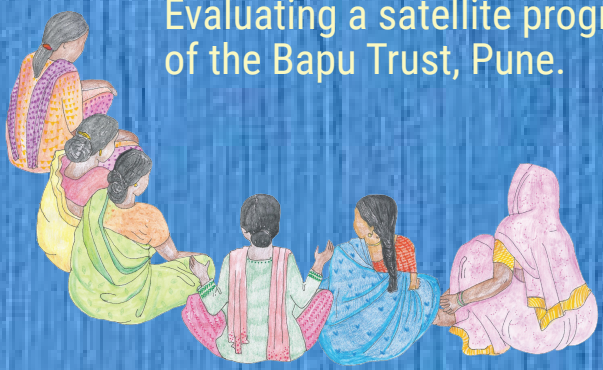
EVALUATION REPORT

RUNNING **THERAPEUTIC SUPPORT GROUP** IN LOW INCOME COMMUNITIES

Evaluating a satellite program of the Bapu Trust, Pune.



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CONTENTS

List of Tables and Charts

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List of abbreviations

BT – Bapu Trust
FGD- Focus Group Discussion
TG- Therapeutic Groups
MIS- Management Information System
CBO- Community Based Organization
NGO- Non-government Organization
M&E- Monitoring and Evaluation
SRS- Session Records Sheet
RCV- Residential Community Volunteer
DV- Domestic Violence
UCD- Urban Community Development
CMHV- Community Mental Health Volunteer
MaNaPa- Maha Nagar Palika
KII- Key Informant Interview
PI- Principal Investigator
UNDP- United Nations Development Programme
SDG- Sustainable Development Goals
UNCRPD- United Nations Convention on Rights of Persons with Disabilities
TCI – Transforming Communities into Inclusion
PW- Pregnant Women
MR- Mental Retardation (Children with intellectual disabilities)
SMD- Severe Mental Disorders
DPS- Depression and Psychosomatic Symptoms
CMD- Common Mental Disorders
Dept.- Department
OT- Operation Theatre
HOD- Head Of Department
GP- General Practitioners
MBBS- Bachelor of Medicine and Bachelor of Surgery
BAMS- Bachelor of Ayurvedic Medicine and Surgery
BHMS- Bachelor of Homeopathic Medicine and Surgery
ECT- Electroconvulsive Therapy
ABT- Art Based Therapy
KEM- King Edward Memorial Hospital
AB- Adolescent Boys
WHO-SRQ- World Health Organization- Self Reporting Questionnaire
WHO-QOL- World Health Organization- Quality Of Life
HTP- House-Tree-Person test
DASS- Depression, Anxiety, Stress Scale
BPRS- Brief Psychiatric Rating Scale
OD- Organizational Development

About the author

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Dr. Sadhana Natu is currently an Associate Professor and Head of Department at Modern College of Arts in Pune. She has 30 years of teaching experience at both undergraduate and postgraduate level. She has won numerous accolades *viz* Innovative Teacher Award of Pune University (2010), Best teacher award of PE Society 2012), Best book award of Marathi Manasshastra Parishad (2014) and Teacher Fellowship of Women's Studies Centre, Pune University (2011). She has been a part of Board of Studies in Psychology and Women Studies at Pune University and St. Mira's college (Psychology). She has been a guide for MPhil and PhD students, advisor to research organizations, completed seven independent research projects and undertaken numerous consultancies. She has also worked on the interview panel of Infosys technologies, conducted trainings for corporates and works as an external expert in Anti Sexual Harassment Cell of these companies. She has published 6 books on psychology and numerous research papers. She has also written for newspaper columns, has worked on the Editorial Board of three National Journals for fourteen years and is also a peer reviewer for national and international journals of psychology and women's studies. She has appeared on radio shows and television programmes on psychology. She is also a trainer and resource person on personality development, mental health, youth issues and gender issues for academic fraternity, activists, NGO employees, students and researchers. She currently resides in Pune.
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Acknowledgement

At the outset, I wish to thank Dr. Bhargavi Davar of Bapu Trust for inviting me and my team to conduct the Evaluation Study of Therapeutic Groups. Discussions with her have helped to frame the study and to understand the processes involved in the work. She also spared time to discuss the finer points of the Monitoring and Evaluation Systems and give an overview of Seher project and its trajectory. Her inputs have been valuable.

I also wish to thank the Staff of BT Kavita Pillai, Bharati Misal, Dharmendra Padalkar, Swaroop Waghmare and Niharika Shah. They shared vital information, their beliefs and insights with a lot of honesty and humility. They also helped in the planning and implementation of the field work, data collection and conducting the FGDs and interviews. Their participation and help are truly appreciable.

Without the support of the Field Staff: Almaas Momin, Ratna Bagry and Najiya Khan the data collection, in depth interviews and FGDs would not have been possible. They spared time and effort to guide our team into the field with warmth and helpfulness. I am grateful to them.

I am indebted to all the respondents who participated in the empirical study and to clients, carers, BT staff, Kavita and Bhargavi for their involvement and participation in the FGDs and interviews. Their perceptions and feedback form the core of this evaluation. I also wish to put on record the hard work put in by my team Nashome Crasto, Sumita Chavare, Sangeeta Deokar, Shivani Vani, Devika Murali and Sonika Sharma and wish to thank them as well.

I wish to thank Satish Deshpande for giving technical support and helping with data management and graphical representation.

I was involved in an earlier Evaluation of the project in 2013. It gives me immense pleasure to see how much progress has been made both in terms of systems management, service delivery to the target population and in vision and mission implementation in the last 3 years. I hope that this Evaluation Study will help Bapu Trust to further strengthen its work in mental health programs and advocacy.

Dr. Sadhana Natu

Pune.

1. Introduction

Bhargavi V Davar[1]

"*Therapeutic Groups in low income communities*" is a unique intervention program aimed at providing psychosocial support services to the urban poor. The aims of the program is to improve the social capital and support systems available for people with psychosocial issues and disabilities in low income communities, especially for women; to enable the recovery and wellbeing of persons with mental health issues and with high support needs; and to offer or refer persons with such needs to various healthcare, restorative and social services as needed and available in the community. The project is intensive service delivery, based on the design developed and owned by the Bapu Trust. Thus, the purpose of Therapeutic Groups may be described as,

> *"Co-producing a participatory and sustainable community model of psychosocial care and support, by running groups in low income communities for people with low and high psychosocial disability support needs".*

In the initial phase, through this support program we expected that:

- Specific groups in our working communities will have benefited from the intervention, with at least 100 persons in one project cycle (18 months)
- At least 6 vulnerable groups will have benefited in one project cycle.
- The social capital for people enrolled in the program will improve.
- The health and mental health status of persons enrolled will improve.

Other than this direct impact, we also expected that a mental health volunteer system in the community from our existing or ex-group clients will have been created. And, sustainable pathways for old group members to meet and support each other will also have been created. We also hoped to co-create the 'design' of the therapeutic groups, by studying effectiveness.

[1] Bhargavi V Davar, Director Bapu Trust, studied, designed and supervised the TG program as a Satellite program for direct service delivery. TG program was implemented by Kavita Nair, Co-ordinator and Project Leader, over 6 years. Bapu Trust is grateful to Forbes Foundation for the financial support. And to a number of facilitators, co-facilitators and fieldworkers for the implementation, including Almas Momin, Anita Ubale, Dharma Padalkar, Ratna Byagary and Naziya Shaikh.

1.1 History and Evolution of TGs

The Therapeutic Groups project was first initiated in the year 2006-2007, in Wadarwasti areas of Pune city, 2 years after Seher Community Mental Health Program began. The idea came about after studying social exchanges in the *bastis*. Individual counselling, which Bapu Trust offered at the time, was not very sought after. The number of persons who came, or continued our services, was quite low. We reflected that the self help groups, *bhajan*, sports, youth, and other groups were possibly the model of social exchange in our communities.

The design of the groups evolved from 2010-11 upto 2016-17, until which time the 'TGs' as they were called, were run as a 'satellite program'. Following this period of piloting, studying effectiveness and refining the process as well as content, 'TGs' were mainstreamed into the core Seher program.

At first, 6 groups were conducted in 2 areas, for adolescent boys, girls and single women. Every group used a different modality of therapy including: Arts Based Therapy, Peer support and talk therapy. A systematic research study to compare the three models of intervention was conducted simultaneously to determine effectiveness of the group therapy as a model as well as to determine outcomes associated with kind of intervention. Outcomes of all three approaches were the same.

In 2013-2014, groups were conducted using a matrix of facilitator skills, needs and activities / modalities / techniques. Specific theme-based modules, based on intensive learning cycles, were designed, to address common areas of concerns raised by clients during their course of needs assessments. Tools for baseline and end line studies were created and included into the research component of groups. A rudimentary observation tool was designed, which when complimented with facilitator and fieldworkers' subjective observations helped in tracking client changes and group effectiveness. Apart from working with high risk groups, the team moved into providing group interventions to the Seher clients in the community- group for people with high support needs (at that time called as 'severe mental disorders').

Until 2014, groups were run as a distinct satellite program of Seher. Group members were not formally included within MIS and client registration. Observations were mostly subjective, made by the facilitator and fieldworker and most session planning was done prior to groups. Session plan structure was rigid when it came to addressing group needs, which was much more dynamic. In addition, facilitators moved in and out of groups. A solid anchor for every

group was not therefore felt by many group members. Clients needing other supportive services were referred to other CBOs and NGOS and many partnerships were established within the community to enable these referrals. The group clients largely seemed to be left out of the core Seher services program. Sustaining the group was a challenge but no solid interventions took off in the direction to make it so.

In 2014-2016, the TG work took a leap forward as most process and systems related issues in the context of the group's service program were standardized. Intensive brainstorming and discussions were conducted to determine micro and macro level processes and systems within the TG framework, M&E and setting this within context of the larger organizational plan and vision. These include:

- Systematic exercises on group facilitation, group process and protocols to be followed.
- Registration of group members as Seher clients, bringing group members within our MIS registry.
- Strengthening identification of potential group members and further processes related to entry-movement-closure and onward journey.
- Determining objective of each group and indicators of change.
- Setting up a TG planning wall through the group cycle with all relevant information on session vision, therapeutic domains, objectives, indicators, activities and plans, for memory recall and easy reference.
- Training schedules for the facilitators and the observers, including training on group facilitation.
- Development of modules on each domain (Self, body, cognition, social, spiritual - cultural, other).
- Establishing roles within the group team and team co-ordination across groups.
- Setting up monitoring and evaluation systems and routine review processes.
- Strengthening the documentation (registers, forms, pre- and post-assessment system, etc.).
- Validating the tools used for pre- and post- tools.
- Linking up the TG members with community processes to make the model a sustainable one.

In its most mature phase, TGs were anchored by facilitators and fieldworkers from the community to facilitate greater accessibility to services and information at both ends. Groups were integrated into Seher mental health services (core) program. Integrating group's intervention as one of the components of a comprehensive mental health intervention program in the organisation brought more accountability to the group, within a defined framework of care, support and recovery. The client could benefit from not just the group support, but all other services within the

1.2 Group flow and process

Preparation

- *Recognize, Identify, Establish Contact, Solicit Voluntary participation, Recruitment through Assessment*

  - Meetings with key persons from the community for ideas, FGDs and an ethnographic baseline if possible, to recognize and identify 'vulnerable' groups.

  - Taking local / staff perspectives of needs, and identified groups and persons, engaging with prospective group clients through one to one meeting, home visits, dialoguing, informed consent and voluntary recruitment into TGs, meeting and dialoguing with family members wherever necessary: e.g. Adolescent boys and girls, caregivers etc.

- *Logistical Arrangements: Venue, Trainings, Materials, Consent Forms*

  - Exploring community venues and selecting one that would be most convenient for *most* participants, being proximal to clients' homes,

  - Having meetings with area corporator and other key resource persons to seek community consent to run group in the selected venue and area, if necessary, getting a written letter of permission from him

  - Initiating trainings of group teams in different roles (facilitator, observer, trainer, logistics support, home visitor, etc.), building their skills and capacity in appropriate roles

  - Consolidating materials required for sessions: charts, instruments, paints, handouts, posters, props etc.,

  - Enrolling each member to the group, reading out consent form to each, explaining the same and seeking signed consent on the forms

- *Assessments and Pre-Tests*

- Assisting group members to Centre for needs assessment through Seher assessment process, registering the members

Initiation to Closure (Implementation)

- *Conducting Sessions-Session Planning-Rehearsals-Home visits-Follow Ups-Referral (In House/External)-Maintaining Records-Documentations*

  Once 'what to do', 'how to do', 'with whom' 'when and where' and 'who will do it, of the TGs were sorted, the team entered into the actual implementation of groupwork.

  - Roles of the team, group objectives are determined (through the needs assessment and baseline study of clients) and finalized.

  - The facilitator and fieldworker team of every group worked together to make the actual session plans in a form called the SRS (Sessions Record Sheet) the plans are shared with the TG co-ordinator / leader

  - Practice sessions are held over 1 or 2 days to revise the sessions plans, activities, addressing roadblocks and to prepare for Plan B, C, etc.

  - Implementation of the sessions and feedback mechanism with team and co-ordinator

  - Establishing contact with each group member for mobilizing them to attend session through home visits and follow up visits

  - Entering the logistics (footfall per group), sessions plans, actual description of the session, changes observed through the observation sheets, etc. are documented immediately and sent for MIS data entry.

In this way, a*bout 20-25 sessions are conducted in all per group, including assessment and closure, with one session held once in a week for duration of 1 to 1 ½ hour each.*

Review meetings are conducted once every two weeks to touch base with all group team members, exchange news and information, make forward plans, set timelines, resolve technical or field issues, provide and accept feedback of peers, track movement and speed of group progress. In addition, case conferences are conducted once every two weeks to discuss barriers to therapeutic change and figure out improvement of skills or new interventions with them. If required, group members are referred internally for support counselling sessions, lay counselling sessions, intensive individual sessions, family or social interventions. External referrals are made to other organizations which may be able to help the group member. For e.g. many women suspected of being malnourished are referred to the local public health hospital for general health check up and procuring vitamin supplements; in addition to providing nutrition feedback in sessions. In every session, some example of nutritious, balanced food is

provided, and information given, so that members can improve their nutritional intake at their homes.

- *Networking & Partnerships*

  Contributions from a number of people and organizations go into supporting group members who form the T.G.s: E.g. venue within the community provided by the local corporators or local governments, resource support from *anganwadi* and *balwadi*workers, the RCVs, local government departments or authorities like the DV cell of the UCD, Sonawane hospital or local youth groups, clients and their families etc.

- *Participants move on*

  Once the groups close, participants chose either of the one route:

  1. Psychosocial issues are resolved, and the member moves on, it is so recorded in the documentation

  2. Member does not require group services but requires other services such as support counseling or livelihood help, and suitable referrals are made

  3. Member requires continued groups support, is referred to other supportive/peer groups run by the organization

  4. Member becomes a self-volunteer and refers other community members to Centre, provides peer support or offers other kinds of support to community members

  5. The member is recruited voluntarily into the CMHV program, or

  6. The member is inducted into the UCDs RCV program.

  Whichever way a person decides to go, every member has the potential of doing basic mental health work in the community to various extent. A grassroots cadre is thus developed as an outcome of the T.Gs.

- *Post Tests*

  Conducting base and end line study for ever member in every group is part of the research protocol of T.Gs. A team of trained individuals who are not involved in the services, administer the research tools. All data thus collected are entered into the organizations MIS system and marked for analysis by statisticians and researchers to study and determine intervention impact. The study informs the organization about the efficacy of the group strategies and contributes in refining the program further. Incidentally, such studies also contribute to research.

- *Evaluation*

Bapu Trust has done a systematic impact study for the single women's group in the past. An evaluation study, in collaboration with Forbes Foundation, which has supported this work, has been undertaken. The objective is to assess changes that can be attributed to TG intervention program and demonstrate it as an effective intervention strategy to invest in, within a comprehensive urban community mental health and inclusion program.

1.3 Therapeutic cycle protocol for the groupwork process in the community, Flowchart:

1. Decide group

What is the group you want to work with, why?

⇩

2. Group Members Identification

Who are the group members, How will you identify them?

⇩

3. Group members recruitment

Recruitment to group services based on standard recruitment procedures of the organization

⇩

4. Group Members Needs Assessment

Needs Assessment to be done either as part of recruitment process or as a baseline study of members before groups (for evaluation purposes); what tools will you use?

⇩

5. Group Goals and objectives

Once individual and group needs are identified, organize them into group goals and objectives (what outcomes would you like to see, or what changes do you propose to bring about)

⇩

6. Session Plan

What will you do in the sessions to achieve your group objectives/goals (methods, techniques, activities, logic to sessions etc)

⇩

7. Indicators

How will you determine if the objectives are being realized: development of appropriate indicators against each objective? Who will observe, what will the observation tool look like

⇩

8. Logistical Arrangements

Thinking about session venue, timings, how many participants, open/closed groups, how frequently, total no. of sessions etc

⇩

9. Documentations and Recordkeeping

What documentations, records, and registers will you maintain and where: e.g. Session record sheets, audio visual footage, attendance sheet, observation forms etc

⇩

10. Roles: who will do what in the groups

Who will do what task and for how long, having good and realistic role clarity: from research to service provision to advocacy

⇩

11. Group Monitoring and evaluation systems

Group review meetings, reporting lines, crisis management etc

⇩

12. Important strategies to remember

Consent, contract, home visits, liason, resourcing, referrals, involving caregivers, alternatives

⇩

13. Group Closure

Consolidating learnings, setting forward directions

⇩

14. Report writing

⇩

15. Sustaining group

(CMHV program, linkages with UCD, local agencies, training and capacity building)

2. Evaluation Report

'Running therapeutic Groups in Low income Communities'

Sadhana Natu, Ph.D. [2]

2.1 The Objectives of this Evaluation study are:

a) Impact (immediate and long term) on their group clients since the beginning, especially after applying the 8 Point Recovery Framework. which focuses on Self and Self -care, Nutrition, Family Counselling, Group therapy, Individual counselling, Health care, livelihoods and the client.

b) Impact on systems (Sonawane, MaNaPa, quality of partnership relationships).

c) Quality and effectiveness of the M&E system used by BT

d) Finally, comments, lingering challenges and unresolved issues.

2.2 Study Design and Methodology

The following design and methodology were used in this study:

1. Perceived impact of the TG on psychosocial coping mechanisms of the user was measured by a tool developed by Dr Sadhana Natu.
2. Perceived impact of TG on clients and their families in terms of long-term sustainability was assessed through Brief Interviews with a select number of clients and their families.
3. Overall impact on Systems was assessed through Key Informant Interviews with Sonawane hospital Staff, Tarun Mandal and other functionaries in the community.
4. Assessment of current M&E systems was done through analysis of current systems in use and interviews with Bapu Trust key personnel.

Sample Size:

1. Around 75 persons covering the subcategories of Common Mental Disorders, Severe Mental Disorders, Single women, Pregnant women, adolescent boys and girls, care givers and DV victim users of TG.
2. Inclusion of entire client sample, leaving those who have moved on, do not want to participate, etc.

[2]Sadhana Natu (PI), led the evaluation of the satellite programme along with her team.

3. Around 4-5 interviews each, of clients and families for obtaining nuanced information about long term impact as well as challenges and unresolved issues.
4. 5/6 KII for impact on systems (MaNaPa, Sonawane staff, Bapu Trust staff, CMHVs, etc.)

Report Writing:

1. Analysis of quantitative as well as qualitative data.
2. Reports of TG group and other resource material generated by Bapu Trust were used as additional data sources.
3. Recommendations for going ahead.

Information about the tool:

A tool on Coping Skills was prepared by PI with assistance from the team. It is a 4-point Likert Scale with the responses of 1= Never, 2= Sometimes, 3= Usually and 4= Always. The tool consists of 27 items with dimensions of problem solving, physical coping, psychological coping, emotional coping and social contact. The items were then transferred into a random order and the tool was finalised. It was translated into Marathi and Hindi in order to be useful in the community.

Procedure:

The team used a chart with the legends for the scores (1,2,3,4) for better communication with the respondents and to explain the meaning of the ratings and used several examples. A mock administration of the test was conducted and after that the data collection schedule was completed. All the ethical guidelines were followed rigorously, and informed consent was obtained from the respondents. Confidentiality in data collection, management and dissemination has been maintained.

Scoring:

The items were scored using straight scoring and the total score was computed. Its classification is as follows: 27-54 low coping skills, 55-80 average coping skills 81-108- high coping skills.

2.3 Brief Review of Literature

The UNDP Sustainable Development Goals 2030 have a broader sustainability agenda than the Millennium Development Goals of 2000. They want to address the root causes of poverty and

the universal need for development that works for all people. Many of the SDGs of 'good health and well-being, gender equality, reduced inequalities, sustainable cities and communities, peace and justice, strong institutions and partnerships for the goals sit well with the vision and mission of BT as well as TG, and the entire Seher project.

TG are also anchored and in tandem with United Nations Convention on Rights of Persons with Disabilities (UNCRPD). BT has been both a service provider as well as advocacy organisation since its inception. It has been involved actively in TCI Asia Pacific and various other actions at the international level and Jan Maanasik Arogya Abhiyan at local level and National Alliance on Access to Justice for Persons living with a Mental Illness at the national level. They have created multiple strategies of research, trainings, information activism, collectivization and peer support, in order to address the problems related to service provision and advocacy. Their research makes a studious effort to fill in extant psychiatric research with voices of persons with psychosocial disabilities by making linkages between gender, culture, development and human rights (Davar, 2016).

People with mental illness were hitherto considered "non-persons", lacking recognition before the law, on any life dimension. The macro-environment within which the mental healthcare system, supported by the Mental Health Act 1987, still works is that of custodial law. However, in 2007, the government signed and ratified the United Nations Convention on the Rights of Persons with Disabilities, which shifts the policy gaze away from a medical model to a more encompassing social paradigm, where long-term impairment - physical, mental, sensory, or intellectual - combined with social barriers is understood to create disability (Davar, 2012).

It is within this ambit of psycho-social disabilities that BT and TGs operate. In this journey they have worked on facilitating a variety of community-based strategies and skilling of communities for peaceful, healthy and harmonious living. For BT, 'Inclusion' and 'well-being' have been the key words in planning for mental health. BT has also been a facilitator for Transforming Communities for Inclusion in the Asia Pacific regions, working with 21 country partners. In the process, it has deconstructed the notion of community' Bapu Trust did not assume that 'community' means 'family'. Community included enabling 'Social capital'… a network of interlinked resources available to people on daily basis, and available to people as safety net when someone needs it. Seher recovery groups may be led by peers, but a peer is not just a user / survivor; rather a 'peer' was someone who shared the socio economic and other elements of marginalization (ethnic minorities) with group participants (Davar, 2014). It is

against this local and global backdrop that the work of TGs must be understood and interpreted.

The 'community mental health approach' ensures greater attention to the impacts of context, culture and local survival strategies on peoples' responses to adversity and illness, greater acknowledgement of the agency and resilience of vulnerable communities and increased attention to the way in which power imbalances and social iniquities frame peoples' opportunities for mental health (Campbell & Burgess, 2012). Researchers in the field underscore the point that delivering mental health care in India will require task-shifting. Responsibilities will have to be shared with the community and non-physician health workers who are trained and supervised (Patel, 2010). The field worker driven, and community centric approach of BT underscores the community mental health approach.

The District Mental Health program which began with ambitious objectives has remained largely dysfunctional and ineffective in practice (Murthy, 2011). Looking at the unmet burden of the mental health of the urban poor, the significance of the work that Bapu Trust has undertaken in the form of TGs specifically and Seher in general cannot be emphasized enough.

The TGs project in particular and the current work of BT in general, reflects the UNCRPD paradigm shift from the medical model to a more encompassing social paradigm, where long-term impairment (physical, mental, sensory, or intellectual) combined with social barriers is creates disabilities.

UNCRPD melds together socio-economic and civil-political rights in ways that makes human rights truly indivisible, inalienable and universal for all people with disabilities. It also recognises the existing and potential contributions made by persons with disabilities to the overall well-being, and diversity of communities. Disability is considered evidence of human diversity and potential and not an obstacle or a hindrance. People with psychosocial disabilities are perceived as 'legally capable human beings' who can contribute to sustainable development.

When, all the UNCRPD rights are ensured by a state, a world where people with disabilities are fully included and participating in their communities, living independently, with dignity, and able to make their own choices, can be envisaged. There is a view expressed in international advocacy that Article 19, embodying the "right to live independently and being fully included

in the community" is perhaps a new right offered by the UNCRPD. For people with psychosocial disabilities, this could be the foundational right on which to pitch all advocacy efforts (Davar, 2014). It is plausible that the future work of therapeutic groups in particular and Seher project and Bapu Trust in general is geared towards taking steps in that direction.

2.4 Findings of the Evaluation

2.4.1 Sample for the Evaluation (Empirical Study):

Status of the Client	No. of forms
Completed	77
Dead	04
Migrated	20
Not consented	05
Not attended TG	31
Not available	25
Discarded	02
Married and moved away	12
Total	176

Table1: Sample for the Evaluation (Empirical Study)

2.4.2 Demographic Data tables:

a. Category wise:

Category	Number of Clients
A. Single Women	3
B. Single Women	4
C. Single Women	5
D. Adolescent Girls	8
E. Adolescent boys	17
F. DV[3] Group	5
G. PW[4] Group	8
H. MR[5] caregiver	8
J. SMD[6] group	7
K. DPS[7]	5
L. Pregnant Women	4
P. SMD group-continuation	2
Q. CMD[8] group- current	1
Grand Total	**77**

Table 2: Category wise break up

[3] DV- Domestic violence,
[4]PW- Pregnant women
[5]MR: Children with intellectual disabilities
[6]SMD: Severe Mental Disorder
[7]DPS: Depression and Psychosomatic Symptoms
[8]CMD: Common Mental Disorders

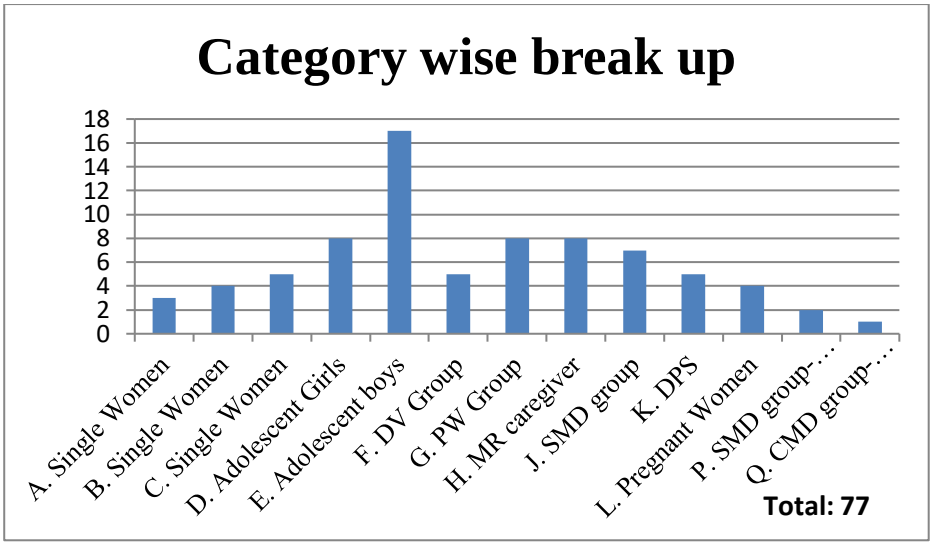


Chart 2: Category wise break up

b. Age wise:

Age	No. of Clients
Age 14-30	44
Age 31-60	32
Age Above 60	1
Total	**77**

Table 3: Age wise break up

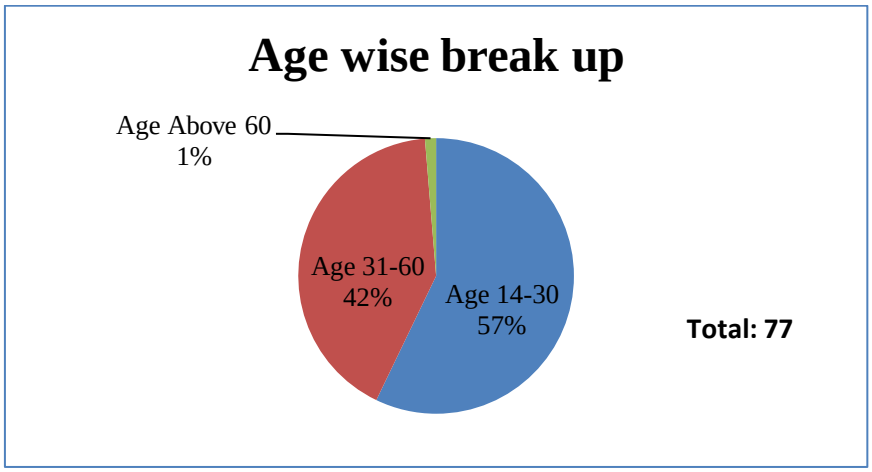


Chart 4: Age wise break up

c. Gender wise:

Gender	No. of Clients
Male	23
Female	54

Table 5: Gender wise break up

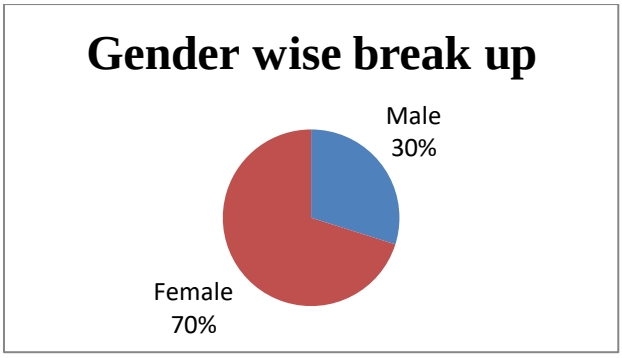


Chart 6: Gender wise break up

d. Marital Status wise:

Status	Number of Clients
Divorced	3
Married	26
Separated	7
Single	27
Widowed	14

Table 7: Marital Status wise break up

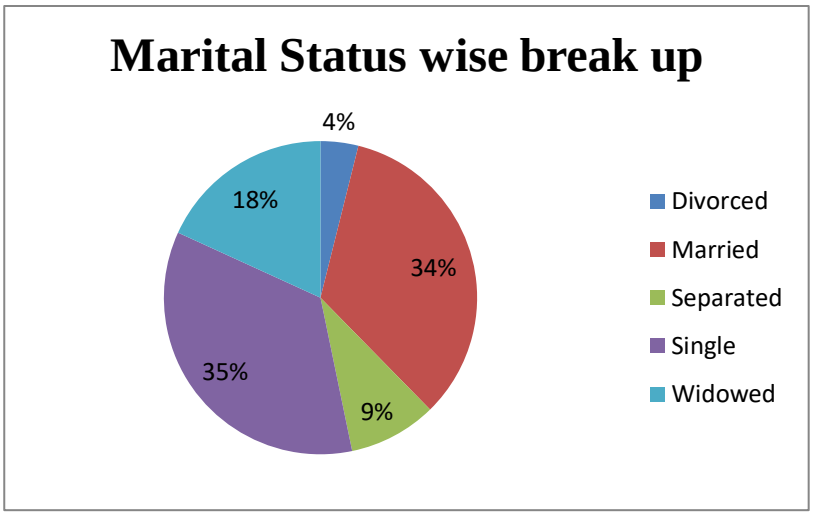


Chart 8: Marital Status wise break up

e. Family Type wise:

Family Type	Number of Clients
Extended	8
Joint	41
Nuclear	28

Table 9: Family wise break up

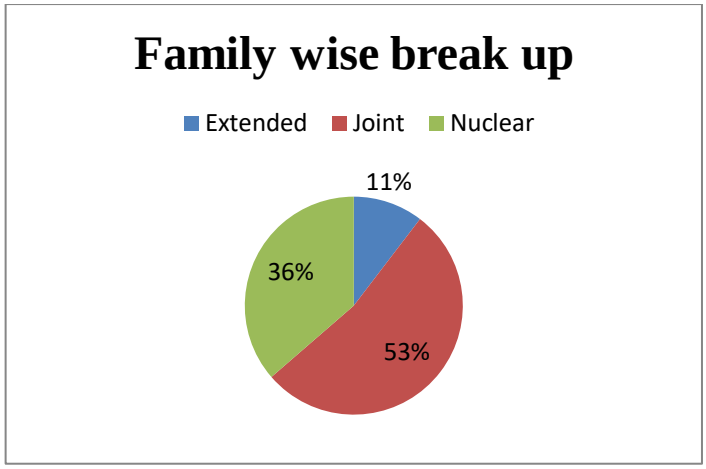


Chart 10: Family wise break up

f. Literacy:

Literacy	Number of Clients
Non-Literate	12
Literate	65

Table 11: Literacy wise break up

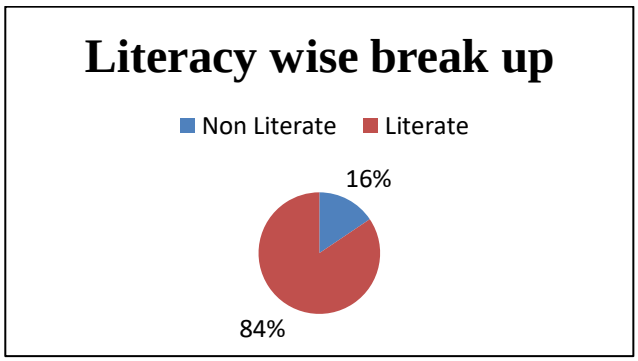


Chart12: Literacy wise break up

g. Religion:

Religion	Number of Clients
Hindu	48
Muslim	18
Neo buddhist	11
Grand Total	**77**

Table 13: Religion wise break up

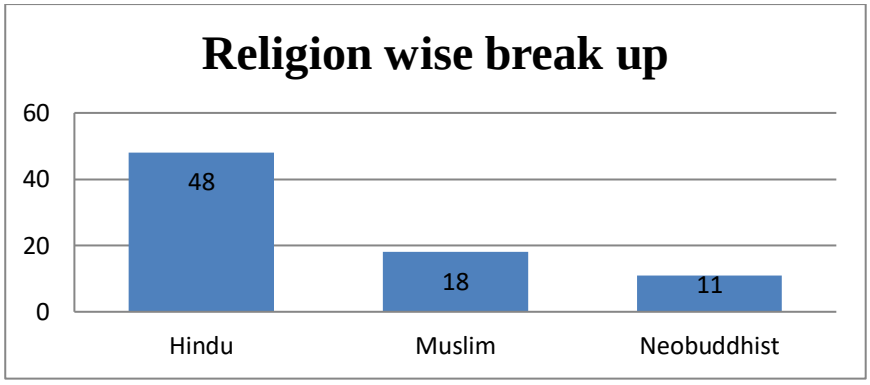


Chart 14: Religion wise break up

h. Caste wise:

Caste	Number of Clients
Not Applicable	26
Bairagi	1
Kalwa	1
Koli	1
Mahar	5
Maratha	7
Matang	29
Padmashali	4
Pardesi	1
Shimpi	1
Kshatriya	1
Grand Total	**77**

Table 15: Caste wise break up

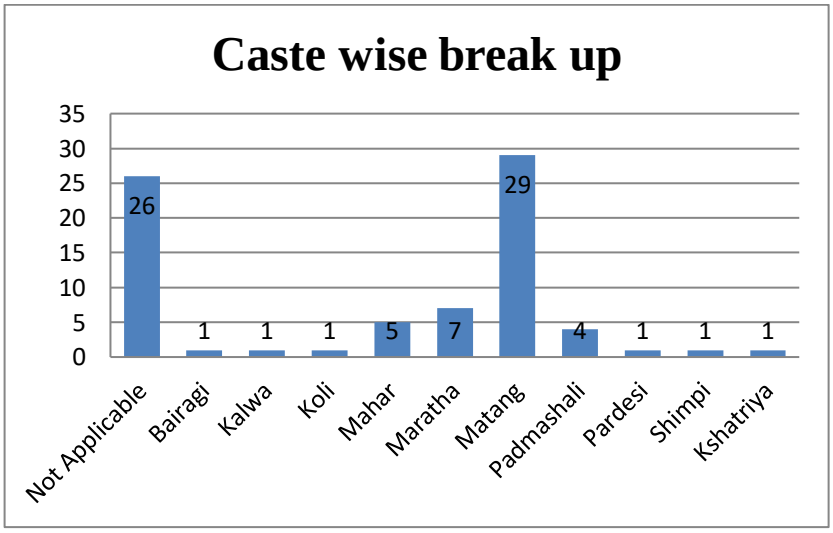


Chart 16: Caste wise break up

2.4.3 Coping Score Distribution:

a. **Low – 27 to 54:** No Client was found with a Low Coping score.

b. Average – 55 to 80:

Category	Number of Clients
A. Single Women	1
B. Single Women	2
C. Single Women	4
D. Adolescent Girls	2
E. Adolescent boys	9
F. DV Group	4
G. PW Group	5
H. MR caregiver	6
J. SMD group	4
K. DPS	3
L. Pregnant Women	3
P. SMD group-continuation	2
Grand Total	**45**

Table 17: Coping score distribution for Average grade

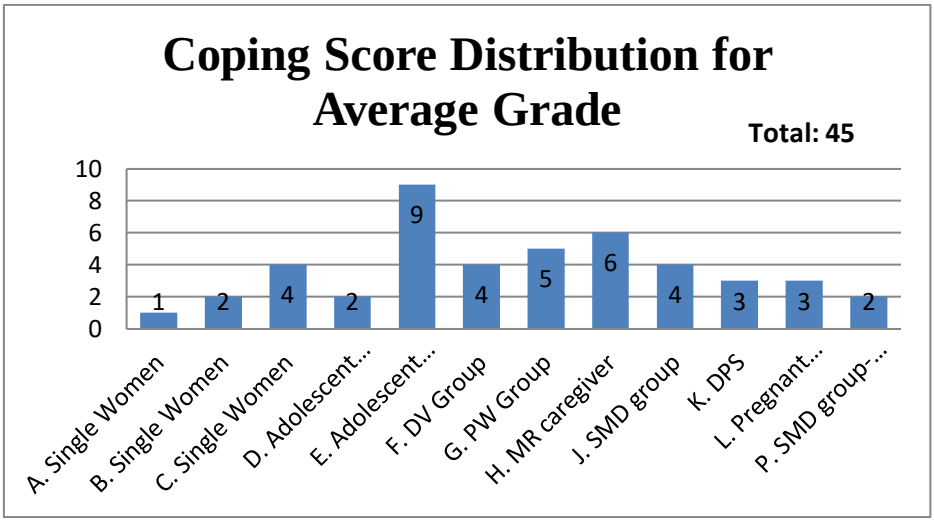


Chart 18: Coping score distribution for Average grade

c. High – 81 to 108:

Category	Number of Clients
A. Single Women	2
B. Single Women	2
C. Single Women	1
D. Adolescent Girls	6
E. Adolescent boys	8
F. DV Group	1
G. PW Group	3
H. MR caregiver	2
J. SMD group	3
K. DPS	2
L. Pregnant Women	1
Q. CMD group- current	1
Grand Total	**32**

Table 19: Coping score distribution for High grade

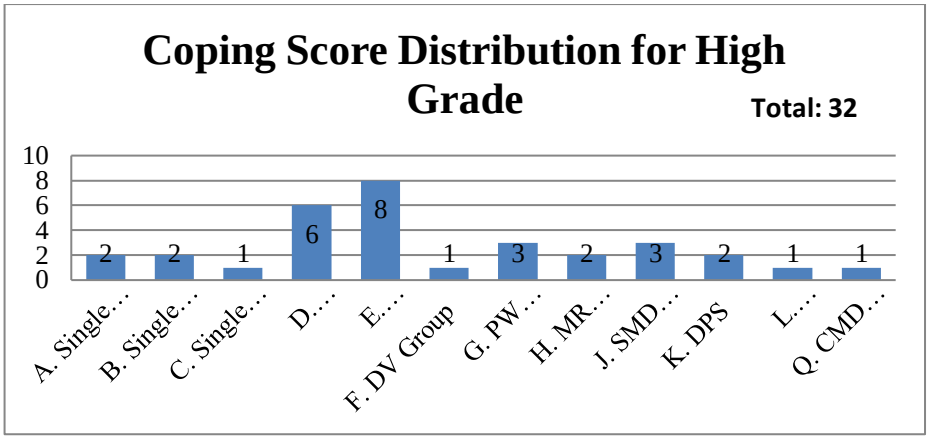


Chart 20: Coping score distribution for High grade

2.4.4 SMD total number of clients age wise differential

	Age	25	27	30	33	45	50	55	60	Grand Total
	Number of Clients	1	1	1	1	2	1	1	1	9

Table 21: SMD clients Age wise differential

2.4.5 Benefit of TGs:

a. Individual benefit:

Score	Number of Clients
Never	4
Sometimes	19
Usually	22
Always	32
Grand Total	**77**

Table 22: Therapy group – Individual benefit

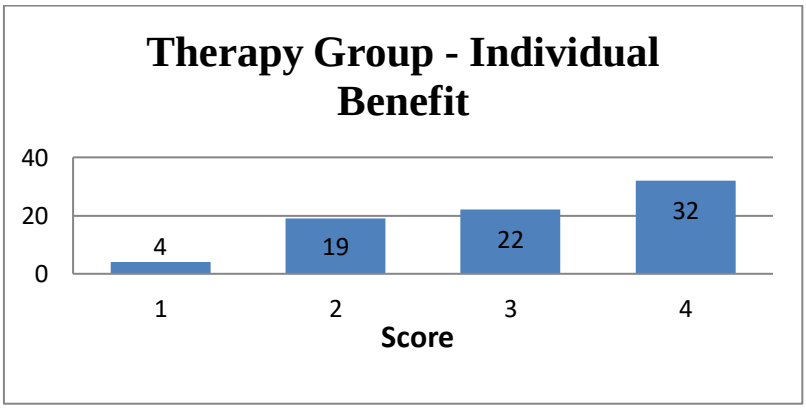


Chart 23: Therapy group – Individual benefit

b. Family benefit:

Score	Number of Clients
Never	8
Sometimes	13
Usually	24
Always	32
Grand Total	**77**

Table 24: Therapy group – Family benefit

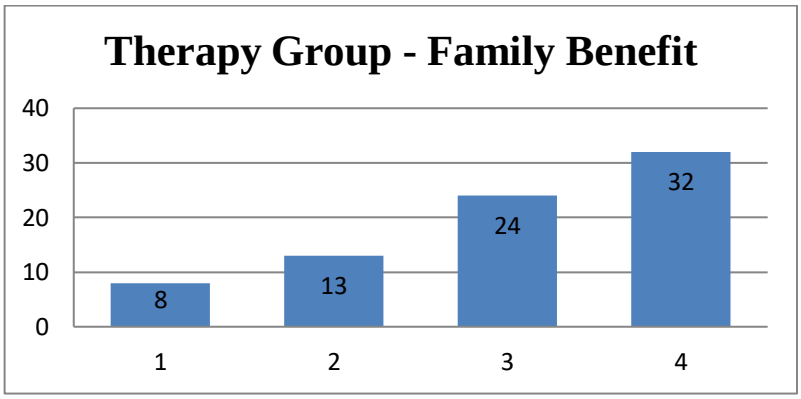


Chart 25: Therapy group – Family benefit

The tool was primed to ask questions related to coping in the context of attending TGs. None of the respondents got a low score on coping skills. 45 respondents got an average score on coping and 32 respondents got a high score on coping. TGs helped majority of respondents to cope well.

In response to the question about benefit for the individual after attending TGs 4 said never, 19 said sometimes, 22 said usually and 32 said always. In response to the question about benefit of TG for the family, 8 said never, 13 said sometimes, 24 said usually and 32 said always. TGs were found generally useful for individuals and families.

There were 9 SMD clients amongst the 77 respondents.

2.4.6 Qualitative Analysis

a) Impact on Systems assessed through Key Informant Interviews

1. Senior Nurse, Sonawane Hospital
2. Security Guard at Sonawane Hospital
3. Head, Dept. of Psychiatry at Kamala Nehru Hospital
4. Manus Pariwar, an NGO
5. Homeopath
6. Senior Psychiatrist and Private Practitioner

The Senior Nurse knows about the work of BT since the last 2 years. She knows that they work to create awareness about mental health. She and the other Nurses attended a session that was organised for them. This training was found to be important and useful. It consisted of exercises related to breathing, drawing, music etc. It gave some breathing space to the overworked nurses. They were also able to express their thoughts and vent out their feelings. They also listened to an informative talk about stress.

The Nursing staff appreciated the help that Seher gave the patients from the *basti*. The efforts that Seher makes to reach out were also appreciated. She felt that BT should increase their efforts of information dissemination about mental health. Her feedback indicated that Seher has succeeded in building an excellent rapport with the para- medical staff at Sonawane hospital. It also indicates that nurses involved in General Nursing as well as OT require stress management workshops!

Security Guard has known about the work of Seher since the last 4 years. "They work on mental disorders". She spoke about a patient X from the *basti* whom she has observed closely. She said that earlier this patient would speak a lot of gibberish, her appearance was unkempt. But with the interventions made by Seher she has seen “a visible difference in this patient”. Now she has a bath, looks neat, speaks properly and has a normal routine and takes her medicines regularly. Earlier we avoided speaking to her, now we don’t. “I have seen this change, improvement”. Another person Y, who was also in a bad condition, had also improved. She attributes these changes to the ‘groups’ that Seher conducts with songs, games, food and fun. She says that she directs patients and others who have psychological problems to Seher." A lot of patients ask us about the work of BT since they are in the premises and I do not hesitate to refer people to BT as I am sure that they will get help". She was all praise for the field staff and said that they have managed to build a relationship with the people from the *basti*. They

treat the people from the community with familial acceptance. She felt that BT should also do similar work in the hospital at Gultekdi Market yard which is accessed by many patients whose mental health problems could be solved.

#Senior Psychiatrist and HOD, Kamala Nehru hospital was like a hostile witness! She said that BT claimed that there were beneficiaries, but since they did not refer patients to her this was all hearsay for her. According to her, "If a patient is not violent then he can be treated in the community and does not need in door treatment or government services. In such cases grass root level organisations and their services are needed in the community". Since she is busy with work in Kamala Nehru, Sassoon and Sonawane hospitals she has not seen or met the patients "that BT claims to have helped".

In a country like India where the number of psychiatrists is so small it is a luxury to consult one, for an ordinary citizen. There is a lot of stigma attached to consulting a psychiatrist too. In such an atmosphere very often GPs (MBBS, BAMS, and BHMS) do not do referral to us, was her complaint. Government health services and NGOs should work together and in tandem. Right now, she felt that the NGOs had an upper hand, had too much freedom, and very little accountability.

Her department was working without a Social worker and psychologist and they were much needed. This set up should improve. NGOs role is supplementary, she felt. Seher has acquired Corporation space and funds, but they are not transparent in their approach and work. There is a need for more transparency. If Seher has developed a new model of psychosocial mental health, then they should share both the information and credit with the Corporation, why not include us, is her question.

This is a government set up and why should the demands of Seher be entertained. She accepted that the field of mental health and psychological problems is very challenging, and more people were needed in this field to face these ever mounting challenging. So, she did not want to discourage the efforts of BT, but she expected more openness from them and a genuine partnering with the Corporation authorities.

This interview must be viewed in the context of a turf war that some government officials want to wage, when it comes to service provision. They are willing to view people centric organisations as their partners in development and bringing about social change. It also reflects the underlying tensions between 'official *babudom*' and a CBO like BT which works on a rights-based perspective.

Manus Pariwar is an organisation that works in adjoining *bastis* on various welfare activities. They have known about the work of BT since the last two years. Though they have not attended any of the programs organised by BT or collaborated on any activity, they said that they have heard good things about BT from the community. They are aware that BT is doing good work. "M*aybe we should organise some programs together and collaborate in the future. Since we are working in the area of physical health and giving free medicines and running a free clinic for poor patients, we are sure that some common goals can be thought of. May be the main persons in our organisations should discuss this in detail. Though we have not spoken to people from the basti directly about BT, we do know indirectly that their work on mental health is good and important".*

Homeopath visits BT once a month. She came to know about BT's work in mental health and volunteered for this task. She said that this experience of dealing with patients who are from completely different strata, from her Upper middle-class clients whom she treats in her private practice has been a great learning experience.

She was all praise for the field workers who help in case history taking, follow up and checking whether the patients are taking their prescribed medicines regularly in their home visits. They are thorough and systematic. This is really important in case of patients with psychosocial distress. In case of schizophrenics whose behaviour is erratic and sometimes violent, changing their behaviour patterns, stressing the importance of personal hygiene, providing them with an enabling atmosphere to recover, is a big challenge.

Handling patients with depression who are not willing to interact and sometimes unresponsive is also difficult. Families do not always cooperate, and they do not allow the patient to come and see her. Hence, she is 'groping in the dark', but feels that she is able to bring about some change in them through Homeopathy. She cites the case of a Hemiplegic patient who has recovered, has found social acceptance, rehabilitation and a job. She attributes this success to the steadfast work of BT.

She knows that only medicines are not enough with patients with mental issues. If the efforts to maintain their mental health is not sustained and they do not get social acceptance, these patients go back into the vicious cycle. She feels that a holistic approach with the help of OPD, Field workers, volunteers, Homeopathy, Ayurveda is essential. BT needs more volunteers and field workers. Mental health is a very demanding field, any amount of work you do is not enough, and so much remains to be done!

Senior Psychiatrist has known BT since 2000. He expressed a very positive opinion about BT. They are full of ideas and they don't remain just ideas, they act on them and implement them consistently. Their developmental perspective is so important. Their critique of ECT, medicines and overcoming the stigma of mental illness to reintegrate the clients/ patients into society and community is commendable.

He believes in the philosophy of 'support for the needy and freedom for the resilient'. He feels that BT succeeds in both. Their use of ABT and Alternative therapies was also appreciated by him. Also, the BT methodology of backing up their intervention with sound and solid research was praiseworthy. The study on caste and stigma was also important.

His suggestion was that when BT was scaling up to 5 communities, they should collaborate with organisations like Tathapi Trust, Sassoon hospital and KEM research centre. There was a lot of scope for collaborations and networking and integration. For instance, BT could run a clinic with personnel trained in Psychology and Psychiatry where he would like to be involved in training. BT should sponsor a project where he and his team would collaborate. He felt that while working on mental health the approach should be 'neither dogma nor stigma'.

An effort was made to seek the interviews of higher authorities in the health department such as Director and Deputy Director Health Services, both in person and telephonically, but due to their unavailability, their interviews could not be taken.

b) Brief interviews of clients and carers:

Overall 16 Interviews were conducted, which included 7 carers and 9 clients.

The two carers of SMD clients reported that they "did not see any change in my daughter/son but was happy that she/he was learning new things." The SMD clients were irregular in their attendance and the carers faced difficulties in getting them to come for the TG sessions. They believed that medicines would help to improve their condition and one of the carers who wanted her son to take Homeopathic medicines was not aware that this service is being provided by BT.

It was evident that they were so overburdened with nitty- gritty that though their daughter and son were attending TG at intervals for a year and more, they did not have enough information about BT and its services. The home visits by field workers are the mainstay of work with SMD clients. The activities like drawing, painting, and *mehendi did* help to calm down the client, but

these are short term benefits. There was no marked improvement in their condition and violence and abuse of the carer by one client was an added problem. Their future, marriage and treatment are issues that remain unaddressed.

Another SMD caregiver said that her brother did *"tell her about what things take place in group. He used to get watermelon, muskmelon to eat. He did exercise, yoga and learned to dance. While coming back from the group, he used to be very happy and used to laugh a lot. She felt like going to group. But she did not go because she used to feel shy about attending*". He attended the group when the field workers came to call him, but not when he was angry. The SMD client who was interviewed seemed very distant and it was difficult to reach out to him. He said that "He likes to play football in TGs. He feels better after playing. When he talks with Bharti madam, his tension reduces. But when he goes home, he feels distress." He was not sure whether he benefitted from TG and sometimes he resented the field worker's home visit. All in all, benefit of TGs for SMD does not seem to be conclusive and there are many challenges in getting the clients to participate regularly.

A caregiver of a person with intellectual disability gave very positive feedback about the benefits of TG for her daughters and herself. Both have learnt self -care, emotional and anger management, she has also learnt more about parenting of children with mental disability. "*They have gained social space in TG"*. They were attending a school for children with special needs, but she was worried about what would happen once they were 18 and finished school. She has referred many children with disabilities to attend TGs. She goes to these children's house for home visits. She was offered work in BT as a field worker. But she could not continue due to the need to stay with her daughters. She continues to play an active role in taking community people to BT. She shared that now she needs guidance about the options for keeping her daughter engaged after they complete 18 year of age.

TGs for adolescent boys and girls has received enthusiastic response. This is what a mother of an adolescent boy had to say: She felt that attending the group brought positive changes in her sons. She was very enthusiastic to share about changes in her sons. "*They have learned how to behave, they have learned gender sensitization and about gender equality, have become sensitive to others and have become socially aware. They have been educated about their body and they have risen above just being 'bastiche tapoori choore' to being well mannered boys. They exercise, play, dance and so on and share with her what is going on in their daily lives. "I like BT very much and was offered a job here too".*

They know now "*how to talk respectfully with girls. They have started respecting elders. Whatever they learn in group, they share with their family members. For example, importance of eating nutritious food*". As a parent, she got to know about physical and psychological changes, adolescents go through. She learned about how to behave with adolescents and need to behave with them as a friend. She said that she likes the way Bapu trust works. Her sons enjoy games and learn through it. According to her, their tension gets reduced. She would like to join BT when she would get free. She wants BT to educate children in community about importance of cleanliness and dangers of addiction. She has studied up to 12th Class and as a parent she seemed aware and emotional stable.

AB group**,** participant mentioned that it had been two years since he had been attending TG groups. He mentioned that he has become more understanding and supportive towards others. He said that BT worked on Mental Health, helping people who were isolated and in distress. He mentioned that he taught dance to the participants of TG and would like to conduct his own group soon. He reported that he has learned to communicate with others without hurting others. About the work of the organization he shared that it helps in creating awareness about mental health, in treatment of people having mental health issues and helping such individuals to participate in the society. He tells his family members about what he has learned in TG. He said that he informs other boys in community and tells them to come to TG. He has not tried to teach people dance to reduce stress, but he would love to teach. According to him, in Lohiyanagar people are more aware about the work of BT.

Another member of AB group said that he has been attending TGs for 2 years and since January he is working with BT as a fieldworker. He shared that his experience is very good. He has learned a lot. Before attending TG, he rarely stepped out of his house. He used to get angry very easily. Now he goes out of the house and does not get angry much. He tells other boys in the area about group and he has brought new clients to TGs. He attended group session and individual session. He learned a lot from Self-care session. Now he teaches the clients about Self-care. He informs people in community about the organization. He feels little scared to talk in front of lot of people. In Rajewadi, he conducts corner meetings. He participates in street plays on awareness of addiction. Overall, he showed good insight about himself as well as the work of BT.

An Adolescent Girls group participant narrated her experience. She has attended the group regularly. She has got to know about TGs from Almas. Now she is 21 years old and is doing beauty parlour course. When she got to know about course, she told her other friends and asked them to also attend it. In TG, she learned about how to calm down when she gets angry. She understood the importance of nutritious diet. She did paint, acting and dance in TG. She said that it helped her to vent out her feelings. Whenever she gets angry, she meditates. This helps her to calm down. In group, she got to know new friends. She understood how to communicate without hurting others. Before attending group, she used to get angry in conflicts at home. She used to fight with others. But after attending group, she does not fight much. In her house, she has her mother, father, brother and sister. Her mother came once to group. In the beginning of the interview, she was little bit shy and hesitated to speak.

Another member said that she got to know about group from Almas. She is doing beauty parlour course. Earlier she had lot physical complaints. She attended group. In the group, she learned about various techniques to manage physical pain. This helped her to manage her physical complaints. She reported that TG helped her to manage her anger. She used the techniques learned in TG to control her anger. But now since group is closed, she is not using her techniques to control her anger. She feels she uses them it will be helpful for her. She used to take her friends along for TG. She does not know much about work of BT. She is aware about Single women group.

Participant of DPS group said she was a part of '*sadakhushraho*'(*tr.* 'Be happy always') group and was attending the group for five years. She mentioned that when she was ill, field workers looked after her. She gave feedback that there was more work happening in Lohianagar than in Kashiwadi. For five years she is attending TGs. She got to know about TGs from Bharati Madam. She shared that Nazia and Bharti came to her house. She told that she feels happy in the group. She feels weakness and finds it difficult to work. She has to keep on changing the house for 11 months as she is living on rental basis. During interview, there was little pause between her responses. She was getting lost in between.

Another member of DPS said that she is attending the group for more than a year. Before attending group, she experienced dizziness, weakness, fatigue. She could not work. In the group, she was doing exercise, breathing exercise, songs and dance. After doing these activities she felt lighter and calm. After going home also, she felt happy and calm. Now a days also,

she feels scared at times. But its intensity is lesser than earlier. She shared that Bapu trust helped her to treat alcohol addiction of her son. Bapu trust guided her to send her son to Mukatangan Rehabilitation Centre. She meets Homeopathy doctor in Sonawane hospital and takes the medicines prescribed to her. She experiences relief due to medicines. She was sharing her experience happily. There was kind of positivity in her narration. Her responses were spontaneous.

A member of DV TG said that she was attending TGs for more than a year. Almas and Nazia came to her house. Before asking questions, she started narrating her experience of TG. She was sharing her experience happily. There was smile on her face through- out the interview. She wanted to share a lot. She shared that in the group her tension reduces. Everybody laughs, has fun. She enjoys listening to stories, drawing, drumming. In TG, she learned about nutritious food, diet helping to improve Hemoglobin, importance of exercise. She met new friends in TG. She went through two divorces. She used to stay worried due to comments of people. She felt immense happiness in TGs. She tells others who are tensed to attend group. She told that she has learned to take help of others whenever she needs.

She lives with her parents. Her family knows about the group. Her mother has attended the group once. But they are not in favor of attending TGs. They think it is waste of time. They allow her reluctantly. So now– a-days she does not attend TGs regularly. She was offered work in BT of making charts. She wanted to do that work. But her parents opposed her due to less payment. She said it is not in her fate. She has to listen to elders.

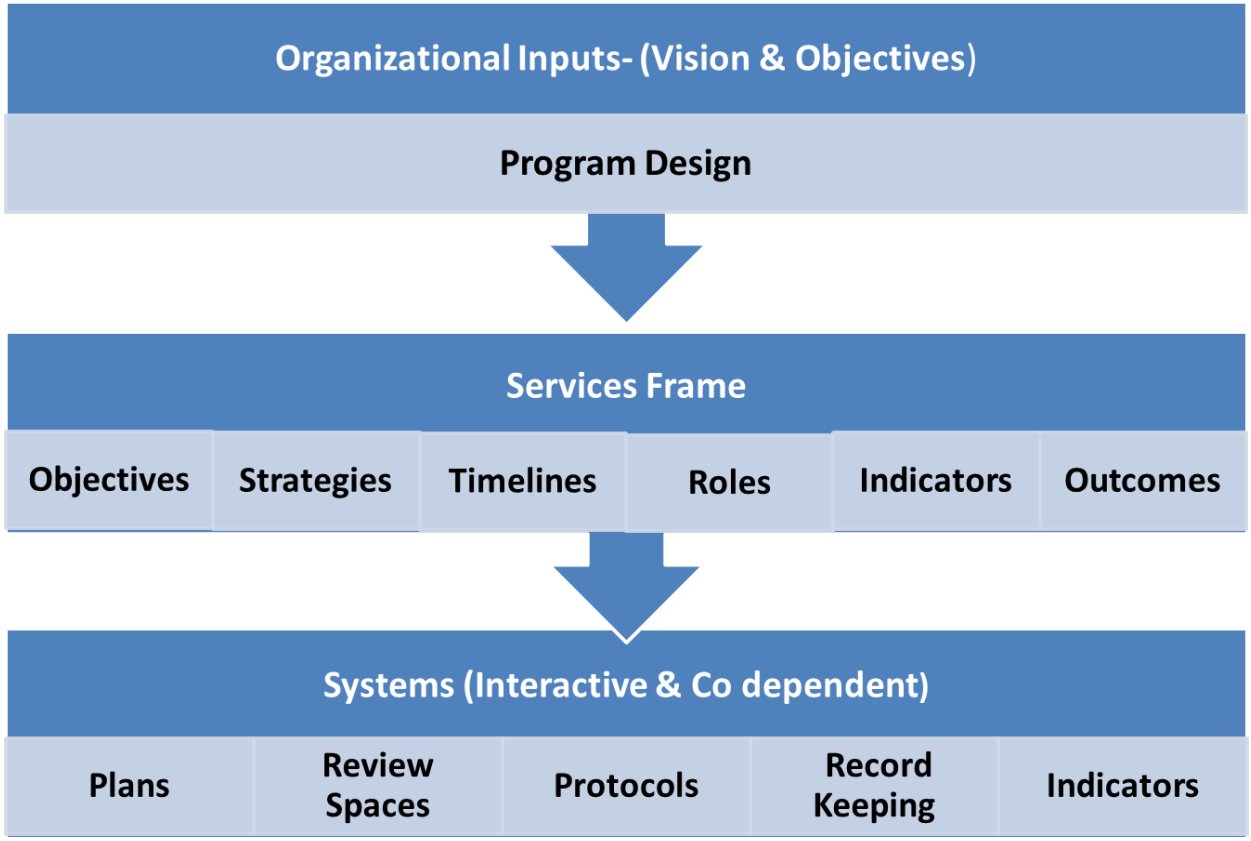
Single women Group participant said that she was attending for 1.5 years. Almas came to her house and told about the group. She said she likes the group. She learned to talk in proper way. She enjoyed doing painting, dancing and exercise.
She shared that she tells other people to join group. They just listen, but don't come.

Two pregnant women (PW) caregivers were interviewed. One PW caregiver said that her daughter-in-law used to attend group regularly. Field worker came near her house and asked her whether there are any pregnant women. She told about her daughter-in-law and other pregnant women in neighborhood. Her daughter-in-law used to tell that madam teaches good things in TG. In TG, her daughter-in-law used to get coconut water, dates, *chikki*, and *shengacheladoo* (tr. peanut delicacy). Due to this, her daughter-in-law's health was improved.

She used to look good. Her daughter-in-law had normal delivery. She did not know much about BT and the group. She could not attend group as she used to take care of her other grandchildren when her daughter-in-law attended group. Overall, she could not say much about TGs.

The other PW caregiver was unwilling to give the interview. Finally, she agreed to do so reluctantly. She was playing some game outside. She said that the group was not at all helpful for her daughter-in-law. She said that her daughter-in-law attended the group regularly. There she used to drink coconut water and did Yoga. During the whole interview, she repeated that her daughter-in-law does not tell her anything and she does not go to ask her anything. She shared that her daughter-in-law had high BP which resulted in swelling. She said that there was proper care taken by family. Her daughter-in-law had normal delivery. But the child was dead at birth. She has not heard about BT. She did not have benefit due to group. She does not tell anything about group to other people. She had lot of negativity in her narration. She was angry due to death of her grandchild.

3. Quality and effectiveness of BT M&E system



SEHER Services Program – BAPU Trust

Services for the clients are made effective through various forms used to identify objectives and outcomes.

Types of forms used:

a. Client Card, Client registration form
b. Corner meeting form
c. Awareness meeting form
d. Client Assessment form
e. Nutrition assessment form
f. Social and family assessment form
g. WHO-SRQ, WHO- QOL, HTP, DASS, BPRS assessment forms
h. Information on addiction form
i. Mental health baseline and end line survey forms
j. Follow up form
k. Exit or Closure form
l. Daily monitoring formats
m. Home visit record sheets (individual, family, group)
n. Support counselling Intake sheet
o. Group attendance sheet (for clients)
p. Group observation form
q. Monthly Report format for field staff

Every client who enters the Service frame does so through various stages such as filling the survey form, client registration form and undergoing the 5 assessments with the help of standardised tools as well as nutrition, social and family assessment and information about addiction. After a working diagnosis, he or she enters the 8 Point Recovery Frame. Then feedback is taken after every session and a client attends at least 25 support sessions, followed by some revision sessions. There is strong, firm contracting of clients and diligent follow up. Clients also fill a follow up form and after recovery an exit or closure form.

This procedure indicates a well thought out service provision model which is an outcome of research and deliberations. It is also a vast improvement on the earlier process of service delivery.

The Staff follows the following protocols: client work, group work, crisis, session and safety. This is reflected in the daily monitoring format of family counselling, group counselling,

support counselling, survey forms, home visit and follow up, group work, case discussions and other work. It validates the fact that the protocols are matched by meticulous documentation and record keeping.

Record keeping is done at every level for every action, meticulously: There is a Client Work register where all the field workers make entries of work done and by whom is it done. This register gives a clear picture of what is happening in the field, at a glance. Besides this, Client Tracker data base has been developed, which is also an improvement on the one used earlier. Pre and post testing of clients is done by the research team, independent of the service team.

For Planning the following systems are used: daily diary and charts, weekly, monthly, quarterly and annual planning and reports. This system helps to plan the targets and to assess the outcomes and do course correction. Sometimes the staff is very busy with daily tasks and they must fill their daily diaries on Saturday. They also use a planning wall where every staff member's responsibilities, goals, objectives, indicators and activities are written down. It serves as a ready reckoner of the targets that they must achieve on daily, weekly, monthly and yearly basis.

The Indicators used for performance evaluation of the staff and the work done are: performance guide (impact assessment of work done for 3 months' timeframe), monthly reports and 360-degree feedback.

3.1 Focused Group Discussion with Staff members

In the FGD the staff expressed that sometimes there were visitors and evaluators who came to BT and this did have an impact on their day to day work. It added to their workload.

They were given training in Organisational development focusing on team clusters, monitoring, defining their roles and reporting it has taken some time, but it has seeped in and the principles discussed in these training sessions are being followed by all.

Review is done in meetings that take place at every level, between levels and between and on a one to one basis. This helps in decentralisation of work and decision making. Mentoring and monitoring is also emphasized. MIS is also in place: corner meetings, household visits, mock, field staff meetings and discussions, middle level management, deputy director and executive director are all connected seamlessly. Case and group reviews are also done. At least 3 people see each client. This is an improvement from the earlier procedure, where only one field worker was taking the responsibility of a client. Various field staff take the sessions on one topic and

attend each other's sessions. This helps in enhancing all the sessions, exchanging ideas, creating a holistic approach.

The problems faced were as follows: due to the heavy workload there are spill overs from the previous day's work and sometimes when the client is not in the mood, then a session has to be postponed. These are genuine difficulties that are difficult to overcome. When a client does not attend a session for the third time, they take cognisance of it and follow up and solve the problem. This is a protocol that has been evolved after much deliberation.

The other problem faced by the staff is how to prevent burn out: there were times when they were overburdened with work and on rare occasions when the clients could not comply there was less work. Most of them have tackled the issue of burn out by following the mantra of self-care daily, regularly at work and at home. As one of them put it "when is working in a mental health organisation, understanding the mind- body connection at all times and self- care is imperative. When we explain this to clients, conduct stress management sessions, it is always important that we ourselves practice it ", This practice has helped them as well as their families too.

One staffer said that another way of practising self- care "was to step back, disengage, don't be passionate and over involved". "When you are doing work with others, it is important that you also learn to do other work (hobbies, interests) and understand roles in terms of parameters and priorities".

As far as hierarchies go, they are functional and not rigid. The opinions and ideas of field workers are always asked, encouraged, taken on board and accepted both by the Executive Director as well as the trustees/ board.

Interview with Kavita Nair, Project Leader, Seher:

Earlier the M&E systems were vague, not well established, research was still on and reviews were rudimentary. The process for monitoring was not very tight. "About a year ago BT went through a period of crisis and that has turned out to be a blessing in disguise". M& E systems are now sound, stable, with good in-house review, pre- and post- test assessment of clients. An external independent researcher did analysis of pre- and post-test methods.

The entire system of work from recruitment, review and training to M&E have all evolved and stabilised. The reviews include logistics, client support, and content of training and therapy sessions. There is a top down and bottom (grassroots) up exchange between all the stakeholders about all the frames, do's and don'ts and practices.

Their learning has been that individual compliance is low, whereas with TG in groups the stigma is less, and attendance is better. “Being together, doing together is more suitable to the community lifestyle that people in Lohianagar and Kashewadi are familiar with”. The locations of TG are Bachat Gat and Tarunmandals which are also more accessible and acceptable to the community. The Eight Point framework includes both: an environment where there are peers as well as one on one and self- practice. This has gone down well with the clients and the community.

With the new M&E systems there is ownership and accountability and “everybody in BT know what is happening with the client.” Leadership and responsibilities are being shared. Delegation of tasks is also done very systematically. Training and mentoring have helped the staff to develop. Teams are working in a co-dependent fashion. Project Director is responsible for processing, preparation and reflection. There are gaps in physical and mental capacity and leadership potential of staff and imminent burn out cannot be ruled out. All this is taking its toll on the staff. BT is resource starved. They cannot take up all the opportunities that come their way and since ‘follow up’ is a habit, sometimes they must learn to let go. Their team is solid in terms of skills and their qualities.

The interpersonal dynamics in the team has been due to lack of clarity of roles, boundaries and lack of clarity in decision making. This has been overcome with training and across levels and between levels dialogues, meetings and reviews. The top leadership welcome dialogue; and when staff has a felt need, they do not hesitate to approach them.

The challenge that BT faces at present is that most of the members of the community are fine with life and there do not have too many aspirations, desires and motivation. Should they be encouraged to develop more ‘dreams, aspirations’ or would that do more harm than good? There is a very thin line between ‘intrusion and inclusion’ and BT goes by what the clients and the community says and wants. Hence, they are not focusing on developing this component. The field workers are also from the community and BT adopts a very flexible approach with them: They are talking, reflecting and processing what is happening in the community and also the concepts and philosophy of BT work and many a times, it is difficult for them to take a stand on issues such as domestic violence.

Interview with Dr Bhargavi Davar, Project Director:

She gave an overview of how Seher project has evolved and grown in the last 10 years. Its inception was as an Individual – centric, expert driven initiative (Therapist, who saw patients in the BT office). Community engagement was very little with some rudimentary corner meetings. There were too many dropouts and eventually this project had to be closed down. However, the learning from this endeavour has helped BT to carve out its authentic signposts in mental health domain.

Later, following the UNCRPD guidelines and learning from the perils of a top-down, expert-driven model, BT has invested in the community and a grassroots and field worker driven program. The work is informed and led by thorough research with a baseline survey about mental health of the community, their socio-economic and material reality, qualitative understanding.

They work with several 'high risk' groups such as single women, adolescent girls and boys, disabled persons, caregivers of children with intellectual disabilities, clients with severe mental disorders, pregnant women and women with psychological distress. Kavita Pillai, Bharati Misal and Bhargavi Davar are all trained in Arts based therapy and this is used in the therapeutic groups.

BT realized that the field workers have a high stake in the community, since they belong to it. So, a big batch of field staff was hired, and these grassroots workers are the bulwark of the organisation. They are engaged in non-formal care giving. They perform diverse roles depending on their individual capacities. Several training programs have been conducted on Organisational Development that have helped the staff to define and implement their roles and responsibilities. The concept of the "Role wall" is a novel way of capturing the roles and activities that each member will be engaged in. For instance, Bhargavi is responsible for numerous and varied training programs and conducts a fortnightly meeting with scheduled time out periods. Services are taken care of by Bharati and Almas.

The 2013 Evaluation indicated that a lot of information was being filtered off and "the field workers were up to their gills with reporting tasks and this was leading to no reporting or delays". Now they have an MIS wherein there is a Client tracker. There is a single window assessment system through which the client enters the service. After assessment, he or she is registered as a client and everybody understands 'who is the client'. The interventions are planned once the assessment has been completed and the client enters the 8-point recovery framework. The field workers, ABT and group facilitators and others take up the task as a monitoring team.

The protocols are the next rung and documentation is meticulously supervised by Kavita Pillai. If clients become too dependent or drop out, case conferences are conducted where all the staff participates, and the future course of action is decided unanimously and after much deliberation.

The challenges that BT faces right now are the following: most of the older people in the *basti* are happy and contented with the bare minimum and their aspirations are not very high. Finance MIS and client MIS are also tricky, and they are trying to build robust systems to overcome this problem.

Bringing in and increasing community participation must done in an innovative fashion like they did in case of a single woman where the community lent her support after BT coaxed the neighbours. In case of a terminally ill adolescent boy too, BT could bring about positive community participation. But the community participation needs to increase and "*they need to own the project".* Co-opting the authorities to participate and support a mental health agenda is also an uphill task!

The success lies in the fact that the staff has clarity about their roles and responsibilities; it was evident that they were working harmoniously and realized the enormity and volume of their tasks. A lot of efforts were being put in hand holding for the CMHV at Kashewadi and Lohianagar. But since delegation and role clarity was established, she could take care of the macro level management while many others were looking into the day to day functioning. Kavita Pillai is working very efficiently as a monitoring manager.

4. Findings and Conclusions

4.1 Empirical Study:

1. None of the respondents got a low score on coping skills.
2. 45 respondents got an average score on coping.
3. 32 respondents got a high score on coping.

   The tool was primed to ask them questions related to coping in the context of attending TG. Hence it can be concluded that for most of the clients have perceived that TG has had a positive impact on their coping.
4. In response to the question about benefit for the individual after attending TG 4 said never, 19 said sometimes, 22 said usually and 32 said always.
5. In response to the question about benefit of TG for the family, 8 said never, 13 said sometimes, 24 said usually and 32 said always.

   This indicates that most individuals as well as families have had a long term and sustained benefit from TG. Some clients (12 out of 77) have stated that they did not perceive any benefits for the individual and the family.

4.2 Qualitative Study:

1. Carers of children with intellectual disabilities, adolescent girls and boys, adolescent boys and girls themselves, members of domestic violence (DV) and depression and psychosomatic symptoms (DPS) group shared a positive narrative about their experience of TGs. They were able to overcome many of their difficulties and distress and make progress.
2. Carers of PW showed some signs of negativity and resistance, but this can be understood in terms of the dynamics of the relationship between the mother-in-law and the daughter-in-law in the household rather than in the context of TG per se. It is also indicative of the challenges that BT must be facing in trying to break through the patriarchal strangleholds of these well – knit communities. May be the daughters in law must have benefitted from the space that TG must have offered them.
3. 2 SMD clients and 2 carers of SMD clients who were interviewed were facing a lot of difficulties and these clients had not recovered. This group is a challenge for TG and the team. However, since there were 9 SMD clients in our total list of 77 and we had

interviewed only 2 of them and had indirect information about 2 of them, it is difficult to generalise about this group. Previous reports of BT indicate that they have made a breakthrough with some of these clients and they have moved on, this is indeed heartening.

4. Both the empirical and qualitative study respondents affirmed that the home visits and rapport building by BT fieldworkers is the mainstay of the work. Though the identity of the organisation is amorphous and not entirely well understood or established (as in branding) they are familiar with the work and the field workers (who are known to them as most of them are from the community). This testifies to the bottom up, field worker/ grassroots driven approach that has now become the hallmark of the work of BT.
5. People with psychosocial disabilities (the clients) from the community have a stake in the community. Many members from the community have been involved in the clients' recovery, with positive interventions by BT and have helped in the process of the clients being 'included' in community festivals, functions, etc.

4.3 M&E systems - quality and effectiveness:

1. The systems are efficient and smooth. With a good training component of OD all the staff members had become familiar with the terminology, well versed in the protocols, practices and knew their tasks, responsibilities and the challenges that they had to tackle.
2. The FGD with the staff was a wonderful session filled with enthusiasm, energy and exuberance, that showed a high sense of belonging and commitment towards the goals and objectives of BT.
3. They have internalised the practices and philosophy of BT and mental health in their day to day life as was evident in their response to how they warded of 'burn out'.
4. The interviews with Kavita Nair and Dr Bhargavi Davar gave a clear picture of the micro and macro picture of the functioning of both TG as well as BT. The meticulous planning (Planning wall, an innovative and creative device), the clarity of goals, co-dependent systems (not top–down), interlinking between advocacy (UNCRPD) and service were evident in the approach towards the work across the board.

5. The M&E systems are a vast improvement on the previous one and they are gathering momentum. The record keeping and documentation is also painstakingly done.
6. Networking with government functionaries, motivating the community while being inclusive and not intrusive are the challenges that lie ahead.

5. Recommendations and Moving Ahead

1. There is a resource crunch and more field workers would be needed to be able to sustain the vision, mission and goals of TG and Seher.
2. Developing strategies for networking with government authorities so that they can be a help and not a hindrance
3. Building the motivation and aspiration of the community by expanding the work with adolescents and youth.
4. At present and in the past BT has collaborated with local, regional and national organisations in training and advocacy, this can be further enhanced with more collaborative research.
5. BT has carved a niche for itself through its work on UNCRPD and TCI, this work also needs to be highlighted locally and in regional press.
6. TG handbooks will go a long way both as resource material to other NGOs, CBOs, academia and activists working in the area of mental health
7. Consolidating the work of TG through school and college mental health (replicating the work in St Hilda's and Abeda Inamdar College) in neighbouring communities.
8. A symbiotic relationship between the clients and the community has been engendered by BT and this can be enhanced to secure for 'the people with psychosocial disabilities, the right to live independently while being fully included in the community'.

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Annexure

Informed Consent

I, _____, am a student/faculty of Pune University, Pune and am helping to collect data, as a part of a project to evaluate the services of Bapu Trust. I seek your permission and consent to respond to a few questions regarding you and your experience in participating in TG (Therapy Group).
The information you provide, and your responses will be kept completely confidential and will be used for research purposes only.
You are free not to answer any question or withdraw at any point if you feel like.

I have understood the consent letter and I agree to give consent for responding to the questions. Signature of the Respondent, _____	Name of the Interviewer _____ Signature of the Interviewer, _____
Date:	

Respondent agrees and gives consent then continue with the interview	Respondent agrees but gives verbal consent, then continue with the interview
Consent is not given	

Demographic Details

Category of Client: _____

Name of the respondent: _____ **Age**: _____

Gender: Male/ Female/ Transgender

Marital Status: Single/ Married/ Separated/ Divorced/ Widowed

Type of Family: Nuclear/ Joint/ Extended

Literate: Yes/No

Education: _____

Employment: _____

Monthly Income: _____

Religion: _____

Caste/Tribe: _____

Photo Gallery: Therapeutic groups in action!












Bapu Trust for Research on Mind and Discourse
Pune

The Bapu Trust for Research on Mind & Discourse (1999-) is a registered NGO, located in Pune city, India. The vision of Bapu Trust is to see a world, where emotional wellbeing is experienced in a holistic manner, and not just as 'mental disease'. Bapu Trust dreams of healing environments, where every person uses their own capacity to make choices, heal themselves, recover and move on. Recovery methods are creative, non-violent, non-hazardous and playful. Bapu Trust works with multiple stakeholders within the development sector on the inclusion of persons with mental health issues and psychosocial disabilities including disabilities, poverty, community development, social justice, policy and law and human rights. The touchstone of Bapu Trust since the advent of the Convention on the Rights of Persons with Disabilities, is 'Transforming communities for inclusion' of persons with mental health problems and psychosocial disabilities. Towards this end, Bapu Trust has invested in developing a sustainable service delivery model, Seher, inspired by the vision of Article 19 (Right to live independently and be included in communities). Bapu Trust's domains of work include research, trainings, enabling multi-stakeholder dialogue platforms in India and Asia and innovative services within community development.

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