides residents into 5 groups as follows:

- Groups A to C: A being least educated
- Group D: for residents with Intellectual Disability and
- Group E: for residents who speak in Hindi.

Initially, to motivate residents to attend classes and learn, they are requested to come and see the process of teaching. Teaching without paper, pen and using television is intended to attract the residents who have left studying a long time ago.

3. The initial promo:

The first session is a movie show. The movie is about a village woman who is duped since she is illiterate. This movie sets the tone for remaining sessions. FLP coordinator then asks who all want to study and not be illiterate. Primed by the movie, all in attendance usually agree to study.

4. Forming the learning groups:

Earlier, haphazard learning groups (of residents) were formed. This created problems. More recently, the FLP coordinator starts with a **baseline assessment** of residents on certain parameters, with help of the counsellors. These parameters were then scored. Scores revealed the status of residents. Based on the assessment score, FLP coordinator designs curriculum suited for the resident. It also form basis for continuous appraisal and corrections.

5. Teaching Curriculum, lessons and assessments:

Teaching is done via a software which has different modules. Assessments are part of the software. This is a structure approach to training. In addition, English language classes were recently started. Residents are divided into batches and each day is divided into 45 minute sessions.

Initially, to motivate residents to attend classes and learn, they are requested to come and see the process of teaching. Teaching without paper, pen and using television is intended to attract the residents who have left studying a long time ago.

As FLP matures, more residents would become trained in basic, intermediate and advanced literacy skills. This would be of great benefit in their reintegration where they could go for the job of teacher, or teaching assistant in their villages, small towns, or provide private tuitions, jobs that are easily available.

5.7 Section 4 / Miscellaneous

5.7.1 Want to go home

Residents have a deep desire to go home, and why not? Even though in some cases there has been abuse at home, the desire to return back is strong! They constantly say – "*I want to go home, take me home*". Residents who have not been home for long (have been homeless for many years) yearn the most to go home. Sometimes they have not revealed their addresses yet they insist on going back home. Residents say they like their stay here yet they want to go home.

Some of them get frustrated with the inability of reintegration team to trace their address. A few try to find their way out themselves from Sarbari by running through the door or jumping the wall; some succeed.

On the other hand, a few residents return back to Sarbari after reintegration with families. They say there is more freedom of movement at Sarbari than at home. They also say that although at home, food is available but people (family members and relatives) don't talk to them.

Most of the residents come from socio economically poor back ground. Facilities at their homes do not compare to that provided at Sarbari, even though they are basic facilities. In the shelter, most facilities (electricity, water, food, clothes) are available without any effort or work; which is not the case in families. Residents could get complacent, lethargic at Sarbari and not work. The staff has to keep an eye out for this and continuously persuade a few residents to work. Many of them however, do work with enthusiasm.

In response to this situation, a contribution system was started at Sarbari for some residents who were required to pay for their stay and medicines at Sarbari. Further, there was a message suggesting that participation in work is essential to continue receiving services at Sarbari. These are efforts towards rehabilitation of residents back into mainstream society.

5.7.2 Attitude of Residents (this would be a separate text box)

In the midst of many residents it is difficult to generalize any single attitude, but few residents feel that Sarbari is a mental hospital where clients come for treatment. Friendships are formed amongst women who share certain attributes such as similar education levels; who come in together; have recovered; etc. Residents have an impression about other residents and do not usually speak with each other, except for their friends. It is difficult for the women who have come later to mix in the group of the women who came in earlier.

While there is show of affection, it is difficult to say if there is a sense of sisterhood or sharing of similar identity. There is no process (cf. Hastings DIC) that aims to enable a common identity. Perhaps there are activities where the group shows or exerts group identity but it was not possible to see evidence of same.

Residents who have been admitted in past to other mental hospitals, often compare Sarbari with those facilities. One of the residents who had earlier been homeless, recovered and was returned back to her family had to seek services of a mental hospital for her continued treatment. The visit to the hospital scared her - *there are many clients; few of them are aggressive- kicking, etc*. She discontinued going to that hospital for her follow up treatment. There was no other alternative. The resident

relapsed, wandered out of her house once again. As luck would have it, she accidentally came to Kolkata and was readmitted at Sarbari where she had been admitted earlier.

There is a deep desire amongst all clients to return to their families. This strange paradox where they themselves recall the sufferings in the family yet show a longing to get back to it is perhaps an indication of their loneliness and alienation. A process needs to be thought of to improve socialization of the residents which could reduce this desire or longing, which in many ways is natural.

On the other hand, some clients served by Naya Daur program are very angry with their families and do not want to return to them. Any mention of the family makes them very angry; a conscious choice of not returning to the family while they are free to do is in deep contrast with the longing of the women in Sarbari.

5.7.3 Legal Issues

Many residents have significant assets (cash and fixed) in their name prior to their being homeless. After recovering at Sarbari they inform staff members at Sarbari of their assets. It is a challenge to get back their assets. At times, families are willing to receive the woman back into the family fold only to ensure that her assets are transferred in the name of another family member. The resident is then conveniently abandoned on one pretext or the other. At other times, there is complete refusal to recognize her claim and hand over the assets.

There are also procedural issues such as documents as proof that resident might not have or were lost. Insurance policies, dormant bank accounts mostly in other cities are all challenges faced and successfully tackled by reintegration team.

The reintegration team is responsible for all legal processes involved. Iswar Sankalpa has made efforts to secure government issued personal identity cards such as Voters ID cards for all residents. This provides them not only with an identity but gives a legal document that allows other procedures such as reclaiming lost or dormant assets. However, in absence of strong legal service backing their efforts whatever reintegration team has achieved is incredible.

6. Phase 4 / DISCHARGE PROCESS

When both conditions, a resident recovers and a suitable destination is found for her, are met, she is discharged from Sarbari. The discharge process involves a hand over of client from Sarbari team to Reintegration team which provides follow-up care to the (ex) resident.

At discharge, the core is to build insight of the resident and her family about her illness, need to continue treatment and perhaps more importantly on empowerment of the person. Communicating to the family that their near and dear one who is now going back with them has capabilities, skills, abilities and she has achieved her own discharge, they should at home focus on her abilities and talent.

The decision to discharge is a team decision involving the psychiatrist-in-charge of case, shelter supervisor, the counsellor & the reintegration officer. A client has to fulfill discharge criterion to receive discharge.

6.1 Criterion for Discharge:

1. Resident shows an urge or a desire to return home. This is a very important requirement. If there is no urge to return home and even though other criteria are met, it is advisable to wait till the resident shows a desire to return.

2. Symptomatically stable: The symptoms have to be in reasonable control and the guiding principle is - Would the client be able to cope up on discharge?

3. She Is Functional:

- Speaks and responds relevantly
- Has Self-initiative to work
- Is able to do her own work
- Eats properly on her own
- Can take care of her own self

4. Knows she has to take medicine (insight into medicine is very important). If there is no insight on treatment and resident is sent home, she could become

troublesome for family. Similarly if the family forcibly takes her away from Sarbari before development of adequate insight into treatment, result is not good)

5. Is she likely to cooperate with others in the community / family?

6. Would she be able to find and perform at work (including domestic chores) to contribute in the family?

7. Does she have some money in her name (from the stipend earned at Sarbari? This is a desired criterion but not mandatory

8. Discharge to family: resident is discharged to family only if address is traced and the family is willing to take her back

6.2 How to decide from the criterion?

There is no cut-off in the above criterion. The staff assesses the primacy of different variables and then decides on the discharge. If the resident fulfils above criterion and her address is traced, she has a separate interview with the reintegration officer.

It is to be noted that even if address is traced, the client is not discharged till she is ready for discharge. Further as stated above, there should be an urge to return as well. Hence, combination of recovery, urge to return and retrieval of address decides when the client goes back home.

6.3 Preparing the resident for discharge

Once the decision to discharge is taken, preparation is done to discharge the beneficiary, this includes following processes:

6.3.1 Termination Counselling

As Counsellor, you will undertake the termination counselling with the resident. This would be scheduled 2-3 days before the actual or planned date of discharge.

The aim of the termination counselling is to inform the resident of the decision to discharge and check her insight on treatment compliance; her role in family, etc.

If you find the resident is unclear on any of these, then you should educate her specifically on the issue and try to build her insight.

You should re-assess after 3 days, if there is improvement then you should proceed for discharge else you should postpone the date of discharge till the time the resident shows insight into her treatment and her role in the family

6.3.2 Exit Counselling

As Counsellor, you will undertake Exit counselling which is a further reinforcement of messages delivered during termination counselling. It is done on the day of discharge. Emphasis on insight of client towards treatment adherence, role in the family are again elaborated.

The exit counselling ends the counselling relationship of the client with the counsellor of Sarbari and it marks the shift of therapeutic relationship from Sarbari team to reintegration team and its counsellor.

6.3.3 Psychometric scales at discharge.

At discharge, as Counsellor you should administer the same set of psychometric scales administered at admission. This is a final check for you to confirm the validity of the decision to discharge. You should ask your colleague to do the discharge scales as she would be less biased. The scales would also inform the reintegration team in supporting the client on dimensions that are found wanting even post discharge.

As mentioned earlier, scales do not get analyzed in any meaningful way currently.

6.4 Preparing the recipient for acceptance:

The homeless woman who has recovered from her mental illness has a different fate facing her depending on following variables:

(i) whether her family is traced and

(ii) if her family is willing to take her back

Discharge Destinations:

Destination is referred to the location where the resident is discharged to. Not all residents go back to families, not all families are traced. Therefore there are other locations that residents go to when recovered and discharged from Sarbari. These are discussed below:

6.4.1 Restoration = Discharge Destination: Family

Restoration: When the resident goes back to her family (destination); it is referred as "Restoration" by Sarbari staff, a kind of code to reflect the destination

Scenario 1:

If the family is traced, two scenarios are possible – first, that they are compliant and ready to accept the resident back or second, that they are not willing to take her back. In the first scenario, the objective of reintegration is on empowerment of the resident so that family treats her well and focuses on her talent and skills and is not critical, suspicious of her, or harps too much on the past mistakes she might have done due to untreated illness. Family is told on the need for treatment adherence and treatment continuity.

Scenario 2:

In the second scenario, repeated home visits or phone calls to the family or both are done by the reintegration team. At each visit or call, the family is informed how their near and dear one with their support could lead a near normal life. Perhaps this would change their decision, success is often mixed!

Families of residents wish them well but don't act accordingly. They might give medicines but don't talk with the resident leading to her isolation. The families get tired taking care of her psychosocial disability hence families need continued support, reassurance and training. This is possible due to the repeated home visits by reintegration team. Given the scale & spread of restored clients, this is a difficult task for the team.

Recently, reintegration team has introduced a form called **RESTORATION FORMAT** which is a check list of conditions that need to be fulfilled before client is discharged. More on this is discussed in the chapter on Reintegration processes.

Processes followed during Restoration (to family)

Whether the family comes to Sarbari to receive the resident or she is taken by the reintegration team to her family, in both the scenarios, the main processes followed are same:

1. Detailed past history of illness is taken from a relative / family member: On meeting the family, reintegration team member asks them about the past history of the resident. This informs on duration of illness, if she had wandered away earlier as

well, possible triggers at home or at that time, any trauma she might have faced, etc. This is important information and asked only from close reliable family members. This information is noted down and later would be filed in the case file of the client

Scenario:

Many families are poor and request Sarbari to retain the resident there. They promise to come frequently to visit her. They also see for themselves that the resident has been taken good care of (nutritional status, appearance, clothes, etc.) Similar question is posed to the reintegration team when they take resident back to their families by a few families.

The family has to be explained the rationale for discharge, for the resident to stay with her family. They are told that the shelter was no more a suitable place for her to stay. Further, the resident herself does not like to stay there with other less recovered person and she has a desire to go home (referred to as urge to go home in earlier section)

2. Information is provided to the family on the treatment at discharge. They are told to continue treatment (medication) and regular review by a psychiatrist. In some cases, they are also informed of the closest location to their homes where they could go for follow-up. In some cases, the reintegration team takes them to the closest facility, speaks to the doctors, explains the case and seeks cooperation from the doctor in maintaining treatment continuity for the resident.

The resident or her family member is handed the discharge summary that contains salient features of her stay at Sarbari; her prescription at discharge and the site of follow up

3. Information and emphasis on job or work engagement: Family is informed of the nature of work the resident had been performing at Sarbari. They are told that the resident should be involved both in household work and if possible in some remunerative work. Her income would support the household income.

4. Phone numbers for any help are given: Family is told that reintegration team was available all the time over phone. Whenever the family wants to contact them, they could phone and speak with them.

6.4.2 Resettlement = Discharge Destination = Any other than family

Resettlement: If either the family is not traced or they are unwilling to take the resident back, the family as a destination is ruled out. An alternative destination is thus required and several options are available. All of these are together called RESETTLEMENT. These are:

- Continued residence at Sarbari: this has been described earlier
- Shift to a new facility called Independent Living at Kashipur, a few hours travel from Sarbari (This is currently experimental): More on this in the Reintegration chapter
- Discharge to Community

Destination: Community

Sometimes a resident is discharged back to the same community (location) she came from, at admission. Typically, this is a case of a woman who was a client of the outreach program and was responding to treatment but was irregular. The plan for her was to bring her to Sarbari for some time to regularize her treatment, hasten recovery and then discharge her back to the community where she had been living. The reintegration along with Naya Daur team checks if in the community she had a safe place for night stay, worked and had several people nearby who kept a vigil on her for her safety. Naya Daur team also creates a circle of protection by identifying care givers from the community. It is also possible that she has some members of her family staying nearby although she does not stay with them and chooses to be on her own. In this scenario, she is discharged to return to the community. Her follow up is done by Naya Daur team

6.5 Conclusion

The discharge marks the completion of the journey at Sarbari of a woman with psychosocial disability who was homeless at the point of her first finding. Iswar Sankalpa tries to maintain regular contact with her through its reintegration team. I have added a section on the role of Shelter Supervisor to provide clarity on this key position. In addition, two important events that are responsible for running of the Shelter have been added in the same section.

Overall, other members of the staff would understand their role by reading the processes; there are exhibits that clarify the role of different staff and processes

7. Management of the Shelter

7.1 Role of Shelter Supervisor

The Shelter supervisor is overall in-charge of the facility for its maintenance and achievement of its objectives. Apart from oversight on regular processes mentioned in details above, the supervisor also has some other responsibilities. The role and responsibilities have been divided into distinct groups:

7.1.1 Liaison Roles:

1. You should liaison with the Ward Councilor to get residential proof (a letter to that effect) for residents of Sarbari. This is a pre-requisite to apply for Disability Certificate for residents

2. You should liaison with the Kolkata Municipal Corporation to ensure general upkeep and maintenance of shelter premises and bring to their notice any problem such as electricity breakdown, white wash that keeps the shelter in a healthy condition

3. You should liaison with forums that work on shelter like set ups, funders who fund such work, technical think tanks, etc., such that advocacy efforts are undertaken on the need for shelter like mechanisms for person with psychosocial disability

4. You should develop contacts that provide employment opportunities for residents to work outside Sarbari

7.1.2 Role in complying with legal requirements:

1. You should ensure that all legal requirements are complied with at all times

2. You should make arrangements for adoption of children who accompany their mothers when they are admitted at Sarbari or who are born to pregnant residents. You should arrange for mothers to meet their children monthly at the adoption agencies.

7.1.3 Administrative Roles:

1. You should call and coordinate the Shelter Management Committee meetings

2. You should convene the shelter staff meeting (monthly) & the House Meeting

3. You should convene other meetings to attend to emergencies

4. You should present to the senior management summary reports on the progress of the shelter

5. You should keep strict control over budget and issue purchase orders for medicines yourselves or in your name

7.1.4 Roles as a Team leader:

1. You should undertake planning for the future activities of the shelter, create budgets and ensure other sources of funding for the shelter

2. You should execute the annual work plan of the shelter and track the progress as per plan and budgets

3. You as supervisor, should allot care givers to attend to hospitalized client or to accompany residents to work

4. You should yourself participate in awareness activities, advocacy and networking meeting with stake holders

5. You should represent shelter in different conferences, forums

6. You should personally monitor the progress of residents and supervise work of all line staff

7. You should create rapport with residents and mechanism to address grievances of both residents and staff. These should be transparent and unbiased

7.2 Shelter Committee

A Shelter Committee is mandatory in a shelter. Councilor of the local ward is the chairman of the 10 member committee.

The committee's mandate includes issues related to:

1. Upkeep of the shelter;

2. to the care of residents and

3. any other issue relevant to the objective of the shelter.

At each meeting, the shelter supervisor updates the committee on the progress made in the shelter. The committee meets once in two months. Members are helpful and proactive.

7.3 House Meeting

The house meeting is called by the shelter supervisor where all residents and staff discuss issues related with living in the shelter specially any concern of shelter residents. If the residents do not like the daily schedule of activities, they could be changed post discussion in the house meeting.

If there is any new rule that has to be announced then it can be done in the house meeting. It is an instrument to listen to what the residents have to say about their life in the shelter.

7.4 Shelter Monthly Meeting

The shelter team and reintegration team participate in the monthly shelter meeting. The agenda of this meeting includes:

(i) Planning of the activities for the next month;

(ii) Issues faced by any of the different departments;

(iii) discussion of difficult cases and

(iv) any other important event in current month with ramifications for coming month.

During this meeting, difficult cases are discussed amongst team members and their inputs taken. A plan of action for the case is then prepared. For difficult cases, Caregivers are asked for their feedback. During the meeting, the Inventory Manager provides feedback on consistency of work performance of different residents as per and their attendance. With all input, strategies for overcoming the problem are discussed. One person takes down the minutes of the meetings and records who is supposed to execute the actions.

An update of the previous months' critical or key event(s) is shared with the team e.g. proceedings of a disability certification camp organized by Sankalpa and follow-up actions, etc. in coming months.

Issues related to physical infrastructure of shelter are also discussed. The meetings are a convergence point for the shelter team and reintegration team who requests the former for a list of residents suitable for discharge (fit for restoration). Additionally, during these meetings counsellors discuss with the vocational trainers and FLP coordinator if any of their residents require counselling or similar support.

Physical health needs of shelter residents is also discussed example those who require cataract operations, refraction testing, etc.; how that would be arranged, etc. and action plans are prepared.

The schedule for next month's major events such as Day Out, shelter monthly meeting, House meeting, FGD, small group discussion is decided.

The meeting lasts about an hour and 45 minutes and ends with signature of all for the record. Minutes are prepared in a separate register.

Suggestion

Doctors are not part of meeting and the Annual Work Plan is not referred to in this meeting. This is more an operations meeting and not a review meeting. The schedule of review meetings is not known. It is important to schedule short and focused review meetings as well. This meeting and the monthly capacity building activity (discussed later) are the two opportunities when shelter and reintegration teams meet together and discuss issues. In view of their work this is a good enough frequency of meeting together. Shelter team could consider adding separate "Case Conferences" once a quarter to upgrade technical skills through discussion of cases.

8. Conclusion

The 80 bed shelter is almost always full to its capacity. Staff and older residents have their hands full each day. Yet new relationships are born and old ones under lined. Residents go through crisis, good days and normal days. Staff shares their emotional journey. Residents and staff have a relationship built around trust and faith. This is essential in a residential setting for the residents to believe that all staff is working for their betterment. They all mix together and some enjoy friendships. Overall, their relationships are informal.

The care giver floats across all different functions. There is no formality in the process of care and no tight boundaries. All staff members are involved in all the different activities inside Sarbari such as personal care, cooking, dispensing medicines, accompanying to place of work, watching films together so on and so forth.

The different residents in Sarbari are therefore involved in care processes such that the atmosphere of care is rather informal. Recovered residents help the staff and assist them in cooking, serving food, dispensing medicines, serving food to shelter visitors and any other task. This is pivotal since care is provided 24x7.When a new admission comes into shelter, the peer volunteers also help in taking care of the person and helping her adjust in the shelter. Some residents who have intellectual disability or are aged or have severe physical disability are helped by peer volunteers in bathing, eating, dressing appropriately and in their activities.

Word is spread about Sarbari and its work by the Social Worker and the Counsellors. They conduct awareness sessions on mental health in housing societies and clubs in neighboring areas of the shelter. Sessions include homelessness and mental illness. These awareness sessions are important since some members of the audience later visit the shelter and could become a well-wisher or a donor. If someone visits the shelter they inform others and word goes around. This opens route for donations especially for food and clothes. Nearby community serves food at Sarbari during puja. Overall patrons for Sarbari have been developed who have a strong connection with the shelter and come regularly with donations.

Rarely, a resident would try to leave Sarbari on her own. She could have an auditory hallucination suggesting her that something bad would happen if she continued to stay in the shelter and that she should run away. She could also find it difficult to

live within four walls of the shelter within a fixed schedule since she is used to roaming freely on the streets and find it difficult to adjust in the shelter.

Usually clients try to leave on their own without informing anyone during the evening during the time when staff leaves for home. The young boys of the neighborhood however inform care givers whenever a resident makes her way out on her own and help in tracing her back. They also sometimes are able to hold on to the person or find her later. But a few times, residents do manage to leave on their own.

In case the resident goes out on her own and cannot be traced with local help, local police station is informed. The local police are provided with a photograph of the resident and other personal details. They in turn inform all other police stations. If the resident is traced, she is brought back to Sarbari and the process starts all over again. Other residents help in allaying the fear, suspicion and anxiety of the resident who had gone out on her own.

The life at Sarbari is dynamic, peppered with all experiences that a human life brings. The atmosphere is informal, boundaries between residents and care givers fluid. Love and affection are served as essential parts of treatment process. Disappointments are shared and so is success. The processes in care are perhaps easy to capture in a written document but what is difficult is to express the sentiments that run this place. As a reader and user of this document, be aware that mechanical processes fall into place today or tomorrow only and only if the right attitude, love and compassion for fellow human beings guide treatment, care and support. There are many stories of Sarbari; its residents and staff. Their lives inspire, shock but almost always touches one deep inside. Spending time with residents, speaking with them beyond boundaries of language is perhaps what is most needed in the mental hospitals in our country. Perhaps this need is higher in the families where communication has come to a crisis. Mental experiences of humans tormented by life circumstances provide a glimpse of how we have come to shape our transactions. Repeated over and over, love and compassion are perhaps as important and more so that the tools of modern science that help recovery of women in shelter and maintain the health of the staff. If you happen to read this document, do visit Sarbari to understand the processes in closer details, for yourself!

END OF THE DOCUMENT

Annexures

Annexure 1: Overview of Sarbari

Annexure 2: An overview of processes at Sarbari

Annexure 3a: Processes in a New Admission

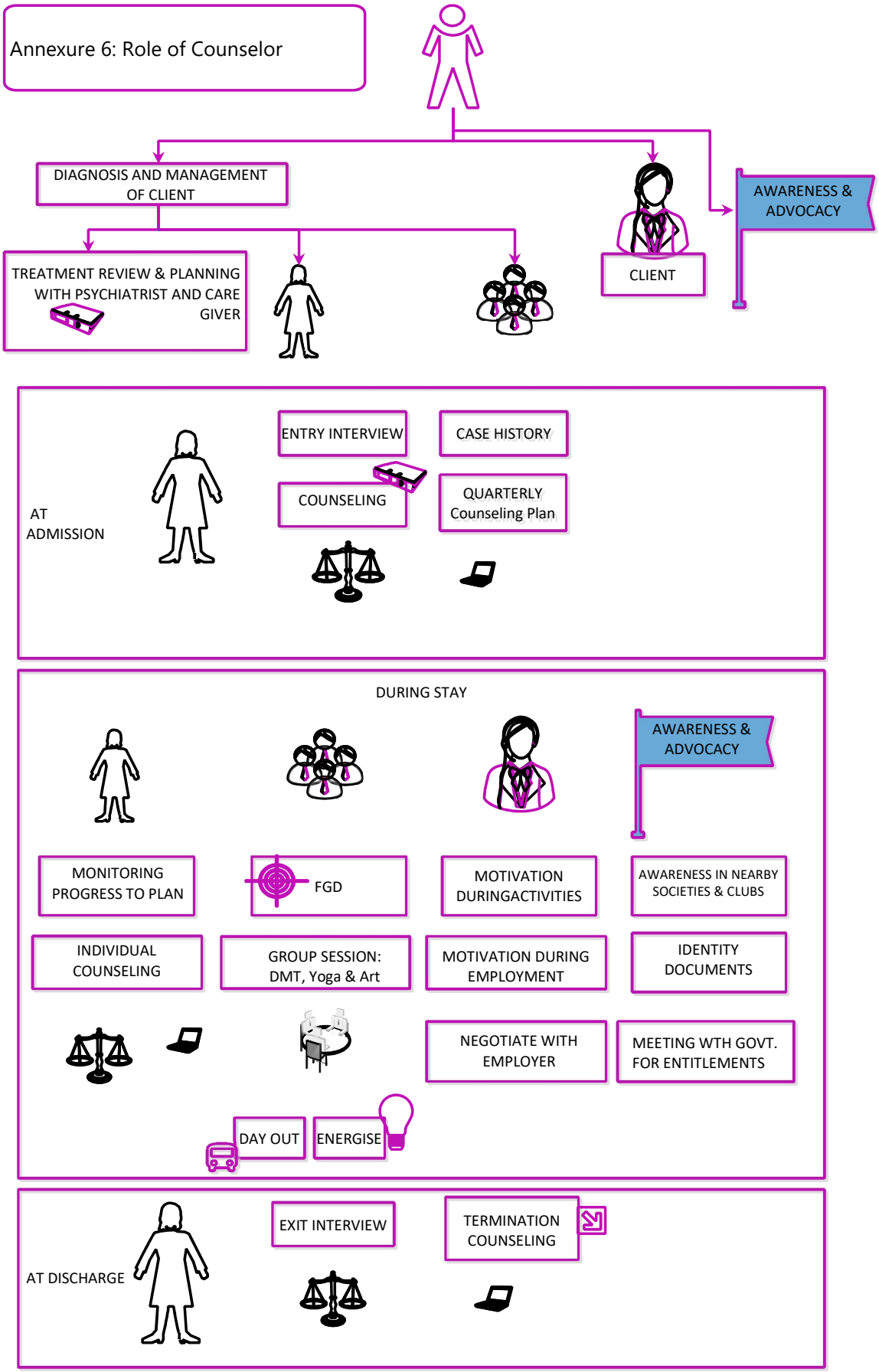
Annexure 3b: Police Referral to Sarbari

Annexure 4a: Overview of discharge process

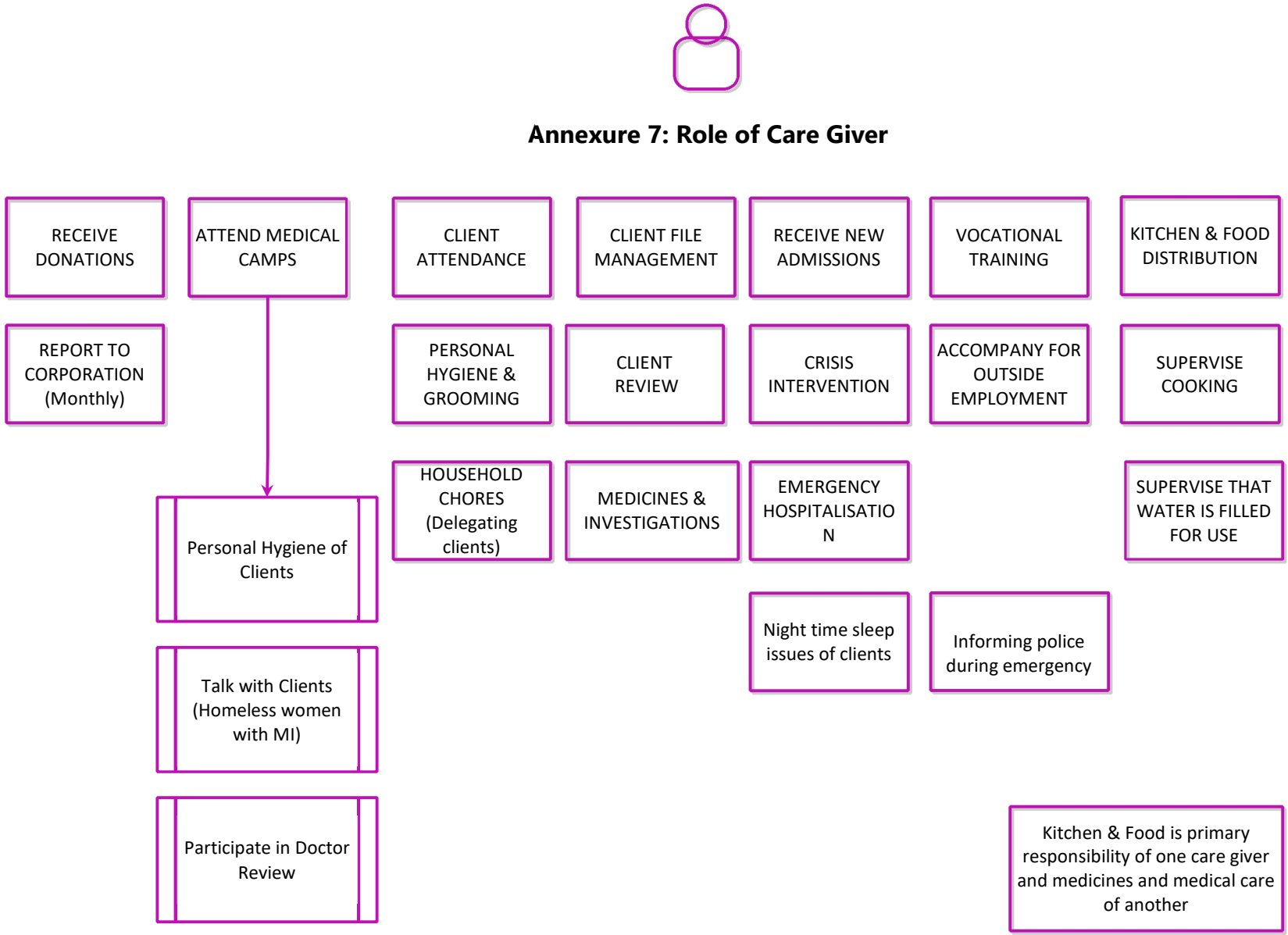
Annexure 4b: Discharge Process

Annexure 5: Vocational Training

Annexure 6: Role of Counselor



Annexure 7: Role of Care Giver



Annexure 8: Sections in a Resident Case File

CARE GIVER REPORT
OBSERVATION REPORT (MIN. MONTHLY)

COUNSELING REPORT
MONTHLY:
1. COUNSELING REPORT
2. LIFE SKILLS PROFILE
QUARTERLY:
1. TREATMENT PLAN
2. SUMMARY OF MONTHLY COUNSELING
SMALL GROUP SESSION REPORT

MONTHLY SCALES
1. LIFE SKILLS PROFILE**QUARTERLY:**
2. PANSS
3. GAF
4. IDEAS

VOCATIONAL THERAPY REPORT
1. DATE WISE RECORD OF WORK
2. MONTHLY OBSERVATION (FORMAT)- summarise progress on different parameters (objective + subjective)

SOCIAL WORKER REPORT
TYPE A:
1. IDENTIFIED PROBLEM AREA
2. IDENTIFIED INTERVENTION OVER DEFINED PERIOD (>= 1 MONTH)
3. OBSERVED CHANGES
4. INPUTS PROVIDED
TYPE B:
MONTHLY ONCE OBSERVATION RECORD OF RESIDENT

MEDICAL RECORD
1. 1st page: Photo of client and brief intake summary
2. Doctor's Notes & Prescriptions
3. Record of hospitalisation in any other hospital
4. Laboratory reports

FLP REPORT
ASSESSMENT PARAMETERS CLEARLY STATED AND MONTHLY SCORES AND INDIVIDUAL OBSERVATIONS NOTED IN A FORMAT

RESETTLEMENT REPORT
1. PHOTO ID OF GUARDIAN OF CLIENT
2. RATION CARD OF CLIENT
3. UNDERTAKING FROM WARD COUNCILOR OF ACQUAINTENCE WITH GUARDIAN AND RELATIONSHIP WITH CLIENT & CONFIRMING ADDRESS OF RESIDENCE OF GUARDIAN
4. Declaration by family that client is received by them (Format)

Entry - Exit Report & Family Identification Process Reports

Annexure 9: Outline of the sections in Phase 3 of care in Sarbari

Phase 3 / Stabilisation Phase	Section 1 <Values>	1. No Use of Force
		2. Residential staff
		3. Attitude of staff
	Section 2 <Management Processes>	1. Quarterly treatment plan
		Multi professional team review of 2. the resident
		3. Directly Observed Medicine, Food and Personal Grooming
		4. Quarterly Psychometric Scales
	Section 3 <Package of Services>	1. Daily Schedule
		2. Physical Activities
		3. Psychological Services
		4. Vocational Services
		5. Functional Literacy
	Section 4 <Miscellaneous>	1. Effect of ideal care giving at Sarbari
		2. Want to go home
		3. Legal Issues
		4. Attitude of Beneficiaries

Annexure 10: Suggested Case entry format for the Quarterly Plan:

1. What is the recovery goal of this person (rephrase it – my plan – what is my goal?
2. When should I achieve this goal (time frame)
3. In order to achieve this goal what all do I need to do? Who all are going to help me achieve my goal?
    a. Treatment adherence:
        i. Drug treatment
        ii. Psychological treatment
        iii. Vocational treatment
    b. Work performance / engagement
    c. Social interactions
    d. FLP
    e. Financial Literacy
4. When do I see how I am progressing towards achieving the goal?
5. Would I like to revise my goal?

Suggestions in general:

1. Summarise the case:

    a. It is essential to summarise the key events with the person at regular intervals irrespective of the service location – shelter, restoration, follow up, etc.

    b. Broad headings of summary should be decided by a small technical team appointed for this purpose

    c. A new page should be added which is the Key Events page. This should record any key event that happened with the person during period of summary, this page should be built over time. Key events need to be defined but our goal is to document those which have a bearing on the quality of life of the person, such as in treatment domain they could be change in class of a drug from one to another, or trial of clozapine, or

failure of CBT, etc. It could also include attempted self-harm, bout of severe depression, or death of a parent. Any event that has a strong bearing on future of person should be recorded in a separate page. Once the client is discharged, some of these key events should be recorded in discharge summary specially the drugs that have been tried in the past, or any specific precipitating or perpetuating factor. This will inform the follow up psychiatrist or physician and even family to take care of the person better.

2. Assessment of pre-morbid personality: Since it is advised to adopt the process of writing the residents' personal recovery goal on the case sheet, it is important to make an assessment of her / his premorbid personality.
3. An annual or frequent enough review of resident's needs and their assessment of their needs being met should be facilitated in the shelter. Studies have shown that residents view of their needs being met is an important indicator of quality of services as well as has relationship with their quality of life. The professionals feel that they have provided good service which residents might or might not agree with. This process also gives a voice to person with psychosocial disability which is essential to prevent social isolation that they are vulnerable to. Accurate measurement of service need and achievement of objectives or goals mentioned in the individual plans is necessary.

Annexure 11: Weekly Activity Schedule of Sarbari

	1030 AM – 1100 AM	1100 AM - 1 PM	Lunch	3 PM – 5 PM	6 PM onwards
Sunday					Movie
Monday	Energizer	Doctor- Team Review for some clients Activity Circles, Session 1 - Other clients		Activity Circles, Session 2 - All clients	
Tuesday	Yoga	Doctor- Team Review Activity Circles, Session 1 - Other clients		Activity Circles, Session 2 - All clients	
Wednesday	Yoga	Doctor- Team Review Activity Circles, Session 1 - Other clients			
Thursday	Yoga	Activity Circles, Session 1 - Other clients		Activity Circles, Session 2 - All clients	
Friday	Energizer	Doctor- Team Review Activity Circles, Session 1 - Other clients		Activity Circles, Session 2 - All clients	
Saturday		Block Printing		Activity Circles - All clients	Movie
DMT – weekly once Gardening - weekly twice		Day Out for a batch, monthly once			

Annexure 12: Criterion for Admission to the 4 psychiatric beds:

1. Adult (>=18 years)
2. Diagnosis of a Mental Illness
3. a woman who is not homeless and her family requests admission. The family need not stay with the client but the distinction is that person is visited often and the family takes back the client, there is therefore no GDE)

Other features of the service are:

1. Family is requested to attend the doctors review although this is not mandatory
2. This is a paid facility
3. All facilities are same and shared except a staff might sleep in the initial days of admission with the resident; if the resident is critical then a care giver could sleep here along with the resident
4. There is no police intimation, no GDE
5. The resident is given a separate set of utensils to eat and separate set of toiletries
6. She could eat in this space if she wants else use shared dining space
7. For follow up residents are referred to UMHP clinics
8. Max stay is 1.5 months
9. there is no conflict in service delivery with other homeless residents

Annexure 13: Checklist for Shelter Working

1	All legal compliances are in order (add the list of items which should be in order, small list is added)
1.1	Registration of the psychiatric facility is valid (Not expired)
1.2	Inspection from different authorities has given green signal to shelter
1.3	All due qualifications of the staff are with the administration
1.4	UNCRPD compliance checklist has been made and is in effect
1.5	Is the shelter compliant with requirements of the new Mental health care bill
2	Staff
2.1	Vacancies are below the threshold of tolerance limit
2.2	Appropriate staff for appropriate position (Qualification wise)
2.3	Staff has updated knowledge & use evidence based methods in treatment of residents
3	Pharmacy & Store
3.1	Inventory systems in place and follow best practices
3.2	Stores are monitored by regular audit
4	Food
4.1	Nutritious, balanced diet is given to residents Optional – Diet is planned by qualified person
4.2	Resident requiring special diets have access to same
4.3	Policy for accepting outside food and testing its safety is in place. As also police for disposal of excess food, if any

5	Grievance Redressal Mechanism is in place for staff and residents and is regularly used
6	Annual plan is prepared for shelter and functioning is as per it
7	Shelter Management Committee meets as per its schedule and mandate
8	Long term financial support for shelter in place
9	Policy for visitors coming in to Sarbari in place
10	Emergency Mechanisms such as fire drill, immediate evacuation, fire extinguishers, etc. in place

	Annexure 14: Forms, Manuals, Policies, Handouts, Auto reports, Flags		
	Forms	**Create / Modify**	**Comments**
1	Resident Quarterly Status Report	Create	This should summarize what transpired in a period of three months
2	Milestone Report of the resident	Create	This should capture journey of resident based on milestones achieved
3	Psychometric Scales Assessment Report	Create	This should capture key features of the scale data, compared to previous quarter
4	Shelter Checklist	Create	Should capture how the shelter as an entity has performed based on a quality checklist
	Manuals		
1	Physical Health Check Up & Management Guideline	Create	
2	Essential Learning for Sarbari staff on Psychotropic medicines	Create	
3	Induction Manual	Modify	Advised to have a detailed manual
4	Framework for Psychological services	Create	What standard therapies would be used for different residents
	Policy		

1	Treatment participation policy	Create	How the resident would be involved in her treatment planning, this is to create insight as well as to know her own needs
	Hand outs		
1	Project hand out to Stake holders	Create	
	Auto Reports from MIS		
1	Summary report for each resident what main events transpired in a period of past three months, preferably illustrated	Create	
2	Residents who faced crisis of any sort	Create	
3	Residents Milestone report	Create	
	Lists / Data bases		
1	Volunteer data base	Exists	
	Flags		
1	Residents who slipped a few milestones in a quarter	Create	

<THE END>