BAPU TRUST FOR RESEARCH
ON MIND & DISCOURSE

ANNUAL REPORT

2020-2021

PUBLISHED BY
Bapu Trust For Research for
Mind & Discourse, Pune

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Our Vision

We want to see a world, where emotional well-being is experienced holistically, and not just as a ‘mental disease’. We dream of healing environments where every person uses their capacity to make choices, heal themselves, recover, and move on. Recovery methods will be creative, non-violent, non-hazardous, and playful.

Our Mission

Bapu Trust creates, pilots, and monitors community inclusion programs with a core mental health segment. Such programs enable the autonomy and independence of persons living with mental health issues and psycho-social disabilities. Our programs foster ‘psychosocial ecosystems’, especially in vulnerable human habitats (slums, rural areas, conflict areas, schools, etc.) We work towards linking people with psychosocial disabilities with Development services. Programs aim to expand on the aspirations and potential of individuals, families, and communities, strengthen mental resilience, and utilize opportunities for the pursuit of happiness. Our program provides modular interventions to address a matrix of psychosocial needs by providing choices. We influence the structural, social, legal, and policy environment, so that they remain inclusive, just, and fair to people with a psycho-social disability. We strive to create enabling environments for people with psycho-social disabilities where they can realize all their human rights and entitlements without barriers (guided by the Convention on the Rights of Persons with Disabilities and the SDGs).

Motivation for setting up Bapu Trust

Bapu Trust’s legacy is linked to the personal history of a woman called "Bapu“ (aka Savithri Mani). "Bapu" faced an intensive history of mental illness, leading to other personal histories of mental illness and discrimination in her family. The younger generation of this family used this experience to open up possibilities of resilience, and recovery using lifestyles, diets, spiritual and creative pursuits, and other ways of life. Bapu Trust was registered on the 1st of April, 1999, by Bapu's daughter, Bhargavi who is the current Managing Trustee of the Bapu Trust.

Bapu Trust works in low-income communities of Pune, in around 30 slums and a population of 800000, in partnership with the Pune Municipal Corporation, providing psychosocial services to families. The program uses a multiple modality in supporting persons with services (called the 8-Point Recovery Framework). Interventions include 'Self-care' (for the individual), Nutrition (for better mental health), addressing barriers to social inclusion, group support, working with partners on improving access to economic opportunities (e.g. livelihood), and comprehensive health care by partnership with public health systems. It offers intensive training on development-linked mental health in other Indian states.

Role of the Bapu Trust in the Mental Health and Disability Sector

Though considered 'maverick', 'offbeat', etc. Bapu Trust has been solution-oriented from the start, creating strategies to address the gaps in linking psychosocial aspects within Development. We have done path-breaking work opening new mind fields within mental health. We are celebrating our 20th year since inception in 2020, and have had the chance to reflect with others, what is the past and future of the Bapu Trust. Bapu Trust stands as a ‘metaphor’ in the mental health sector in India, for some a 'refugee camp' where neglected people arrive and support each other; for others, a 'sanctuary' where people create safety together, and for others, an altar of lateral thinking, new ideas and innovation. For many, Bapu Trust represents a way of life, an enabler of caring communities, promoting organic and holistic lifestyles, linked to city life and community development, and in the service of disabled people. If we ask the question, 'What is the right treatment for mental illness?' answers will be in the direction of a restrictive medical model. If however, we ask the question, 'What is the right process of inclusion of persons with mental illness/disability?' answers will be multifold, in the direction of living a life. Our intensive involvement in the UNCRPD made us reframe our question to the latter formulation. Our priority focus is 'transforming communities' so that they change their view about mental health and illness; recognize the importance of this in their lives and the lives of their families, Neighbours, and communities; and take small steps in their everyday lives to improve their experience of well-being, and if possible, enhance their peace of mind and caring capacity.

Seher Program

Seher (which means 'Dawn' in Urdu) was started in 2004 in two slum pockets of Pune city. As it evolved, in 2012.

Seher came into being with the realization that the development sector neglects psychosocial health and wellbeing and that this aspect needs to be integrated within ongoing development programs as mental health is an integral part of sustainable development.

The nexus between poverty, gender inequality, work insecurity, and various other factors related to people living at the 'bottom of the pyramid' results in psychosocial consequences, sometimes leading to illness and disability. Urbanization, migration, fast-changing economic scenarios, climate change, changes in food production and consumption patterns, etc. all contribute to large population effects on mental health and well-being. However, there are few options available for people with mental health issues and psychosocial disabilities in low-income neighborhoods. Thus, through concerted multi-level actions, and enculturating a very high level of partnerships, both government and non-government, Seher facilitates the creation of caring communities.

In the past five years, in collaboration with the health department of the Pune Municipal Corporation (PMC), Seher scaled up from one to five centers and has been providing free and accessible services at **five public maternity hospitals**:

1)Sonawane Maternity Home,
2)Bharat Ratna Rajiv Gandhi Hospital,
3)Kamla Nehru Hospital,
4)Late Jayabai Nanasaheb Sutar Maternity Home
5)Dalvi Hospital

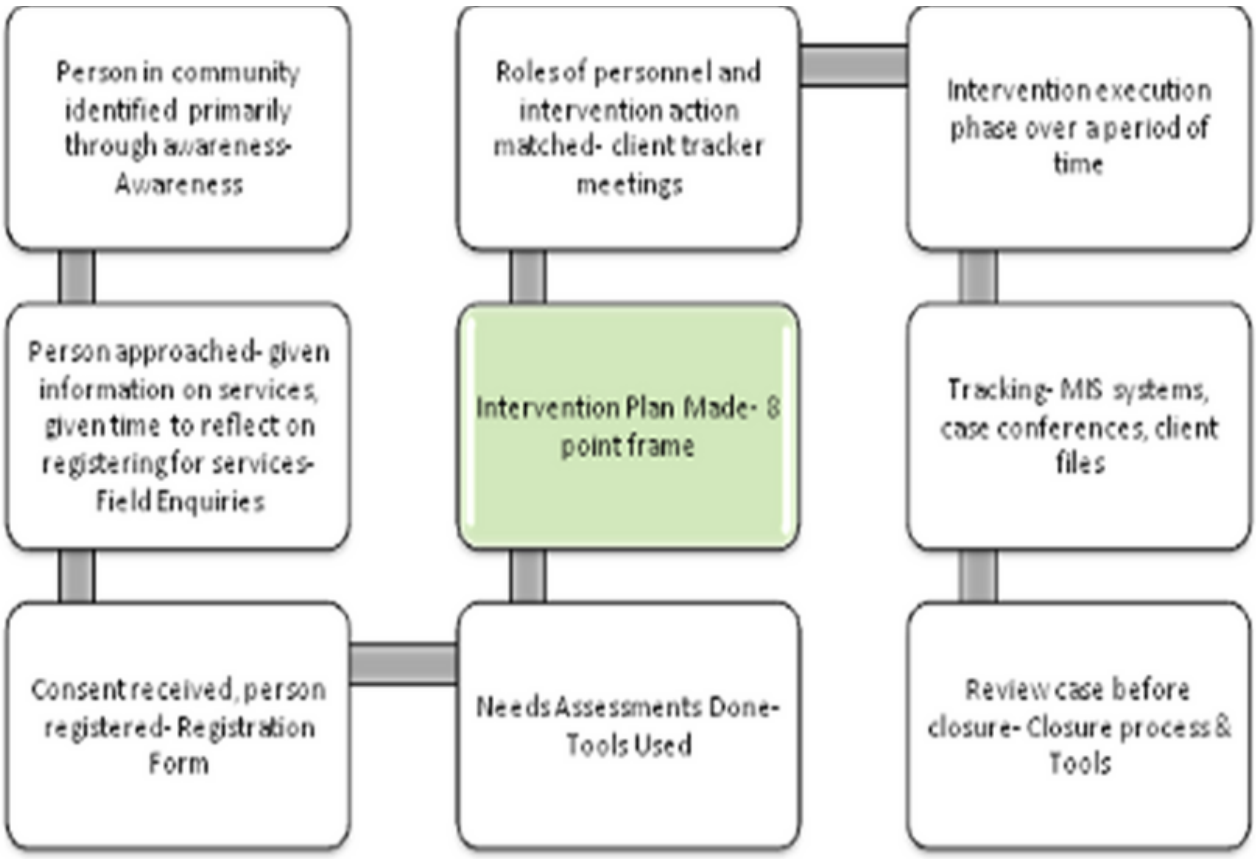
Services are offered through wellness centers. The wellness centers envision **"creating caring and inclusive communities for all".** The center is a nodal point for integrated services offered to low-income communities.

Persons identified through the various awareness strategies and referral resources are registered in the program. Each client registered in the program receives comprehensive services that integrate development, social, and psychological indexes with the help of an eight-point recovery framework. Services are provided until full recovery and full inclusion are achieved. The aim is to remove barriers to client participation in society and full inclusion.

The **8-point framework** and recovery model came into being with joint efforts of Bapu Trust staff and local community members and includes:

1) **Self-care**
2) **Nutrition**
3) **Social Justice**
4) **Families**
5) **Groups**
6) **Individual Support**
7) **Health Care**
8) **Social Capital**

The program adopts the following operational strategies:



Inclusion is the ethos of the program. Seher envisions creating caring communities and a sustainable psychosocial ecosystem for inclusion. With the advent of the UNCRPD, the program has actively adopted ways of healing and social actions that together facilitate inclusion, the right to live in open communities and having equal rights in treatments and solutions of one's choice (without being limited to pharmacology and institutionalization).

Seher offers prevention, promotion, and recovery-oriented services to members in 14 bastis (low-income settlements) covering approximately 2.6 lakh people in Pune city. Please confirm whether the bastis are correct for the year 2020-21.

1)Kashewadi 2)Lohiyanagar 3)Rajewadi 4) Lakshmi Nagar 5)Bhimnagar 6) Shramik Nagar
7)Indiranagar 8) Mariyam Nagar 9) Ashok Nagar 10) Jai Bhavani Nagar 11)Kishkinda Nagar
12) Sagar Colony 13) Wadarwadi 14) Pandav Nagar

Individuals are registered into Seher only after their consent. They are then assessed for psychosocial needs across the eight domains. Psychosocial needs are assessed on a spectrum which we refer to as the Mental Health Spectrum. The spectrum is a dynamic scale that looks at needs from the disability, development, and rights-based framework.

Following a detailed assessment, intervention plans are prepared in accordance with the needs of each domain.

Seher 2020 to 2021

Our partners

Networks and partnerships are a significant part of Seher. Tapping into community resources is a means of building social capital available to communities towards the inclusion of persons with psychosocial disabilities. In addition, it enables us to address the range of allied development needs of persons with disabilities. Our partners include entities from the Government, from the NGO sector, and from among local groups and communities.

Governance systems

The public health system, the law-and-order system (police and legal systems), Urban Community Development Departments (UCD), Social Welfare Departments, the Education Department, Pune Municipal Corporation (PMC), Regional Mental Hospital, State Disability Department, etc.

Civil Society Organizations

Non-government organizations (NGOs) and community-based organizations (CBOs) working on allied problems such as assistance with livelihood opportunities, capacity-building initiatives, access to food, social security (such as Aadhar card, Ration cards, etc), and social entitlements, healthcare diagnostics and treatments (allopathy, Ayurveda, Unani, yoga, etc), etc.

NGO partners

Prahar, Abhinav Sanstha, Deep Griha, Sarvaseva Sanstha, The Family Planning Association of India, Lighthouse, Community Mental Health Volunteers (CMHV), Connecting.Org, Yutak, Foundation for Research in Community Health (FRCH), Spherule Foundation, Kasturi Foundation, Shelter associates, Nari Samata Manch, Snehalaya, among others.

Other participants who helped such as with arranging food distribution and distributing essential commodities included masjids, churches, and groups like the Vishwa Hindu Parishad and Aam Aadmi Party.

Informal community actors

Local community mobilizers and key informants such as Anganwadi workers, Mitra Mandal representatives, nagar sevaks, social workers, religious group representatives, bachat gat representatives, general practitioners within the community, shopkeepers and community mental health volunteers (CMHV's).

Whom we served

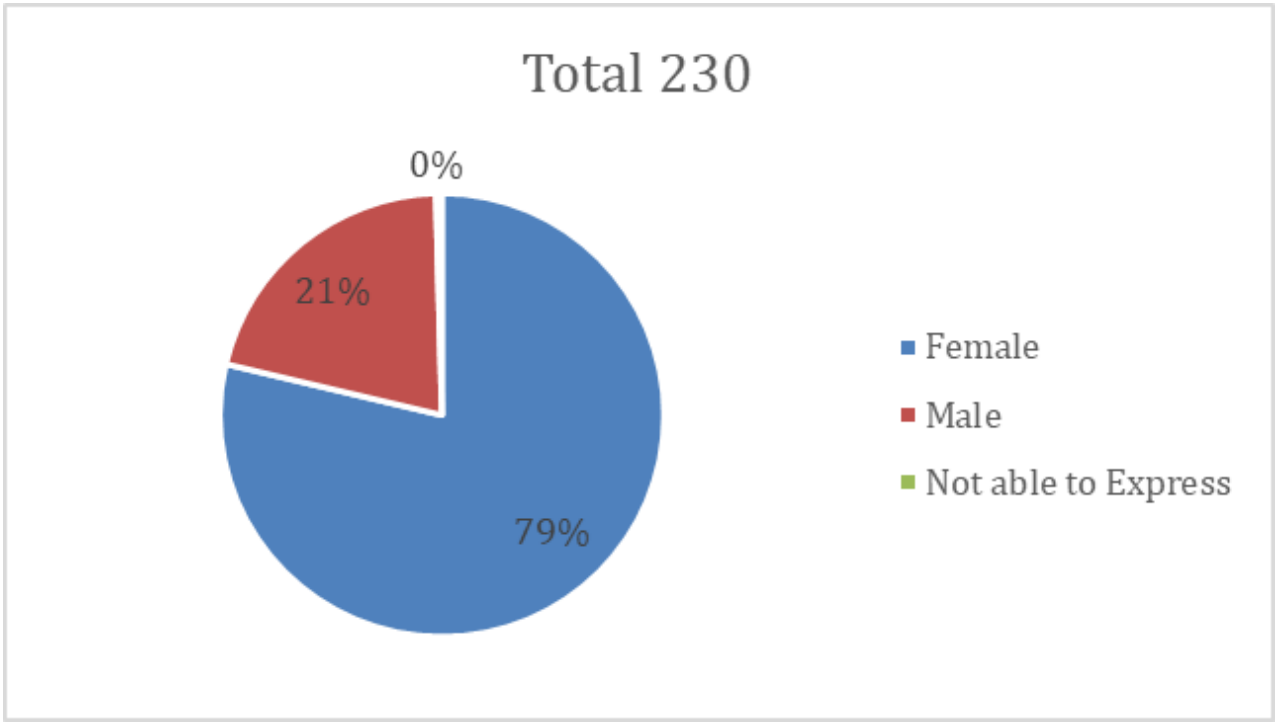
Coverage:

14 low-income settlements, with a population of **230 people**, were served in this year. We covered **73546** population in this year.

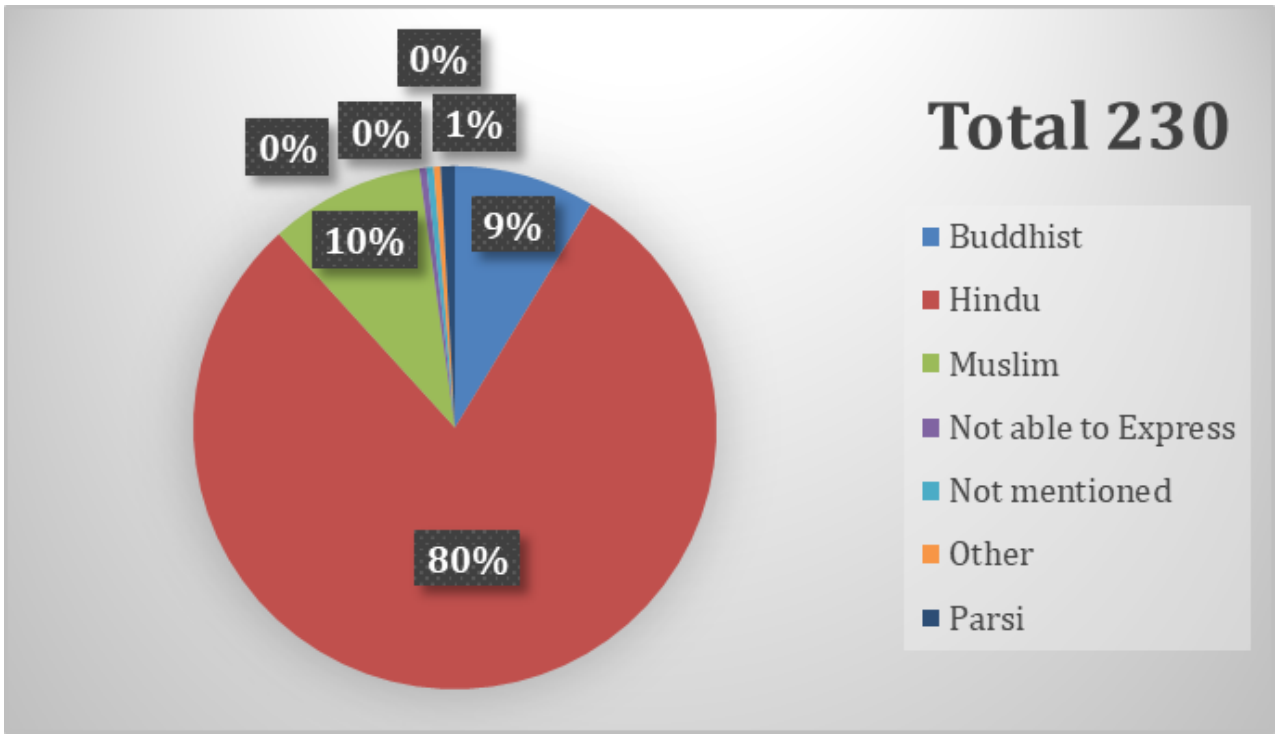
Clients this year

In the year 2020-2021, 230 clients received direct intervention inputs. The following pie charts show the composition of the clients served in terms of gender, caste, employment status, and religion.

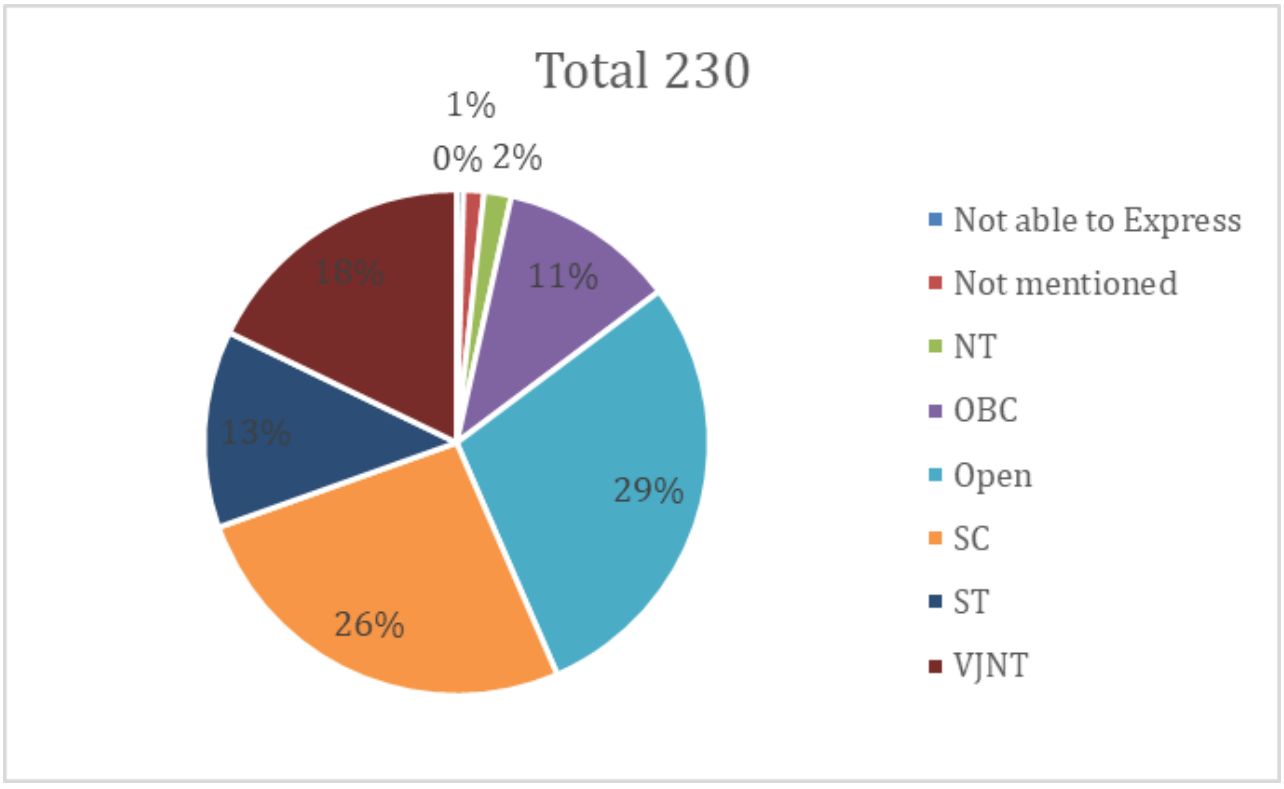
Gender



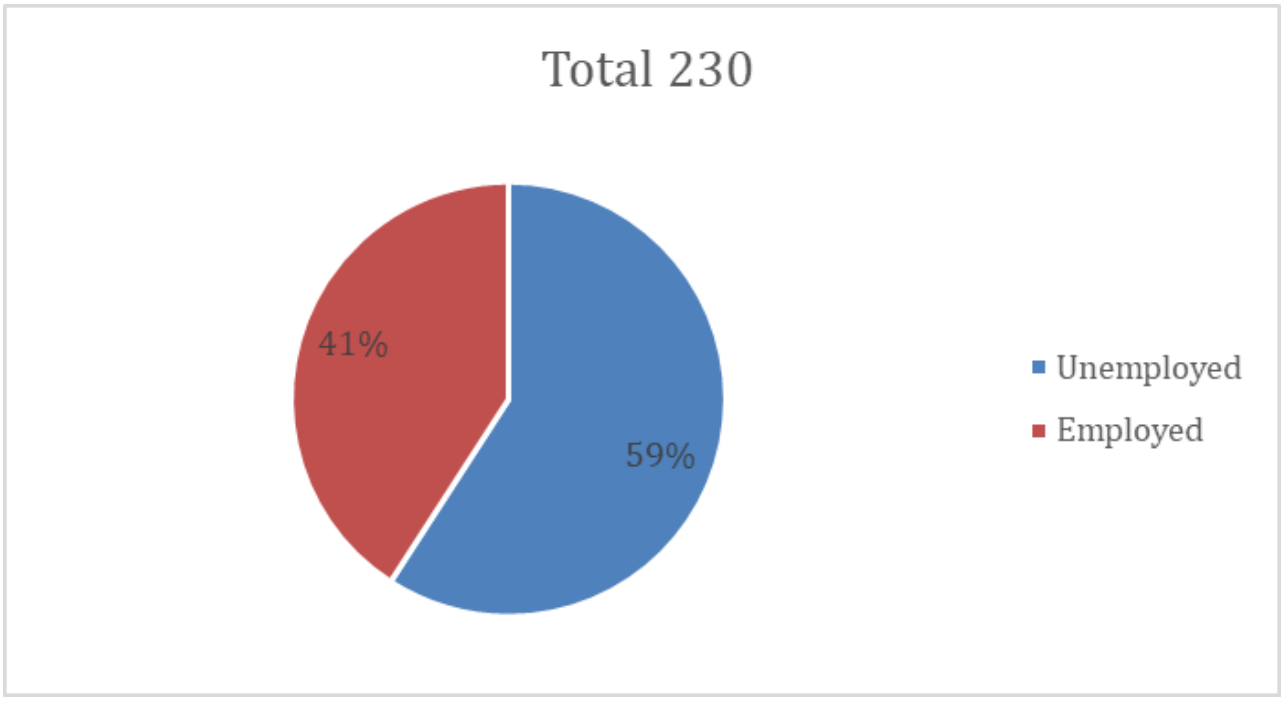
Religion



Caste

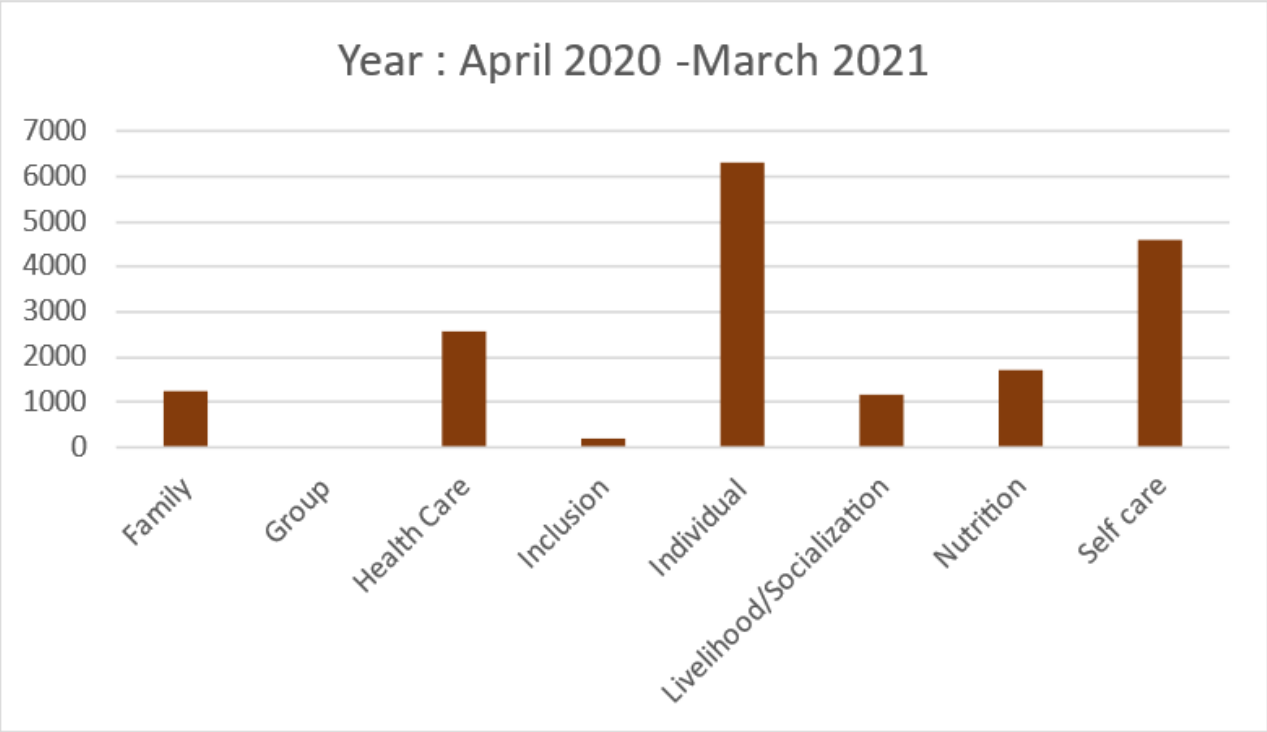


Employment Status



Activities for the year

17791 INTERVENTION ACTIONS WERE TAKEN



Field Activities

Due to the reclaiming of Seher spaces by the public health hospitals during Corona times, Seher services went through space restrictions and were cut back to three centers. We, therefore, carried out wider outreach in the coverage areas for these centers. Additionally, two new centers were started in private premises. Seher's core services continued. These included services like comprehensive assessment followed by the necessary specific interventions based on the eight-point recovery framework. Community-level strategies to address social barriers and to deal with issues like substance abuse, gender violence, etc.

New services were also added during this period, with additional key features like raising awareness in peripheral areas through the Seher Awareness Link Team (SALT); resettlement of persons exiting mental institutions, and ensuring their inclusion in the community through the Going Home Project (GHP); Covid-related relief services including psychosocial trauma relief, linkage with necessary social services, and enabling communities; and working with the government agencies on frontline counseling services for migrants and the homeless.

Through SALT, a generic awareness program was carried out in nine bastis as an extension for inclusion. During this period SALT focused on providing information and support to people during the Covid period using large-scale awareness strategies for engaging whole neighborhoods.

Going Home Project (GHP)

GHP, which had been started as a pilot project in a regional mental hospital in 2019, was put into action during this period. GHP is a pathway for those exiting mental institutions to avail of Seher services with community inclusion. GHP is involved in providing a range of housing options to women after discharge from the mental institution. GHP at this time covered nine women de-institutionalized from the mental hospital who were then taken into the care of Seher. Once the woman made a housing choice, community belonging, and inclusion were facilitated through:

a) **The introduction to the community members:** neighbors, key persons, CMHVs to increase the social support for the women, availing the health infrastructure.

b) **Familiarization with the community spaces** through neighborhood walks and culturing familiarity and support systems in the neighborhood.

c) Supported decision-making: Supporting the women in understanding that they have decision-making capacity and supporting and encouraging them through the daily decisions towards autonomy.

d) Health: Linkages with the local health system, comprehensive health care, homeopathy, reduction of psychiatric drugs, prevention of institutionalization, and ownership of health care.

e) Social Entitlements: Identity and citizenship documents are key for any social protection schemes, bank account, and rental documents. During the second COVID wave, our team learned that social entitlement such as accessibility to health care is interconnected to having the necessary identity documents like Aadhar. Our team had to negotiate with healthcare systems that refused admission to admission or testing due to a lack of necessary documents like Aadhar. The absence of family support meant that the team also had to take charge as caregivers. The teams worked daily on the frontline to meditate and mobilize better health care for four women. Private care through crowd-sourced funding was arranged, and regular visits for care and aftercare were planned. Living in institutions, with many rendered homeless, the efforts for these rights have been ongoing.

f) **Community inclusion and cultivating purpose and belonging** is an ongoing process for women and their communities. The program team as well as it has been learning to implement choice, inclusion, and independence of individuals with psycho-social disabilities with earnestness, particularly considering that the maximum number of women (6) exited during the COVID lockdown.

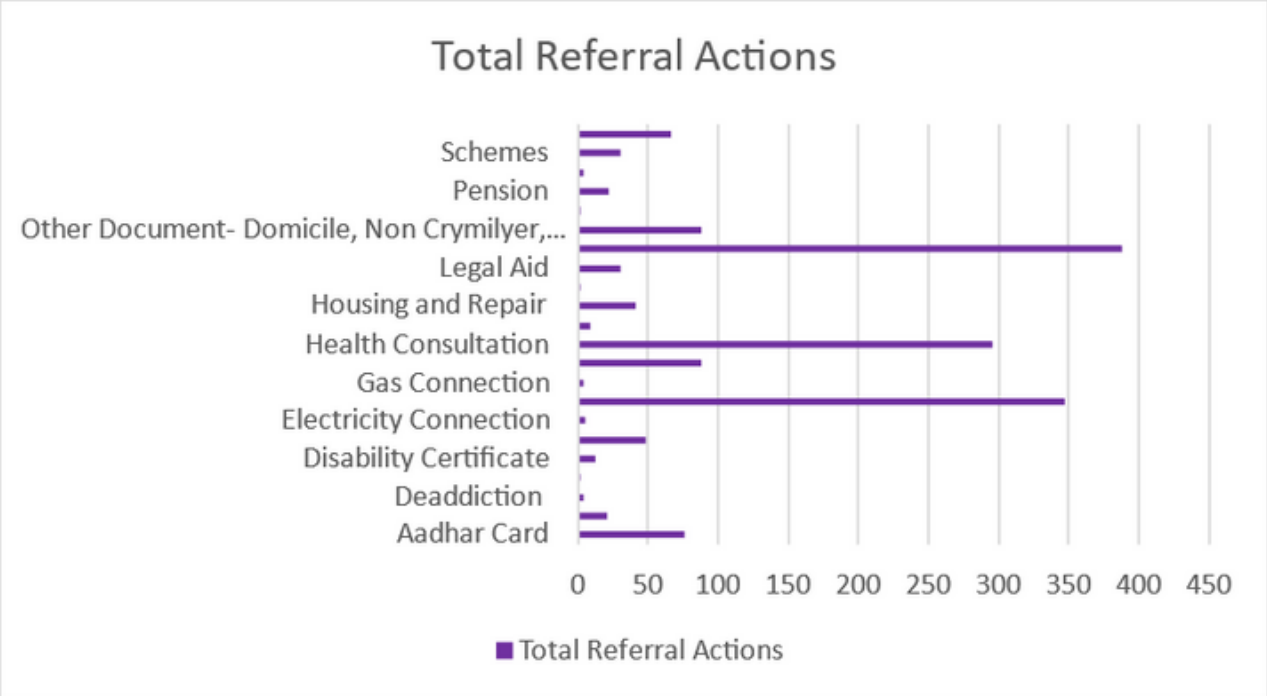
Relief Services:

a) The Seher team was active in Covid-necessary basic relief measures- ration provisions, support for healthcare costs, housing rent, fuel, etc., extensive awareness on Covid as well as psychosocial well-being, phone counseling, providing cash transfers, working with the government and dozens of NGOs to provide support services as needed (healthcare, enrolment in various relief schemes, food security, housing needs, etc.)

b) Despite hazardous conditions of work, we were able to work in communities along with other frontline workers of the system. Our teams worked in government-run shelters, with the homeless, migrants, single women without any other support systems, etc. this time, providing different kinds of services, including mental health services.

c) Through this phase, a large network of small and big development partners, retail donors, and well-wishers in our working areas are now able to support community members with their food and nutrition needs. This has helped our teams support our clients through referrals to partners. While on the one hand, we are continuing with the cash vouchers, distribution of food, and other material support, on the other we are strengthening psychosocial responses in the aftermath of the pandemic, including addressing trauma caused by COVID-19. Our work was recognized as “Essential Service” by the Pune Municipal Corporation. Through a letter and travel stickers, BT teams were facilitated by the PMC to carry out field activities without difficulty.

Referral Activities



A total of 1583 referrals were made in this year. The graph shows the specific interventions these activities covered.

Research Activities

Research is an ongoing activity that we undertake periodically. During this period, the following research activities were started:

·A research survey on psychosocial trauma in low-income communities was started. Household identification was carried out in two pockets each from two different bastis (Sutarvada and Tadiwala areas). Houses for data collection were selected using randomization. Similarly, participants from each household were selected from this sample of households using randomization by gender and age. Preparing a culture-appropriate trauma tool for data collection was conceived and was awaiting training and translation before it could be pilot-tested.

a)An integrated field survey as a part of a larger initiative of the RainTree Foundation. The aim is to link various development factors including psychosocial health and wellbeing. Our team participated in developing the mental health portion of the data-collection tool, training data-collecting field staff, and also gave inputs for analysis and report writing.

b)Another effort is documenting our GHP-related work as a process documentation for dissemination as a best practice keeping the international context of de-institutionalization as a focus.

c)BT also compiled the Art Based Therapy (ABT) student reports and a report on the baseline studies by three of our partners in Chhatisgarh and Madhya Pradesh.

d)We also started a BT academic page on Academia.edu for uploading our research publications and to be accessible through the Research Gate site as well.

Advocacy and Awareness

Awareness raising is an innate aspect of Seher. In a departure from typical illness frameworks used for awareness raising, we frame our awareness messages focusing on the determinants of psychosocial health and wellbeing, inclusion, and rights of persons facing disabilities.[1]The aim is to make communities inclusive of persons with disabilities.

Owing to COVID and the resultant online mechanisms used for our activities, this year, another focus of awareness was on balancing and utilization of both in-person and online mediums. As a part of this effort, our team offered the “No contact and safe distance” offline format along with video format. Zoom meetings were offered as an online means to facilitate wellness sessions for newer organizations and communities.

Furthermore, the accessibility to digital media also created avenues for advocacy campaigns that met wider audiences and wider topics.

The team also adapted to a hybrid model of digital and physical activities to strengthen their linkages in the community. The thoughtful and necessary conversation continued through the organization of awareness events and webinars online.

* Awareness as a tool of spreading messages about mental health has been researched heavily within literature. The lack of awareness of the population is cited in nearly every research and report as the main reason for the need to spread awareness. However, studies measuring the lack of awareness within a population have measured the lack of awareness of mental illnesses (or dis-order) as traditionally defined within diagnostic systems (Kermode, Bowen, et. al, 2009; Jorm, A. F. 2012; Zeeman, Pathare, et. al, 2017; Pandya & Shah, et. al, 2020). Framed in this ideology, mental health is conceptualised as a financial burden (Pandya & Shah et al, 2020) and the purpose of awareness is rigorous identification of illness to prevent the country from an economic burden (Wahlberg, A. & Rose, N., 2015). Thus, the goal of community mental health gets restricted to an illness model as opposed to promotion of mental health and wellbeing for all in everyday living.

Corner Meeting

Galli Charcha

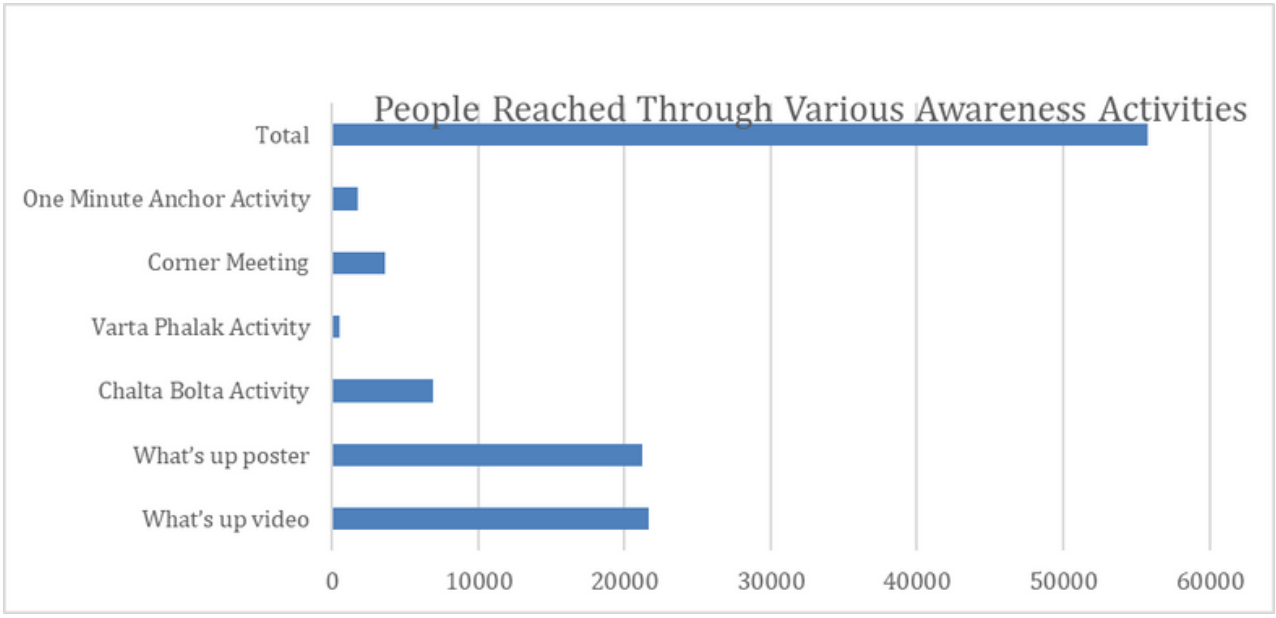
Varta Falak


आखल मीग वाडा प्रतिष्ठान
आपण जीतका सकारात्मक विचार
करू तेवढे आपले मानसिक
आरोग्य चांगले राहते
〈बापु ट्रस्ट〉


स्थापना :- १४/०४/१९८९
सुचना,

One Minute Anchor Meeting

The distribution of the awareness activities carried out from 2020 to 2021 is shown in the bar graph that follows.



Seher Awareness Link Team: SALT: SALT has been working actively towards innovation and material creation in compliance with Article 8 of the CRPD on Awareness Raising from a rights-based perspective of persons with disabilities. This involved engaging in study circles, discussions on the CRPD, capacity building of self, implementation of the knowledge in awareness material creation, and developing training modules for the same.

Activities with Partners

Significant partnerships and related activities with partners in this period need to a mentioned.

Community-related partnerships: Responding to the pandemic situation, this period witnessed participation from individuals and key entities in the community such as local community leaders, corporators, youth leaders, local grocery stores, neighbors and many religious organizations mentioned above in the partner list.

Lighthouse: Long-term partner Lighthouse resumed physical sessions in November 2020. A pilot vocational training program for clients discharged from mental institutions was initiated after this wherein the nine GHP clients availed of the benefits and attended the course. The course covers personality assessment for vocational options, business management, and other professional skills. Another partnership effort was organizing awareness and wellness sessions for volunteers.

Community Mental Health Volunteers: The CMHVs in the Seher program are envisioned as key to the sustainability of support in the community. With our focus on capacity building of CMHVs, we were able to strengthen our relationship with this group. In this period, 32 new CMHVs were recruited. Eight CMHV meetings were held wherein the wellness needs of CMHVs were emphasized along with content on understanding mental health. CMHVs have been key in supporting our inclusion work along with referrals for pregnant women and the facilitation of fitness sessions for clients. This group supported the BT team admirably during the lockdown. Our team ensured all CMHVs received the COVID-19 safety kit.

Connecting.org: we have revived our partnership with Connecting org and four sessions on suicide awareness for our team were organized by them.

Challenges

a) Sustainable Livelihood: As expected, COVID-19 impacted the economic well-being of the communities through loss of livelihood, hence referrals for income generation activities rose. Some referrals like Rakhi-making and vegetable packing were either seasonal or low-paying and had to be resorted to based on educational qualifications, we continued to focus on the aspect of livelihood and inclusion and the right to equal opportunity. Thus, skill building for long-term sustainable opportunities were the strategy we decided on for the coming year.

b)Livelihood challenges for GHP clients: As noted, nine women who left mental institutions were rehabilitated under the GHP. Many of these clients did not have the necessary educational documents as families were resistant to providing these. This created barriers to livelihood opportunities. Post-employment challenges for this group included the after-effects of institutionalization including continuing medication leading to tiredness, drowsiness, inability to regularly attend work, low energy, and low immunity. Our team tried to sensitize coworkers and supervisors in place of employment, but in many of the instances, employers were unable and/or unwilling to make exceptions leading to the loss of the job. Often, the rehabilitated women themselves did not trust their own ability to continue at the job and perform reasonably well and inputs to change their mindsets would be required.

c)Proper documentation for access to Social Entitlements: For accessing the benefits of social protection schemes and even for rental agreements or hospital admissions during COVID-19, identity documents are crucial. For many of our GHP clients, actions were taken to trace documents, trace family, or request family to support access to these documents. Similar actions were taken also from mental-health institutions but our team did not succeed and was rejected thrice in such endeavours. Many clients who are migratory workers also need document support either in terms of correcting errors in documents or help with application fees. Our program team persistently carried out multiple bureaucratic and advocacy efforts and was able to help 40 clients but outcomes were achieved only after six months of administrative and bureaucratic mobilization! Thus, the lack of a sustained administrative system to support documentation of persons living with psycho-social disabilities, those who are rendered homeless, or fall into low-income social groups are met with debilitating systemic challenges that prohibit their equal participation in the community.

Challenges

d)Challenges relating to deinstitutionalization: Under the GHP, nine clients were resettled and the number of necessary per-client actions for GHP clients was found to be five times higher when compared with actions needed for clients already residing within the community. Several rounds of actions for inclusion, health care, livelihood, and socialization are needed for GHP clients and additionally, special actions are also needed for resettlement. For clients within the community, these outcomes are achieved with fewer rounds of referrals. This is indicative of the challenges that GHP clients face in order to feel a sense of belonging in the community. Clients already residing in the community are a part of the existing social milieu which organically sustains their well-being.

e)In most cases, the family systems, neighborhood, and familiarity with local health care and administrative institutions make clients within the community not feel alienated. GHP clients tend to feel alienated until the familiarity is established and also, these systems have often to be made sensitive to their needs. There are cases when existing systems are negligent of individuals already residing in the community and sensitization becomes necessary even for them. But in the case of GHP clients, this is almost always the case and they often face debilitating systemic challenges in their already vulnerable state. Our team has countered these challenges more specifically those relating to livelihood and social entitlements with focus and persistence.

f)Monitoring: Planning of outreach to far-flung areas proved challenging for monitoring of activities. During the lockdown, teams worked predominantly from home and carried out most activities via phones and over Zoom, etc. Team members felt scattered and struggled with the program protocols. Senior managers therefore focused on strengthening monitoring systems to facilitate feedback mechanisms for ensuring that team members' morale remained high along with the quality of output. This effort culminated in the establishment of a strong monitoring team in March 2021 intending to put in revised review and monitoring processes.

g)Research-related challenges: Among research-related challenges, apart from funding restraints for research, creating culturally valid trauma tools was one challenge. Additionally, the field situation was unpredictable which created obstacles for fieldwork during the survey period.

Challenges

h)Awareness-creation-related challenges: Pandemic-related movement restrictions and fear among community members implied that regular interactive avenues of awareness raising like corner meetings, poster displays, or small gatherings could not take place. Later, very small gatherings were arranged to avoid overcrowding and maintain social distancing. This was a challenge in terms of widely disseminating messages.

i)To circumvent these issues, digital mediums of awareness raising were adopted by the team and these had their own challenges such as difficulty in gauging the impact of efforts, evaluating how the community received videos, not being able to get direct feedback through questions and interaction with the community, and not being able to reach those who didn't have smartphones, etc. These very valuable aspects of awareness became challenging in the online medium.

j)Networking-related challenges: We faced challenges in our interaction with PMC during the Covid period. The distress that PMC experienced due to the increase in Covid numbers in Pune and scarcity of space, is often reflected in the pressure on our centres to either be closed or converted into Covid units. Ongoing negotiations with PMC officers were needed to retain spaces. Therefore, meetings with PMC officials to sensitize them to our activities and programs had to be prioritized. These helped in receiving their support and receiving the Essential Worker Pass for our team during the intense lockdown. Another issue was that nurses and other hospital staff were short of time during the lockdown and therefore we had to reschedule conducting sensitization and wellness sessions with them.

Learnings and overcoming challenges.

a) Expansion and service delivery were adapted to the changing needs through strategic changes including reassigning staff based on identified needs and developing ‘nomadic movement plans.

b) Operational strategies were reviewed for implementing field programs as online ones and the team was trained in digital presence. Training of trainers was also planned as the general need for training increased. A full Training Department was created to cater to capacity building and other forms of training requirements (in-house, local, national, and international).

c) Our team was empowered with new skills to deal with relief measures and post-Covid health and trauma support. Thus, the team now was able to grow beyond being able to offer psychosocial support and handle the trauma experiences of communities. Field teams comprised of Supervisors, Project Assistants, and Field Workers were mobilized to study emerging community needs during the pandemic.

d) Another adaptation was the merging of wellness centers along with the type of services provided and serving additional bastis/communities. Thus, the operations of the Pehel and Charvi communities were merged under Pehel. Operations of Dwi and Trish were merged under Dwi. The Pancham Center was reassigned areas. The main center was now used for administrative work.

e) Covid necessitated a degree of experimentation and development of adaptation techniques. These have provided insights to Bapu Trust and we are now able to look at the idea of scaling and deepening activities in a new way. Consolidation and integration of new aspects are now considered as workable mechanisms for scaling and expansion.

SUCCESS STORIES (INTERVENTION RELATED) (Names have been changed to protect identity)

Rohit

Identified during a corner meeting, Rohit, a 16-year old hails from Rajewadi Basti. Rohit's parents approached the team after the corner meeting and shared their child's struggles owing to physical and developmental disabilities: speech delay, hearing disability, and ADHD. Rohit had been tested for learning and developmental disability at the Sassoon Hospital and documented as having a noticeable delay in education.

Later, Rohit's parents revealed that Rohit had been admitted to the mental hospital for three years when he was just 14. The admission to the institution had been managed through the influence of a local corporator. The parents' attitude towards Rohit was that of resentment and anger. Frequent violence and teasing by children and community members often led Rohit to react with anger, violence, and frustration. Rohit's parents felt tired. Listening to them speak, we spoke to them about the services (non-psychiatric nature of our work) and requested consent to begin our work.

When carrying out his assessment, the team noticed Rohit's speech delays impacted his understanding and answering of questions to our assessment tools. He tried communicating through gestures, but the verbal elements of the assessment posed a challenge. To develop rapport and form a holistic way of understanding the client in their milieu, the counselor decided to pay regular visits to his home. Speaking slowly, careful use of gestures, attentive listening, and a writing pad created an initial dialogical space of listening and hearing between the counselor and Rohit.

Diverse art forms such as drawing, straw painting, and storytelling created alternative modes of expression. Rohit began to feel comfortable. He felt that he was being provided a space to speak in his language rather than being pushed into the language of dominant others. He began to trust the counselor who had patiently waited for this. However, Rohit would continue to test the boundaries of the relationship. He often narrated stories of ghosts and witches, noticing subtly the reaction of the therapist and testing if she would react to him in the same way as the community did: that is rejecting him or being fearful of him.

As Rohit became comfortable with the team, the focus moved to the theme of sexuality. Often community members would complain about Rohit's actions of peeping into female bathrooms, spontaneously hugging someone in the community, or wanting to kiss strangers. It was observed that Rohit felt confused about his sexual desires, the need for intimacy, and ways to express his sexuality. Through slow speech and drawing, topics of sexual health and education were introduced to him.

Rohit Story Continued...

In one of the sessions, Rohit alluded that a group of young boys had snatched his towel in the community bathroom, leaving him vulnerable and confused. Being teased, laughed at, and beaten by the community's peers was common for him. Thus, ensuring inclusion became key in our work.

Rohit tended to react to the community violence with violence, but when he did use violence, the family and the community punished him severely. Therefore, Rohit had no way of understanding the violence he had to endure as a person with a disability. Owing to the frequency with which the family or community resorted to violence, the community felt that the best possible designated space for Rohit was a mental institution. The family too wanted the same. In order to sensitize the community our team organized a community street play on this issue. This facilitated a neighborhood conversation on the topic. The community was sensitized with the type of actions they should carry out like smiling at Rohit, extending kindness to him, and checking on how he was doing. Such sensitization through posters and corner meetings was done every day for six months.

Once Rohit received warmth and friendliness from the community, he felt welcome in his own space and he became more grounded. Rohit also received self-care sessions where he was introduced to Hum chanting and activities like straw painting. He practiced these activities every day. Even during this phase, whenever he felt restricted by his mother or felt his voice was unheard, he would express himself aggressively and even violently. Family sessions along with self-care sessions were now introduced, focusing on regulating his anger issues.

Parents learned to use touch and soothing techniques to calm Rohit down. This enabled them to develop a caring relationship with him. As a part of self-care, Rohit was introduced to daily running as an activity. This helped develop a routine for Rohit and also channeled his energy effectively. His family also learned how the nutrition module allowed Rohit ‘s physical health to be regulated through routine and proper care.

Rohit progressed to a place where he could be referred to a nearby vocational center where he began to use his creativity in making crafts. Thus, Rohit has started to feel a sense of belonging in the community while at the same time having a meaningful and productive routine that keeps him going. A community member has also supported the family in helping Rohit attend a school that attends to his developmental needs.

Anand

During a corner meeting at Nana Peth, 35-year-old Anand approached the team with complaints about stress. His family is composed of his wife and two sons. Anand shared that his choice of livelihood (selling tobacco and cigarettes) in his small stationary shop was a point of family conflict. After we provided due information about our services and received his consent, Anand was called in for assessment. He was registered in the program in 2018.

During the assessment, Anand shared that he used to work in a bank with his wife. His wife was an accountant and he was an office boy. The financial difference in pay and aspiration to earn well made him quit his job. After a lot of struggle, he negotiated with the local corporator (Nagar sevak) and bought himself a small stationary shop that also sold tobacco and cigarettes. The choice of his profession often led to family conflict and distress.

Anand also blamed his father and wife for not taking care of him. Anand shared feeling aloof, judged, and disrespected in his family. The circle of care form showed low support from family and judgments from neighbours because of his profession. His nutrition intake was low (only one meal a day). Anand shared that he lost his mother a few years back and always felt resentful that his mother did not support his financial aspirations. Anand expressed that his maternal side of the family had many properties in their name, but his mother never legally asked for her rights on them.

When we began our work, we realized that Anand's hygiene was very low. The team worked on the importance of self-hygiene and feeling well. Taking a bath, and changing clothes introduced him to the idea of taking care and appreciating himself. We started with self-care practices console breathing, hum chanting, and a pressure cooker to work on the feelings of anger that he often expressed in the form of violence towards his wife. He began to practice humming chanting and console breathing every day. In individual sessions, the counsellor focussed on the repetitive thoughts of feeling financially insecure. We validated his thoughts and acknowledged his feelings of being neglected as a child. He reflected that as a child he always felt angry about the impoverishment at home caused by the addiction of his father. He started to reflect that his anger came from a deep space of hurt as a child. Thus, he began to step back in moments of anger.

Understanding that his family often impacted his well-being, we started our family sessions. This helped build empathy among the family members about his desire to earn money. Family sessions encouraged the family to adopt simple actions that communicated a sense of care and appreciation.

Anand Story Continued...

Since, nutrition was neglected both by Anand and his family, cooking and eating meals together became a way to care for each other. As Anand began to feel welcomed in the family, he became receptive to the kind actions of his father in the current days. He noticed that his father nurtured and cared for his children and extended support like paying the children's fees, preparing them for school and also supporting Anand's wife when Anand became angry and violent.

However, addiction remained a common thread between Anand and his father leading to Anand: dealing with his distress through numbing. The team provided referrals to a local addiction center, but Anand refused. However, one day, when heavily intoxicated, Anand argued with a young girl while he was shutting down his shop. The Neighbours misunderstood the young girls' cry to be caused due being sexually assaulted and called in the cops. Anand was arrested for the night. Our team helped with legal aid and he was acquitted. This incident impacted Anand and his family and he decided to stop substance abuse. He began to find support and appreciation in his family. His Neighbours have also begun to support him.

Financial Report for the Year 2020-2021

BAPU TRUST FOR RESEARCH ON MIND AND DISCOURSE
TRUST REGD.NO. : E2970 PUNE
INCOME AND EXPENDITURE ACCOUNT FOR THE PERIOD 1ST APRIL 2020 TO 31ST MARCH 2021

PARTICULARS	ANNEXURE	FCRA	INDIAN	TOTAL 2020-21	2019-20
INCOME					
GRANT & DONATION INCOME	VIII	1,03,63,365	1,16,26,508	2,19,89,873	2,80,25,355
OTHER INCOME	IX	-	71,744	71,744	7,27,226
INTEREST INCOME	X	1,42,011	2,39,867	3,81,878	6,00,131
TOTAL		1,05,05,376	1,19,38,119	2,24,43,494	2,93,52,712
EXPENDITURE					
RENT EXPENSES	XI	2,67,561	1,72,840	4,40,401	3,86,400
AUDIT FEES	XII	78,750	15,000	93,750	60,000
REMUNERATION TO TRUSTEES	XIII	9,68,702	4,14,698	13,83,400	22,70,190
EXPENDITURE ON OBJECTS OF THE TRUST	XIV	84,64,605	1,05,97,273	1,90,61,878	1,98,57,953
ADMINISTRATIVE EXPENSES	XV	5,88,779	3,83,119	9,71,898	36,18,767
DEPRECIATION	IV	29,608	1,85,497	2,15,104	2,24,563
LOSS ON SALE / DISCARDED	XVI	-	3	3	-
EXCESS OF INCOME OVER EXPENDITURE	VII	1,07,371	1,69,689	2,77,061	29,34,839
TOTAL		1,05,05,376	1,19,38,119	2,24,43,494	2,93,52,712

NOTES FORMING PART OF ACCOUNTS - XVI — AS PER OUR AUDITED REPORT OF EVEN DATE

For Bapu Trust for Research on Mind and Discourse

Bhargavi Venkatasubramanyam
Managing Trustee
Bapu Trust

Place: Pune
Date: 08.09.2021

For H.Rustom & Co.
Chartered Accountants
Firm Rgd No.108908W

HRD Dalal
Proprietor
Membership No. 031368
UDIN:
Place : Ahmedabad
Date:

For A S Shaikh & Co.
Chartered Accountants
Firm Regd No. 139775W

Aslam Shaikh
Proprietor
Membership No. 162345
UDIN:
Place : Ahmedabad
Date:

Contact Details

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Thank You