DISABILITY-INCLUSIVE DEVELOPMENT MODEL: AN ASSESSMENT STUDY OF PARTNERSHIPS OF BAPU TRUST WITH DEVELOPMENT ORGANISATIONS

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Disability-inclusive development model:

An assessment of partnerships of Bapu Trust with development organisations

1. Introduction

Bapu Trust (BT) initiated a community mental health program called Seher – Comprehensive Urban Community Mental Health and Inclusion Program (SCMHI) in the city of Pune, Maharashtra in 2004, working primarily in low-income neighbourhoods. Evolving eventually into a "prevention, promotion, recovery and inclusion" program, rather than merely a "treatment" program, the services of BT were essentially guided by the definitive principles of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) for inclusion of persons with psychosocial disabilities within the ambit of development. Since 2009-2010 the program has aimed to comply with the CRPD and to focus on facilitating inclusion outcomes for persons with psychosocial disabilities. Over the past decade or so, the program has thus transitioned from a stand-alone mental health service to a disability inclusive development model, forging partnerships with development organisations and engaging in capacity building of these organisations by developing simple and accessible modules of core key concepts of mental health, and linkages with several support services and micro actions for fostering well-being.

The conceptual approach and vision of BT is anchored within the social determinants of disability inclusive model, linking health and development to human rights, social and economic marginalisation and exclusion. Subscribing to the paradigm of disability-inclusive development, BT's services represent a shift away from the dominant bio-medical model, to the view that psychosocial health needs to be addressed within the larger framework of development. The services of BT over the past few years have thus been informed and grounded in the conviction that development cannot be achieved

without including those with psychosocial disabilities and that development which excludes or overlooks people with psychosocial disability cannot be said to be true to its definition.

Mental health and development

More than a decade ago, the World Health Organisation in its policy analysis of integrating mental health in development had asserted, "Mental health represents a critical indicator of human development, serves as a key determinant of well-being, quality of life, and hope, has an impact on a range of development outcomes, and is a basis for social stability" (WHO, 2010). Further, a significant milestone has been the adoption of the *Convention on the Rights of Persons with Disabilities* in 2006 by the United Nations General Assembly that provided momentum to highlight the importance of the nexus between disabilities and mental health within a human rights-based approach. In addition, *the Ministerial Declaration on Implementing the Internationally Agreed Goals and Commitments in Regard to Global Public Health*, in the Economic and Social Council session of the United Nations in July 2009 highlighted the importance of integrating mental health into the implementation of the Millennium Development Goals (MDGs) and other internationally agreed development goals and commitments, in order to reduce poverty, promote better health, and achieve other development outcomes. Similarly, the World Health Organisation report on *Mental Health and Development* (2010), based on a comprehensive review of literature from varied sources, underscored the obligation of development stakeholders to include people with psychosocial disabilities in the development agenda. Further, the report pointed out that as bringing about improvements in the lives of the most vulnerable, including those with disabilities, needs to be a key development goal, it is through development programs that people with

mental health conditions can be enabled to participate fully in society. As the report emphasises, social participation can be achieved only when they "have access to opportunities and services, be liberated from stigma and discrimination, and be free to exercise their fundamental human rights" (p. 11).

Despite this growing global recognition however, of the integration of mental health in development, it has been observed in the same report that mental health has remained "one of the most neglected yet essential development issues" in achieving development goals (WHO, 2010).

The bulk of development practices currently in India, both by the state and by non-governmental organizations (NGOs), are geared towards addressing structural inequalities and for enabling and providing access to varied services ranging from education, healthcare, livelihoods, to water, sanitation and so on, and directed at the socially and economically disadvantaged communities in particular. These programs and activities are in line with the development phenomenon and agenda that had gained traction in the 20th century to mitigate poverty across the world (Rocha, 2013). The development NGOs are oriented therefore towards addressing socio-economic disparities that, besides stemming from historically ingrained hierarchies such as caste, gender, ethnicity and other such social markers, are also often said to be offshoots and consequences of the development policies pursued by the state.

In the past decade or so, a key focus, of these organisations has been the pursuance of the Sustainable Development Goals (SDGs) with their activities aimed to realize these goals in the areas of poverty reduction, livelihoods promotion, gender equality, education, healthcare, climate action, to name a few.

While such activities are numerous across the country, a rather striking gap is the virtual absence of the integration of psychosocial disability/mental health services within these activities. Psychosocial health and disability has not received due attention by organisations working in the development sector in India. Similarly, while there are several community mental health organisations across the country, identifying and providing treatment to those with mental health concerns, and again, primarily aimed at the disadvantaged (e.g., Balagopal & Kapanee, 2019), their attention is not directed towards as much to development issues, that could be at the root of mental health concerns. More importantly, these services are often not aligned to the larger framework of development, nor are they aligned to the CRPD or operate from a Disability Inclusive Development framework.

Indeed, the National Mental Health Programme (1982) itself, while underlining the emphasis on availability of mental health care to all, and envisaging the provision of community mental health services, has directed the effort primarily at integration of mental health care with general and primary health care services, as the principal means of achieving this goal (Ahuja et al, 2020). However, recent outcome evaluation studies have identified a major barrier to integration of mental health in primary health care services to be the already burdened primary health centres with limited staff, huge patient load and so on (Hans & Sharan, 2021).

While it is not the place here to put forth a critical view of the mental health policy and program in India, critics have pointed out that the vision of minimum mental health care as articulated in the National and District Mental Health Programme (NMHP and DMHP) has been equated with psychotropic medication, is not user-centred, & relies on pharmacological solutions for psychosocial problems (Jain & Jadhav, 2009).

It must be acknowledged nevertheless that following India's ratification of the CRPD in 2007, affirming its recognition of the rights of persons with disabilities, and the obligation the CRPD enjoins upon the state to amend existing laws and policies in line with the CRPD, mental health planning and legislation in the country have witnessed a significant impact. This impact has been in the direction of a shift away from an institutional model to a more community-based model of care (Ranade et al, 2022). Similarly, internationally recognised agendas of development including the current SDGs also have influenced mental health planning in the country with mental health currently being understood as an issue that is seen as cutting across key development concerns such as poverty, social inequalities, and so on (Patel et al, 2018). While these developments have certainly drawn attention to the mental health sector, the disability-inclusive

Box 1*: *Mental Health Policy Environment in India

National Mental Health Programme (1982)

- Availability and accessibility of minimum mental health care to all
- Integration of mental health care into primary care services
- Operationalised through District Mental Health Programme (started in 4 districts in 1997, currently covers 704 (Shastri, 2021)
- Provision of community mental health services, decentralising treatment from specialised mental hospitals and integrating mental health care in primary health care (Ahuja et al, 2020)

Mental Health Act (1987) enacted after repealing of Indian Lunacy Act of 1912

Mental Health Policy (2014)

- Delivery of mental health services within existing health system using primary care approach based on principles of universal access, equitable districution, community participation, intersectoral coordination (Hans & Sharan, 2021)

Rights of Persons with Disabilities Act (2016) to give effect to the UNCRPD (2006, ratified by India in 2007)

Mental Healthcare Act (2017) in pursuance of provisions of UNCRPD

- Provision, protection, and promotion of rights-based mental health care to people with mental illness
- Responsibility on state and mental health professionals for the protection of autonomy and dignity of people with mental illness

development framework is however, yet to be reflected in actual practice, with perhaps a few exceptions [e.g., the mental health and development (MHD) model of BasicNeeds, an international not-for-profit organisation set up in 2000 with work in India too (Underhill et al, 2017)]. This is particularly so in low and middle income countries wherein mental health continues to be perceived as a 'specialist domain' with limited or negligible relation to social development policies and programs (Plagerson, 2015). For instance, Ashley and Carney (1999) in their analysis of the evolution of the sustainable livelihoods approaches to poverty elimination, have pointed out that although these approaches are people-centred, responsive, and represent multi-level approaches to development, there is no reference to 'psychological capital' in these frameworks. Similarly, researchers and practitioners have pointed out the absence of mental health in the Millennium Development Goals – the previous set of development goals identified and accepted by the international community (Miranda & Patel, 2005).

It is thus in this context of a *crucial gap* – of integrating mental health/psychosocial disability within the larger context of development – that the work of BT assumes a special significance, both for social policy and development practice and for mental health promotion. BT's program aims to place *psychosocial inclusion* in the broader development agenda involving a paradigm shift from the dominant biomedical model of mental health to the social model of psychosocial disability, from health/public health to development, and from treatment to support care services and systems, and to ensure the right of people with psychosocial disability to be included in the community – thereby yoking the CRPD and SDGs together.

Mental health could get included for the first time in universally identified and agreed goals for sustainable development when the SDGs, adopted in 2015, included the

commitment to prioritize the prevention and treatment of non-communicable disorders that are now being recognized as constituting a major challenge to sutainable development.

According to this understanding of the linkages between mental health and well-being with SDGs, poverty, social and economic marginalisation, violence and violations of human rights and such other forms of social and economic vulnerabilities are major threats to human development and sustainable economic development and hence constitute an important context for mental health (McCabe & Davis, 2012; Raja et al., 2012; Underhill, 2010). Simply stated, good mental health and well-being is intrinsically related to the ability to reach and fulfill the SDGs and conversely, poor mental health represents key risks to changes that are needed in order to realise the SDGs (Dybdahl & Lien (2017).

A second key understanding is that mental health is a field that requires intersectoral coordination and working together in broader development agenda and strategies. This implies mainstreaming of mental health interventions into sectoral and broader development policies and plans and involves the use of the human rights approach to development. Such an approach recognises the protection and promotion of human rights as an explicit development objective and the inclusion of people with all forms of disabilities (Underhill, 2010). Both these developments – the SDGs and the CRPD had provided momentum to highlight the integration of mental health into development efforts calling for basic reappraisals of police and practice by governments as well as the voluntary sector (Mittler, 2015).

BT's recent work on scaling up its efforts and building partnerships with development organisations draws from this understanding that good mental health is related to the

ability to reach and fulfill the goals of sustainable development, as the very definition of mental health reflects. Although on a modest scale, as against the enormous burden of unmet mental health and development needs in the country, BT's scaling up initiative reflects the CRPD's emphasis on mainstreaming of disability issues into strategies for sustainable development, as underscored by Underhill (2010). The recent initiative therefore, of BT to scale up its efforts in other states represents the current global recognition of mental health as an integral part of the SDGs (Dybdahl & Lien, 2017), and may be characterised as a distinctive example of this approach in India, as this assessment study attempts to demonstrate.

2. Programming for Inclusion (PFI)

Drawing from the lessons and insights gained over the past two decades of its experience of providing services to the economically and socially disadvantaged in Pune city, and from the key principles of the community mental health model outlined above, BT set up the Programming for Inclusion (PFI) capacity building program in 2018-2020. This novel initiative was primarily aimed at creating pathways for "creating enabling environments for persons with mental health problems and psychosocial disabilities to achieve their full inclusion in communities" (Bapu Trust for Research on Mind & Discourse, Nd)

In line with its conceptual approach and vision outlined above, a key objective of PFI is to include psychosocial health within the overall frame of disability inclusive development. In this process, the PFI program, according to the core members of BT, aims to build partnerships with stakeholder groups through that is to develop a comprehensive training program on psychosocial health, and integrated development and inclusion. The key focus of this training is on building competencies, knowledge and skills in the participants as to how persons with psychosocial difficulties and disabilities can be

identified and included in their existing development programs, and in community life; how to respond to the mental health needs of constituencies served by them; how to develop and deliver psychosocial care skills - not just for the person but for the family, the community at large, persons with disabilities etc.

The key aim of this endeavour is thus to enhance the capabilities of stakeholders working in the area, in a Disability Inclusive Development Framework, and to convey the essential message that "creation of inclusive communities built on psychosocial sustainability can … mitigate the stresses of daily living" and that communities can be empowered to be psychosocially contained and experience wellbeing (Bapu Trust for Research on Mind & Discourse, Nd).

Accordingly, an 18-month long training program was designed and put in place in 2018 and currently, two batches of 30-35 participants from 7 organizations (development NGOs) comprising both senior-level functionaries as well as the field staff, in the states of Madhya Pradesh and Chhattisgarh have completed the training under the aegis of the program. The selection of these organisations was based on well laid-out criteria such as experience of working on development issues with marginalised communities in rural, urban or remote areas; robust governance and compliance systems in place; and willingness and openness to new learnings on psychosocial wellbeing and inclusion with an intersectional approach.

Supported by the Paul Hamlyn Foundation (PHF) the capacity building project included two 8-day long residential workshops along with online online supervision, field visits, and referesher courses. The training modules consisted of introducing participants to the spectrum of mental health; assessing people with mental health concerns by using standardized scales; identifying the gamut of psychosocial needs ranging from mental

health and counselling support to varied other support and mainstream development services; designing a customized intervention plan according to the individual needs and after obtaining consent; making referrals where necessary; and facilitating convergence with state institutions and other support structures for addressing the specific psychosocial needs of people. Additionally, the participants were provided with training kits of posters, games and booklets in three different languagues – English, Hindi and Marathi -- that could be used by them during the course of their engagement with the community.

The training is not aimed *only* at equipping participants with the knowledge and competency to identify those with mental health support needs, but also to *psychosocial* needs, and to provide them with the required support with the larger aim of facilitating community inclusion. This capacity building project of BT thus represents a major step forward in its efforts towards upscaling that it has done through forging partnerships with development NGOs in other states such as Madhya Pradesh (MP) and Chhattisgarh in India. It may be relevant to note in this connection that these are also states with relatively lower human development indicators in key areas of education, health care, gender equality, and designated as left wing extremism (LWE) affected states by the central government.

3. The present assessment study

The effectiveness of the training program has already been externally evaluated (Venugopal, 2020). An impact assessment on the ground of the intervention adopted by the stakeholder organizations following the training they underwent at BT is included in the second part of this report. The present study aims to address the following major research questions.

Key research questions

- What are the emerging lessons from the experience so far of implementing BT's disability inclusive development model in the states of MP and Chhattisgarh by local NGOs?

- What challenges and gaps remain to be met in terms of resources, training and communication materials, and knowledge transfer from the perspectives of the stakeholder organizations?

- What linkages and implications do these scaling up efforts have for psychosocial inclusive development in the country, especially in the context of India's commitment to the CRPD and to SDGs?

Method

The primary methods for gathering data to address the above-mentioned objectives are as follows.

a) Discussions with core members of BT involved in conceptualising, designing and implementing the PFI
b) Semi-structured interviews with key informants – the chief functionaries/ representatives of the partner organisations in MP and Chhattisgarh
c) Focus group discussions (FGDs) with the Community Mental Health Intervention Program (CMHIP) team in each partner organization in MP and Chhattisgarh.

The purpose behind selection of a qualitative research design is mainly to gather in-depth responses from the stakeholders involved so that the viability, facilitating and impeding constraints of the replicability/scalability exercise of BT's distinctive model of disability inclusive development can be better understood and analysed.

The data were collected through in-person visits to the field sites in the month of November, 2022. Except for one organisation that could not make itself available during the period of data collection, owing to prior commitments, the remaining six organisations that had undergone training by BT in two phases since 2018, were contacted and recruited for the study.

Field sites and sample

Interviews and focus group discussions (FGD) were conducted in the following sites and with the following participants:

Table 1: Field sites and method

	Organization*	**PFI Cohort Group**	**State**	**Year Estd**	**Field site**	**Method**	
						Interview of Chief Rep.	**FDG with CMHIP**
1	Chhattisgarh Agricon Samiti	Cohort 1	Chhattis-garh	2007	1. Raipur 2. Jagdalpur	2 1	1 1
2	Samaan Society	Cohort 1	MP	2010	Indore	1	1
3	Bastar Samajik Jan Vikas Samiti- BSJVS	Cohort 2	Chhattis-garh	2003	Jagdalpur	1	1
4	Community Development Centre (CDC)	Cohort 2	MP	2000	Balaghat	1	1
5	National Institute of Women, Child & Youth Development (NIWCYD)	Cohort 2	MP	1985	Bhopal	2	1
6	Vikalp Samajik Sanstha	Cohort 2	MP	2005	1. Indore 2. Anjad	1 1	 1
	*Of the seven organisations that received the training, only one organisation – GASVIS based in Pandhurna, MP – could not make itself available for the study					**10**	**7**

In addition to the initial discussion with core members of BT in Pune prior to preparation of the study proposal followed by an online interaction subsequent to formulation of research questions and objectives, a total of 10 individual semi-structured interviews with chief representatives/functionaries of the organisations and 7 FDGs with the field staff implementing the program on the ground were conducted in six different sites in the two states of MP and Chhattisgarh.

Ethical procedures of taking informed consent by way of introducing the researcher, explaining the purpose of the interview, and taking consent for recording the interview was done before commencement of every interview. The duration of each interview was between sixty to seventy-five minutes, while each FDG lasted for about two hours. The size of the FDG group ranged from three to five in each site. In addition to the audio recording, notes were taken during every interview and FDG.

The semi-structured interview schedule consisted of the following questions. However, there were several additional follow-on questions too, based on the responses given by the participants.

Questions for chief representatives/project coordinators of the organisations:

1. When and how did you get this idea of including/integrating psychosocial disability in your development activities?
2. You have now been implementing this program for some time, what has been your experience so far?
3. You have been already working with the community on various issues. What if any is the difference when it comes to working on including psychosocial disability in a development framework?
4. What have been the key facilitating factors for implementation?
5. What have been the major barriers/challenges that you have faced? What are the additional needs that you have and that you think will make the program more effective?
6. Based on your experience so far, do you think it is a good idea to integrating mental health in the development agenda and activities of NGOs?

7. What are your thoughts on including psychosocial disability in the development policy in the country?

Questions for CMHIP team members:

1. You have gone through the training given by BT. What has been the one key lesson you learnt and wish to implement it or are already implementing in your program?
2. How many people with psychosocial disability do you see on an average per day?
3. What have been the key facilitating factors for implementation of the program?
4. What are the major difficulties/challenges that you face?
5. When you do awareness programs in the community, what has been the most difficult barrier that you have faced?
6. You have been dealing with people with psychosocial disability, what is it that has given you the most satisfaction when addressing their concerns?
7. What are the additional needs – training or in terms of other resources – that you think will make the program more effective?

4. Analysis of data: What do the interviews and FGDs tell us?

The interview and the FDG data were analysed following the principles of thematic analysis and the following thematic categories were gleaned from this data:

A. Pathways of introduction and integration of mental health with development

B. Process of implementing the PFI

C. Enabling factors facilitating inclusion of psychosocial disability

D. Convergence of institutions: Implications of the program for development goals

E. Key challenges to implementation

A. Pathways of introduction and integration of mental health with development

The seven organisations with which BT has attempted capacity building of their staff for disability inclusive development, have had extensive prior experience working at the grassroots level with development issues such as poverty reduction, livelihoods promotion and mobilisation of women into self-help groups, violence against women and operating of ChildLine for issues of child marriage, child labour, and sexual assault of children and so on. All of them have also had experience of partnering with organisations such as UNICEF, APPF, CARE, to name a few, from whom they have received funding support for the development activities they have undertaken.

The organisations' experience ranges from 37 years (NIWCYD, Bhopal) to 12 years (Samaan Society, Indore) and they have had varied pathways in arriving at the importance of including and integrating mental health into their existing programs. A chief representative of Agricon in Raipur, Chhattisgarh recalled that a question posed to him by one of the key members of BT — *will you ignore mental health if you notice such concerns amongst the people you work with in your development activities* – resonated with him and spurred him to suggest and recommend to his board of directors about the necessity and usefulness of introducing the mental health component in their existing programs on agriculture and livelihoods.

Similarly, the Indore-based Samaan Society that had been working in the area of violence against women realised that an understanding of psychological factors associated with the causes and consequences of violence was also necessary in order to intervene in such cases. Further, when the organisation had planned and put in place livelihood promotion activities for women such as car driving and two-wheeler mechanic training, it was found that factors such as loss of concentration or easy distractibility precipitated primarily by domestic violence and the ensuing tension at home were impeding the women's full participation in these livelihood promotion activities. As the program manager in Samaan observed *Through the course of our work we found that freedom from (domestic) violence was not enough, what is needed is how to make them empowered".* This made them realise, she said, the importance of paying attention to safeguarding mental health and wellbeing of the women while at the same time ensuring sustainability of their livelihoods and economic self-reliance.

The chief representative of another organisation, Vikalp, working with women's self-help groups for poverty-alleviation in Barwani district of MP, observed that these women were often seen to be depressed due to family indebtedness, alcohol addiction of their husbands, domestic violence. Furthermore, while working with Child Line, the team often found the children to have made suicide attempts or to run away from home, primarily due to conflicts at home. It was these conditions of psychological vulnerability of the people they were working with that got the organisation to think about ways to address such concerns. According to the project coordinator of Vikalp, the training program offered by BT appeared to do so, and hence they expressed their willingness to partner with BT.

Similarly, the chief functionary of Community Development Centre, Balaghat in MP observed that although they had been working on social and economic issues ranging from mobilisation of women's self-groups for livelihoods, conservation of local resources in the tribal region of the state and so on, they came to realize that addressing livelihood issues in a stand-alone fashion was not enough. He pointed out that they had earlier been under the misconception that "*Livelihoods theek karne se, sab kutch theek hojayega"* (If we fix livelihoods, everything else will be sorted out) which got dispelled when through the course of their work, they observed psychological conditions of depression, frustration, anger, and aggression arising from socio-economic conditions. However, it was the realisation that they had no capabilities and skills to handle such vulnerabilities that spurred them to move towards equipping themselves with training for enhanced competencies in understanding and implementing interventions for mental health.

Significantly, and in addition, a critical event that acted as a catalyst in directing their attention to mental health issues was the Covid pandemic in 2020. All the four organisations from the second cohort (that were initiated in the second cohort of the training program in 2021) emphasised that it was the pandemic and the ensuing heightened psychological vulnerability created by the rising number of infections and deaths, and the resulting social isolation, fear and anxiety, and uncertain future due to loss of livelihoods, deaths, and health concerns, that made the organisations realise the deficit and gaps in their own knowledge and capabilities in dealing with psychological suffering and distress. They mentioned that the pandemic was a specific event of

enormous import, and a unique occurrence for which they were totally unprepared. As one of the project coordinators of Agricon observed, the pandemic and its psychological ramifications of anxiety, depression, fear and panic, amongst other emotions, was the latest feature to be added to the emergent mental health concerns, that they had begun to observe, either as causes, correlates or consequences of structural inequalities such as poverty, income disparities, unemployment, loss of jobs, distress migration, gendered and caste inequalities, poor governance and so on.

Thus, all the organisations had arrived at this understanding, albeit from different points of entry that a crucial *gap* in their development work was the attention that needed to be given to mental health and wellbeing and that this was the primary reason for their participation in the BT training program.

Box 2: Awareness strategies

- Corner meetings
- Poster meetings
- Awareness meetings
- Chalta Bolta
- Gully Charcha
- One minute anchoring

All of them asserted that they did not have clarity about what is mental health before embarking on the program; undergoing the training enabled them to first, clear their misconceptions about mental health; and that it was possible to integrate/include the mental health component into their ongoing development programs; and that the beneficial outcomes and impact they witnessed initially on their own selves, family and members of their organisation provided an encouraging fillip to experiment and attempt inclusion of mental health in their development activities.

B. Process of implementing the PFI

Following the training they underwent in BT, all the organisations reported pursuing a systematic process of beginning with

- Conducting of baseline survey; The WHO's Self-Report Questionnaire (SRQ) was used to gather data from random representative samples in the villages and blocks they were working with on their development activities.
- Community contact through a variety of strategies -- awareness, poster, and corner meetings in the areas wherein the organisation was already working

and was familiar; and in addition, brief, simple and innovative techniques termed as Chalta Bolta (talk while you walk) (Box 2).

- Identification and gradation of those with psychosocial needs from the survey scores as well as from these meetings.
- This was followed by designing of individual and customised interventions for those thus identified as clients with psychosocial needs.

Box 3: Customised intervention plan based on a 8-point framework of BT

- **Self-care**
- **Nutrition**
- **Social justice**
- **Family**
- **Group**
- **Individual support**
- **Healthcare**
- **Livelihoods**

The CMHIP staff in all the organisations reported using the techniques learnt and systematised by BT related to individual self care including deep breathing exercises, nutrition, one-on-one personal conversations with listening to their concerns, identifying their needs and then linking their needs with the required services from the community or from the government (Box 3).

When queried about what is the intervention they deploy for social justice, they responded that awareness of social inequalities in the village, based on caste, religion, class and gender in particular is the starting point for their intervention. The field staff of Community Development Centre, Balaghat narrated a simple strategy for ensuring inclusion and which they said may not be of enormous significance but which is nevertheless important for gently nudging the hierarchies of social geography of the village. They said that while conducting the awareness meetings, they ensure that the audience is not seated on polarised lines of these social groups and with village elders and others in the top rungs of the village hierarchy including the organisation staff on chairs but in a circle facing each other. In the customised intervention plan, the field staff said that they incorporate the notion of social justice by ensuring that people with any kind of mental health concerns are not discriminated against, are assured of care and support, and inclusion through community involvement and participation in their well-being.

Further, the district coordinator of Agricon in Jagdalpur, Chattisgarh observed that unlike in their livelihoods promotion and other development activities wherein they had target groups for particular programs and specific criteria for inclusion in the target group, the mental health component was open to all and hence there was horizontal integration and enabled the organisation to ensure inclusion of all.

As the project coordinators of Samaan and Vikalp stated, the emphasis of their interventions is not so much on mental illness and pharmacological solutions, but rather on maintaining *psychosocial well-being and inclusion*. Similarly, the district coordinator of Agricon observed that a common opening line that the staff used during the awareness meetings is *We have come here to talk about health, and not illness.* They reported that the training by BT helped them to learn techniques to promote wellness by drawing out people to share and ventilate their concerns, connecting them to other agencies for social and economic support, directing their attention to self care, nutrition and to the importance of keeping themselves physically and mentally healthy.

While awareness generation about mental health is the initial step to secure entry into the community, the gamut of services that fall within the ambit of diability-inclusvie development constitute psychological first aid for responding to people through providing non-specialist care services, psycho education, early detection, eliciting active involvement of family and community, support for livelihoods, home visits and establishing a circle of care with linkages to government agencies for getting access or clearing delays in securing services such as pension, Aadhar card, disability certificate etc.

The CMHIP team of Community Development Centre in Balaghat, MP narrated the example of a young woman with three children who was reported to be extremely withdrawn and unresponsive even to her children, occasionally wandering off and sitting alone in the cremation ground, preoccupied and lost in her thoughts. Upon inquiry, the team found that a critical incident that had triggered these behavioural changes in woman was reportedly the collapse of her house roof during the recent floods, and the family's financial inability to get it repaired, and the consequent deplorable condition in which the family was currently living. As the team had identified the housing condition to be a key factor leading to depression, they contacted the village panchayat and other concerned

government authorities to facilitate funding of her house repair from the Prime Minister Awaz Yojana. The team reported that currently the paper work was in process and that after they had given this assurance to the woman and that her housing need would be fulfilled soon, they noticed a beneficial change in her as she was seen to be conversing with others, and resuming attending to the family, and engaging in her daily routine of activities and so on.

All the CMHIP teams gave several examples of such individual interventions: of identifying a range of psychosocial needs and concerns in individuals, encouraging them to engage in a daily regimen of self care activities, and providing them with the requisite linkages with government services, schemes and resources and actively supporting them in getting their due from the state.

However, these individual interventions were not merely between the individual and the organisation's field staff. As the intervention involved enlisting the community support to ensure that the individual is not excluded or discriminated, soliciting institutional support, e.g., the sarpanch/panchayat, anganwadi workers, other government functionaries, school teachers and so on for the range of support services the individual may need, and informal support of neighbours, other family members for daily needs and care, the intervention ensured that the decision making and support strategies that were deployed remained *community-driven* with the active participation of the community at all stages.

Apart from these individual interventions, the field staff engaged in regular and planned community level involvement through holding awareness meetings either in the form of holding poster exhibitions and/or corner meetings with small groups; and simple and quick forms of contact such as *chalta bolta* or talk while you walk wherein the field staff strike conversations with the local people and enquire about their well-being and concerns. In the awareness/poster/ corner meetings, the field staff attempt to convey mental health messages through fun-filled activities that elicit a relaxed atmosphere.

While adhering to the procedures and interventions learnt in the course of their training in BT, some organisations also reported designing and putting in place innovations of their own. Integrity with the BT model and innovations put in place: For instance, Bastar Samajik Jan Vikas Samiti (BSJVS) in Jagdalpur, Chattisgarh has put in place a feature

involving training of young women called Sangwadis for testing certain physical health parameters such as blood pressure, blood sugar, haemoglobin etc, providing them with devices to do so, and then to speak about mental health and the importance of maintaining mental well-being in the course of their interactions with people. Similarly, the *Manmitra* initiative of Agricon in Chattisgarh refers to the approach to utilize existing multi-purpose workers and create and train a tier of workers to provide healthcare and make available simple interventions.

The process of integrating psychosocial health and wellbeing in their development activities thus involves a two-pronged approach:

- At the community level: promotion of mental well-being through ventilation of concerns, reflection, emphasis on self-care, nutrition conveyed via fun-filled activities; raising awareness about importance of mental health; dispelling myths about mental health/illness
- At the individual level: designing and customizing intervention plan for recovery and inclusion that involves providing support for varied needs; monitoring and follow-up through home visits; making referrals wherever necessary and connecting them to other agencies for social and economic support (e.g., enabling them to secure disability or pension certificates, Aadhar cards, assistance with police or legal support, information about govt schemes and so on).

The investment of resources -- of time, money, and importantly of human resources – is therefore directed towards ensuring that individual well-being remains connected to community support services and support systems and with access to mainstream services rather than turning towards 'expert' oriented treatment and institutionalization. This vision of BT's PFI is elaborated in the principles of community inclusion (Box 4 below) adopted by *Transforming Communities for Inclusion* (TCI), a global organisation of people with psychosocial disabilities, of which BT is an important constituent (TCI, 2022).

***Box 4: Basic principles for ensuring community inclusion of people with psychosocial and multiple disabilities* [TCI, 2022]**

- Access to mainstream services (health care, education, skill development, housing, food & nutrition
- Community support services (social protection schemes, pension schemes, disability card etc)
- Erasure of some legal and allied services associated with institutionalisation systems
- Enabling de-institutionalisation and preventing institutionalisation
- Removing social, legal and attitudinal barriers preventing persons with psychosocial disabilities leading uninterrupted lives in the community
- Allowing communities to perform some of the support and care functions as found in human habitats more naturally, trusting processes of community exchanges, trust and negotiations
- Active role of governments in removinng barriers and discriminatory services and practices

From its vision and practices followed, it does appear that BT has taken a leaf out of the community mental health approach, especially some key principles and messages of integration of mental health into public health such as for instance, a) that such efforts need to be anchored in local community, incorporating input from the community, family groups and using locally appropriate models and working in close partnerships with local community; b) best chance for recovery is in the community; and c) implementing a spectrum of services -- early case detection, follow-up, rehab and recovery; monitoring and evaluation for scaling up (e.g., Ginneken et al, 2017; Giri et al, 2021; Pandya et al, 2020). But the distinctive practice of BT through its capacity building efforts seems to be focused on getting the community to be invloved in ensuring inclusion of people with disabilities. Thus the mental health promotions sought to be put in place by the development organisations are rooted in community support and strengths in contrast to those that are entrenched in models of community pathology (McCabe & Davis, 2012).

The tables below indicate the expanse and reach of the seven organisations in taking the program to the people in the areas of their work.

Table 2: Expanse and Reach of the Organisations through Programming for Inclusion

Cohort 1 [October 2020-Sept 2022]					
Organisation	Awareness strategies	Total no. of meetings	Total no. reached	Male	Female
Samaan	Corner meetings	472	3850	587	3263
	Poster meetings	153	1652	499	1426
	Awareness meetings	9	244	35	209
Agricon	Corner meetings	431	10,038		
	Awareness Meetings	407			
Cohort 2 [Oct 2021-Dec 2022]					
Vikalp	Corner meetings	58	535	247	288
	Poster meetings	40	712	380	473
	Awareness Meetings	38	386	143	243
	Chalta Bolta	34	338	181	157
	One minute anchoring	37	229	108	121
	Gully Charcha	34	266	98	168
CDC	Corner meetings	198	1414	1034	1180
	Poster meetings	133	2002	988	1014
	Awareness Meetings	15	175	39	136
	Chalta Bolta	17	146	61	85
	One minute anchoring	23	135	68	67
	Gully Charcha	26	174	91	83
BSJVS	Corner meetings	74	1015	362	653
	Poster meetings	43	620	246	374
	Awareness Meetings	14	295	104	191
	Chalta Bolta	20	191	104	87
	One minute anchoring	9	45	24	21
	Gully Charcha	54	200	100	100
NIWCYD	Corner meetings	66	1239	332	907
	Poster meetings	13	361	38	323
	Awareness meetings	23	1828	540	1288
	Chalta Bolta	27	683	170	513
	Gully Charcha	6	37	5	32

Table 3: Client work by the organisations

Indicators	Agricon	Samaan	Vikalp	CDC	NIWCYD	BSJVS
No. of Clients Identified	43	21	18	88	49	28
No. of individuals for whom field enquiry is complete		34	17	9	8	22
No. of individuals for whom Assessment is complete			8	9	8	16
No. of assessments completed successfully		20	8	9	8	16
No. of clients served			0	9	13	16
No. of clientwork sessions done in support work	19	131	0	14	13	28
No. of self care sessions done	308	464	0	0	247	32
No. of individuals who were referred for other services		10	3	9	1	14
Nutrition sessions	65	12	0	0	0	0
Family session	32	6	0	0	0	0

Source: Data shared by the organisations and compiled by BT

As can be seen from the above tables, individuals who can be termed as 'clients' with varied psychosocial needs are not in huge numbers although the populations reached out in terms of their participation in different modes of awareness meetings are higher. Even if these numbers are not substantial, what is perhaps of more significance is that the conceptual basis of integration of mental health in development programs and activities can be seen in practice on the ground.

C. Enabling factors facilitating inclusion

The credibility and familiarity with their constituency that the organisation has achieved so far is the key factor enabling them to establish rapport and provide assurances of safety and confidentiality and serves as a sounding board for people to air their concerns and to serve as a one stop centre for resolution.

Both the chief functionaries and the field staff of all the organisations reported that the primary reason for easy acceptance of the mental health component can be attributed to the prior experience of working on development issues and through which they had

garnered credibility with people and which eased the process of communicating the importance and relevance of mental well-being in their daily lives.

Given the challenges in negotiating communication of the concept of mental well-being, and use of vocabulary that would be easily comprehensible to the community, two of the organisations ensured that they recruited project staff who were either from the community and/or who know the local dialect. This ensured better connect with the community encouraging them to come forward and either speak about their own issues or to refer anyone in any sort of distress to the project staff. The CMHIP staff of Bastar Samajik Jan Vikas Samiti, Chattisgarh pointed out that the use of the local dialect (Halbi) by the field staff ensured that they were not looked upon as 'outsiders' and as 'different' but rather as 'one of us'.

A second major facilitating factor, according to all the organisations was the simplicity of the interventions that was able to catch the attention of the villagers, elicit their immediate attention and interest, and did not involve additional investment in terms of resources except for human resources.

The CMHIP field staff in particular reported that the opportunity their intervention provided to the community for ventilation and sharing of their concerns, be it personal, related to family, economic issues or those related to delays and difficulties in accessing government services, on an *individual* basis is what is enabling them to connect with the community. The individual connect is further cemented with the follow-up and monitoring that the field staff do through regular home visits and enquiries about their well-being.

Third, it is through integrating mental health in their development activities that they perceive that there has been a perceptible increase in their engagement with the community that in turn is further leading to a re-envisioning of what is development and how and why mental health should be integrated for a more inclusive development framework. For instance, Agricon, one of the organisations in Chattisgarh, adopting a bottom-up approach, conceived of a program to involve young adults for communicating the importance of mental wellness. Started initially in ten villages, the youth program has now spread to four districts in the state of Chhattisgarh with three different types of volunteers: one, a cadre of volunteers termed as the 'influencers' who are entrusted with

the responsibility of communicating with the community about what is mental health; second, the 'campaigners' who use the medium of *nukkad natak* or street plays to drive home their message about importance of mental health and ensure participation and inclusion of those with mental health concerns in the community; and third, the community mental health team known as *manmitra.*

A fourth facilitating factor is the space provided by the intervention to focus on 'interiority' – emotions such as anger, fear, sadness, disappointment and such other emotions. As the chief representative of Community Development Centre, Balaghat pointed out, although they had, as a development organisation been working in the field for several years now on issues that have an immediate bearing on people's social and economic lives, there was no platform or space to talk about feelings, emotions, the everyday stresses and tensions people experience in their lives. He observed that through the mental health intervention, they were able to provide just this kind of space; and in the absence of any kind of mental health professional services in the area – psychiatrist, psychologist or counsellor – this "*experiment has turned out to be successful … and effective for release of tension that we were earlier not aware of how it affects all aspects of our lives…".*

D. Convergence of institutions: Implications of the program for development goals

Sharing his reflections on how they got started, the chief representative of Community Development Centre, Balaghat observed that their initial work with women's self-help groups for livelihood programs, child malnutrition and building capacities of front-line health workers made them realize the importance of 'system strengthening' and the strengthening of *panchayati raj* institutions (local level state institutions) in particular if effective development is to be delivered. Observing that over the past four decades or so, NGOs have sought to fill in the deficit gaps left by the government, and that he was acutely disappointed with the way in which the government was addressing issues of development and delivery of services including education, water, sanitation, health care, livelihoods and conservation of local resources in regions such as the tribal belt of the state, this functionary shared his views on the vital necessity of an integrated approach to development. He emphasized that sectors such as health, education, and livelihoods

and government policies and programs in these sectors need to function in convergence, and second, that livelihoods and economic empowerment cannot be addressed in a stand-alone fashion by ignoring or overlooking mental well-being.

The chief functionary of the Bastar Samajik Jan Vikas Samiti in Chattisgarh said that their long and extensive experience of working with different state institutions and establishing a convergence with them for development programs helped to create an ecosystem such that the mental health component could be seamlessly integrated. A network of institutions such as various line departments of the government, ASHA workers (referred to as *Mitanins* in Chhattisgarh), Anganwadi workers, school teachers, self-help groups, with whom they have been already working with and who are familiar to the community, is what eases their entry into the community. Further, the continuing support the organisation receives from the community leadership such as the village sarpanch /panchayat, school teachers, and the network of healthcare workers serves as a crucial glue with the community.

In the case of high-need clients in particular, it is this networking and linkages with community-level representatives that ensures monitoring and follow up of the cases. For instance, the project coordinator and field staff of Agricon in Jagdalpur narrated the case of a young woman in her twenties who had been kept confined in a small room in her house, was found to be underfed and severely malnourished to the extent that she could not be on her feet, completely withdrawn and unresponsive, and unkempt in appearance. After having identified from a source in the community about the possibility that this woman could be a client with high need, the field staff of the organisation first got her admitted in a hospital in order to check for any infection, and then on her return home connected with the village sarpanch and an anganwadi worker, got the village sarpanch to provide travel charges to the hospital and arrange for a bed, and ensured that the neighbours in the community kept an eye on her. The regular home visits ensured that she was fed daily, and importantly, the personal one-to-one interaction with the client helped to draw her out of her isolation. The field staff reported that after nearly three months of follow up and monitoring, the client was able to walk, take care of herself, and respond when spoken to. Although the changes noticed in the client were not extensive, the field staff said they were nevertheless in the direction of regaining of psychological well-being and as one of the staff said their primary intention was to enable her to be

connected and be included in the community — *samaj se judna* (or be connected to society/community). A second signficant feature of this case study is that the field staff through their intervention were able to prevent *institutionalisation* of the woman, exemplifying the CRPD guidelines laid down in Article 19 on deinstitutionalisation. As a core member of BT emphasised, such cases demonstrate that the intervention ensures not only prevention of institutionalisation of even a high-need client but also that such individuals are "*not dragged further into the quicksand of homelessness, impoverishment, starvation and so on"* .

Thus a key strategy for ensuring inclusion of people with psychosocial disabilities as well as convergence with local institutions was enlisting involvement of state agencies for the varied psychosocial needs of those identified as clients.

In response to a question whether such a mental health intervention could redress or even address the socio-economic basis of psychological distress – poverty, loss of livelihoods, gender-based violence and so on -- one of the project coordinators of the Chattisgarh-based Agricon said that it was their work at two levels that was addressing both socio-economic and psychological dimensions. First, at the community or collective level, their work with issues that were of pressing concern such as livelihoods promotion, agriculture-allied activities involved either providing them with agricultural inputs or learning of new techniques/technologies, or access to additional resources/services from different government departments, and facilitating linkages between people and the government, thereby intervening and resolving issues at the larger socio-economic level. Second, with the introduction of the mental health component in their activities, the organisation was now able to look more closely at individual psychosocial needs, provide a safe space for the person to ventilate and share feelings and emotions, and direct their attention to the importance of maintaining psychological well-being through simple interventions such as self-care and nutrition; further, through addressing taboos and alleviating misconceptions regarding mental illness, the organisation is attempting to put in place the process of ensuring that the person is not excluded by the community, by suggesting simple ways of providing care and inclusion. The project coordinator summed up their approach by terming it as 'holistic' that they felt was having a beneficial impact.

Further, the partner organisations are attempting to plan interventions according to the 3-door intervention framework that they had learnt about in their training: the small door through which they are addressing mental health needs viewing them through the mental health spectrum; the larger door through which they are able to address broader development needs and add the required development services. At the level of the largest door however – that of adoption of a human rights perspective – the organisations are yet to, in my view, internalise the language of human rights. which, to be fair is admittedly a goal that is not easy to reach, to say the least.

In the aftermath of the pandemic in the last two years, the process of ensuring *apnapan* or bonding with the people meant that they often went beyond the call of their duty to establish the connect with the people. For instance, the field staff of Community Development Centre in Balaghat, through their home visits, ensured that those either infected or those migrant workers who had been quarantined on their return home received their share of rations and did not remain isolated without any recourse to assistance. These efforts indicate, as Hutcheon and Steiner (2022) point out to the "growing importance of the role of community led organisations in creating social infrastructure and its impacts on the health and well-being of disadvantaged populations" (p.16).

It is thus this emphasis on recovery, inclusion and promotion of psychological health and well-being rather than on treatment of 'illness', that is distinctive of the approach to disability-inclusive development that BT has adopted and attempts to convey through its partnerships.

E. Key challenges

Both the chief functionaries and the field staff recruited for implementation of the program mentioned that there was initial resistance to the concept of disability inclusive development, both from people on the ground as well as their Board of Directors and other colleagues responsible for decision-making. According to the project coordinator in NIWCYD, Bhopal this resistance partly stemmed from the widely prevalent perception that "*mental health hamari bas ki baat nahin… yeh to psychologists ya psychiatrists ka kaam hai, ham to development NGOs hain"* (mental health is not within our purview, this is the work of psychiatrists and psychologists, we are development NGOs). The project

coordinator in Agricon echoed this statement and further exemplified by saying "*ham yeh sochte the pehle ki yeh mansik bimari jaisi chhesen davai se hi theek ho sakta hai, aur hum to doctor ya psychiatrist nahin hai, to hum kya karsekte hain iske barein mein"* (we were under the impression earlier that concerns such as mental illness can be handled and treated by medicines only, and as we are not doctors or psychiatrists, we cannot do anything about this). As mentioned earlier too, the chief functionaries and the project implementation teams both admitted that prior to the training they had no clarity about what is mental health and had erroneously assumed that mental health referred to only 'illness' or to the widely used pejorative term '*Paagal*'.

Thus the perception that mental health is only about illness, which is beyond their purview – both by virtue of they being development NGOs and the fact that they were not medical doctors/psychiatrists -- and that it can be only 'treated' with medication, was and continues to be a major challenge in the course of implementing and integrating mental health in their programs.

The chief functionary of CDS in Balaghat observed that while they continue to struggle with this perception, a further challenge they face is to make people realise mental health is not mental illness; and to find appropriate language and vocabulary to communicate the concept of mental health. He further pointed out that the techniques their staff learnt in BT and the activities they carry out have, over the past one year or so, been effective in enabling people to open up, share their concerns, release their psychological tension to some extent, a key challenge they face is their helplessness when it comes to severe mental disorders, for which, he said they are not equipped to handle. While recognising that it may not be within their purview to do so, he pointed out that even if they wished to make referrals for such cases it is not easy due to the dearth of psychiatric services in the areas of their operation.

5. Concluding observations and way forward

All the participants whom we interviewed and interacted with — the chief functionaries as well as the team members implementing the mental health program — acknowledged and asserted that it was the credibility of the organisation, the familiarity which they had already established with the community through their long years of working on

development issues with them, that enabled them to introduce the component of mental health in their existing development programs almost seamlessly.

These organisations have both integrated mental health into their development activities as well as provided a distinctive space for it by having a unique name for the program. For instance, Saman Society calls it “Khushaali” or Well-being while Agricon has adopted “Aao Baat Kare” or “Let us talk”.

The differences between the partner organisations stem from their varied histories of involvement and experience in implementation of development programs as well as the duration of association and mentorship by BT. Hence the first cohort of organisations that received the training in person and has now implemented the program for nearly four years now with continuing supervision being provided by BT appears to have stabilised in terms of allocation of field staff, designing and planning of activities, monitoring and extending their scope further. While all the organisations in the first and second cohorts are adhering to the steps and processes as undergone in the training given by BT, the first batch, depending on the resources available to them are going ahead with additional activities such as preparing toolkits in the local language, and creating a helpline and a cadre of young volunteers (who do not receive any payment or incentive, but involve themselves out of a spirit of volunteerism only, e.g., the initiative undertaken by Agricon in Chattisgarh as mentioned earlier).

The scale of operations of the PFI initiative may be modest and small, when viewed against the backdrop of the huge mental health burden and inadequate services for amelioration and access to services in India. All the organisations reported working with 30 to 40 clients from the inception of the mental health component. Although the number of people they encounter during the awareness and corner meetings is much more, the relatively small number of clients who are identified as high need and with whom individual interventions are customised according to their needs, makes it appear as if the project is time intensive and for this reason has limited reach and impact. However, even if the effort takes considerable time and effort, the organisation staff said that it was worth it for the reported positive change in clients and the satisfaction they derived from being given this feedback by the clients and families.

As Underhill (2010) points out in the WHO report on *Mental Health and Development*, "integration is a process, and not an event" (p. xxiii) and as such, requires sustained commitment; and building the capacity of service users to participate fully in public life.

With an overwhelming majority of India's population being rural-based (World Bank, 2015) while psychiatry services remain primarily an urban phenomenon (Nunley, 1996), and a huge care gap continuing to be a marked feature of the mental health scene in India (Box 5), the capacity building initiative of BT and the interventions planned and implemented by the development NGOs with rural populations represent an innovative approach to development and psychosocial disability.

Box 5: Mental Healthcare Professionals in India

Mental health professional	Need	Availability
Psychiatrists	13,500	3,800
Clinical Psychologists	20,250	900
Psychiatric Social Workers	35,000	900
Psychiatric Nurses	30,000	1,500

Source: Ministry of Health & Family Welfare, 2021

While addressing key domains of human development such as livelihoods promotion, sustainable agriculture, education, and (physical) health care, the capacity building program of BT and the interventions implemented by the NGOs are in line with the current emphasis of global organisations such as the WHO as well as by mental health professionals in India and elsewhere on the need for innovation and capacity building to develop and implement locally relevant, feasible and effective mental health care services (Becker & Kleinman, 2012). As the chief functionary of Community Development Centre in Balaghat, Madhya Pradesh asserted emphatically, "*Mental health is an integral part of development; it cannot be treated as a 'program'…. What will the output be? Cannot say, it is not directly visible… what will the impact be? It is not easy to quantify it but we can see from our experience, it is beneficial to the people, and to us too … we want to listen to people and their concerns, not 'sudhar'* [reform] *them"* .

The key interrelated features that have contributed to the effectiveness of the disability-inclusive development model initiated by BT are two in my view: a) the partnerships that

BT has been able to forge with development organisations and b) the transfer of capacity building skills and techniques based on values of social justice and the right to inclusion that BT has been able to convey through its trainings, mentoring and supervision to the development organisations. As stated earlier, the organisations with which BT has partnered are those with long and intensive experience in the development sector, with deep engagement with issues like poverty alleviation, sustainable agriculture, gender equality, child rights and protection and so on. With the incorporation and integration of the mental health component now in their development programs, they are able to put in place a holistic approach to development that has mental and physical well-being and inclusion at its heart. Through the forging of these partnerships, BT has thus been able to demonstrate that it is possible to effectively include psychosocial health in development activities without consigning it to the (biomedical) 'specialist' sector. The mental health intervention of the development organisations have therefore underscored the importance of looking at the "ecology of suffering" (Bayetti et al, 2015) by showing the linkages of mental distress with a wide range of crucial social, economic and local factors, and how organisations such as these can mediate between the individual sufferer and the goal of well-being.

The partnership model also establishes and validates a two-way process. Given the background of the development organisations, it would not have been possible for them to integrate psychosocial well-being and health without the capacity building and mentoring they received from BT. On its part, despite the rich experience BT has had in psychosocial interventions, it is not an organisation that has the kind of experience that the partner organisations have in the development sector.

As Chris Underhill (2003), one of the initial proponents of the integration of mental health and development model had perceptively observed, nearly two decades ago, the model can be effective when the following modules are incporporated: Capacity building; sustainable livelihoods; community mental health; research; management and administration. The BT initiative has demonstrated that the integration of mental health and development is possible through partnerships and thereby the expansion of the model in practice.

The capacity building and training by BT, while engaged in the nuts and bolts of communicating and transmitting information on everyday stress, importance of maintaining psychological well-being, and learning of techniques to do so, is imbued with the philosophy and vision of the CRPD. And it is through this vision that the PFI has sought to make the concept of disability-inclusive development work in practice. To elaborate, the CRPD, as is well known by now, is not only an international, legally binding instrument, ratified by India in 2008, but represents a consensus over disability-related definitions, issues and solutions, built by decades of sustained activism by disabled people's organisations and civil society actors acting on their behalf, and a decisive paradigm shift in the "very understanding of disabled people's way of being" (Mladenov, 2013). This paradigm shift, as articulated in the UN website, has been in the direction of "viewing persons with disability as "objects" of charity, requiring medical treatment and social protection towards viewing persons with disabilities as "subjects" with rights, who are capable of claiming those rights and making decisions for their lives based on their free and informed consent as well as being active members of society" (http://www.un.org/disabilities/default.asp?navid=14&pid=150, cited in Mladenov, 2013). This transformation in the very understanding of the ways of being of people with disabilities is not merely a rhetorical position; rather, as Article 19 of the CRPD exemplifies, the right to be *included* in the community cannot obviously be realised by invoking personal freedom and autonomy alone. As Arnadittor and Quinn (2009) in their analysis of the UN instrument emphasise so effectively, "It is plainly not enough to enact anti-discrimination laws to break down arbitrary barriers. It is also necessary to assist people in getting past those barriers. The deeper paradox – one that obtains for all persons – is that personal freedom ultimately relies on social solidarity" (p. xviii, Arnadottir & Quinn, 2009). It is this sense of *social solidarity* and actions to put this vision in practice that mark the BT PFI initiative as not only being in synchrony with the guidelines of the CRPD, but as an innovative and distinctive approach to translate the disability-inclusive development model into reality.

The experience of the development organisations studied in this impact assessment project demonstrates that the psychosocial interventions put in practice by them augments and supplements their development work in ways that leads them to position their work in a disability-inclusive development framework. Given the modest scale of

operations, the transformation of communities towards the goal of inclusive development may currently appear rather distant, but it is a goal that is certainly feasible.

6. Recommendations

1. Despite the huge numbers of various development and community mental health organisations working in the country for several decades now, they have been doing so, by and large in silos, and the catchphrase *integration of mental health in development* has remained mostly rhetorical. The BT capacity building and partnership strategies have demonstrated that it is possible to a) bring the goals of sustainable development and mental health together in practice and b) development and mental health organisations can and need to forge partnerships of this sort so that strengths of each can be harnessed in ways that can be benefecial to the community. Therefore, the program funding needs to be sustained further for the approach to have sustantial impact.
2. Although the partner development organisations have undergone intensive training by BT, mentoring and supervision on the part of BT needs to be continued. In particular, the second cohort of organisations that underwent online training only (in view of the Covid pandemic) needs additional support in terms of further training and supervision for the disability-inclusive development model to be effective on the ground.

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Appendix I

DISABILITY-INCLUSIVE DEVELOPMENT MODEL: AN ASSESSMENT STUDY OF PARTNERSHIPS OF BAPU TRUST WITH DEVELOPMENT ORGANISATIONS

January 2023

Sustainability of partners' interventions on families and communities

A community based impact study by Dharma Padalkar

20th January 2023

Bapu Trust initiated a training program on inclusion of persons with psychosocial disability for organizations those are working in development sector in two states of India (Chhatisgad and Madhya Pradesh). Out of five organisation we conducted an evaluation of three organisations. The rationale for choosing only 3 organizations is that, the field engagement of other 4 organizations is a little over a year old. The 3 organizations enrolled in the study had about 3 years' practice of implementation. The organizations are Samaan Society, Agricon Samiti and GASVS.

The purpose of this study was to evaluate the impact of the interventions, in which the organizations had been trained, on families and communities. The specific objectives are:

- To understand the impact of partner NGOs services on people and their families who have used the services
- To understand the attitude of team members towards clients
- To understand the training impact on staff
- To understand the contextual modification made while implementing the program
- To understand the challenges faced by staff

Methodology

A survey was conducted from October 2022 to November 2022 among communities of the 3 partner NGOs. All clients whose cases were 'closed' participated in this survey. We visited 70 people who had received services from the partners. We took verbal consent and did the interviews with them. We included those clients who are ready to participate the in study. Migrant people (4), those who were admitted in a hospital (1), refused (2) and death (5) were excluded from the total sample. The objective of the present study was to understand the impact of partners' services on the client and their families.

We used Bapu Trust's semi-structured interview schedule. 58 clients were approached at their home.

We used interview guide for conducting qualitative interviews. For qualitative data collection, the team comprised of two persons, one interviewer and one observer. We conducted 2 focused group with organisation's staff, 3 focused groups with community stake holders and 3 in-depth interviews with organisation's leaders.

Both quantitative and qualitative data was entered and analysed using Microsoft excel software.

Findings from the study

Profile of respondents:

Table 1: Need wise client type per organization

'Support clients' are those whose tensions, stresses and psychosocial distress is contingent upon their social, economic, household or cultural factors. Once those are addressed, the stresses are released and psychosocial needs are addressed. They face lower level of discrimination. 'High needs' clients are those who may be hearing voices, wandering, isolated, suicidal or otherwise facing very high level community exclusion and discrimination.

Name of the organisation	Number of High Need clients n (%)	Number of Support Need clients n (%)	Total
Agricon	0(0)	24(100%)	24
GASVS	3 (25%)	9 (75%)	12
Samaan Society	2 (9.10%)	20 (90.90)	22
Total	5 (8.60)	53 (91.40%)	58

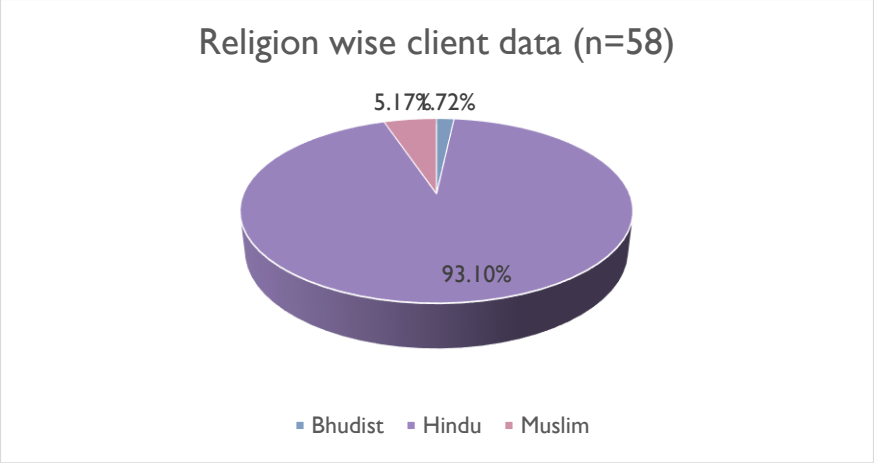
Data shows that almost 91.40% clients are support needs and 8.60% clients are high need.

Table 2: Organisation & gender wise client data

Name of the organisation	Female n (%)	Male n (%)	Total n (%)
Agricon	20 (83%)	4 (17%)	24
GASVS	3 (25%)	9 (75%)	12
Samaan Society	20 (91%)	2 (9%)	22
Total	43(74%)	15(26%)	58

As seen, 74%(n=43) of clients were female and 26% (n=15) were male. Samaan Society and Agricon have more number of female clients and GASVS had more male clients.

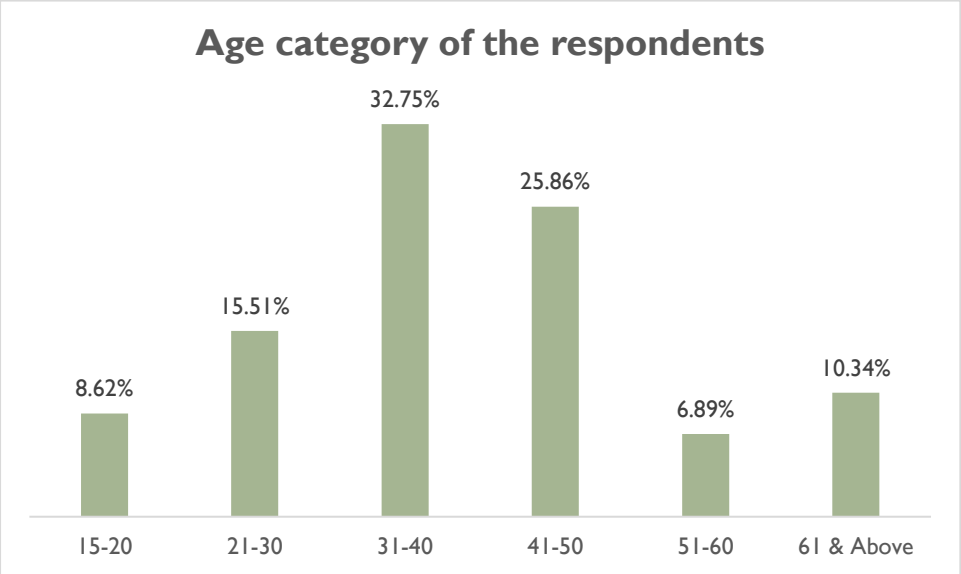
Figure 1: Religion of respondent



Ninety-three percent (n=53/58) of the respondents belong to Hindu religion. Three clients of Agricon were Muslim.

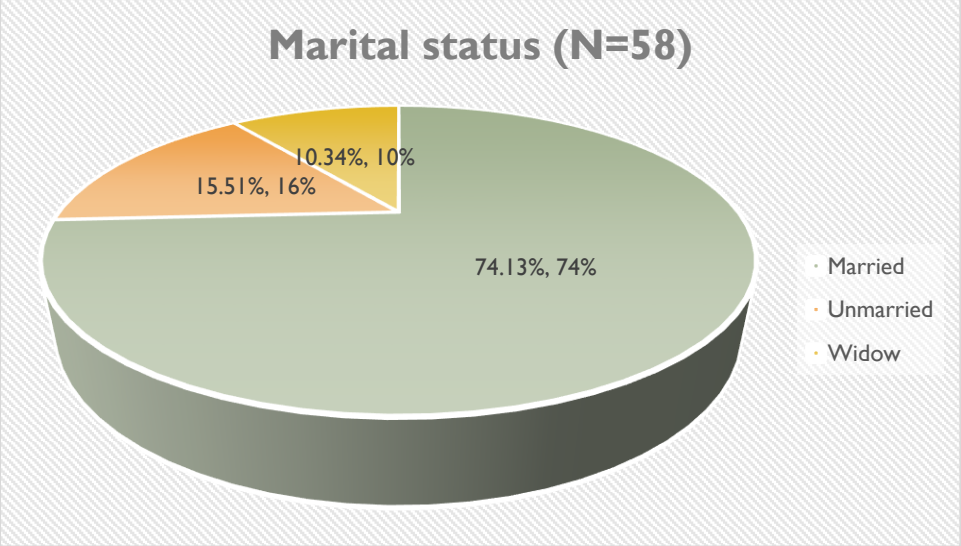
Average age of clients was 39.63 years (16 to 70 years).

Figure 2: Age category of the respondent



Nearly 33% (32.75%; n=19/58) of the respondent were in the age group of 31-40 years. Data shows that more than half of the 59% (n=34/58) clients were of middle age.

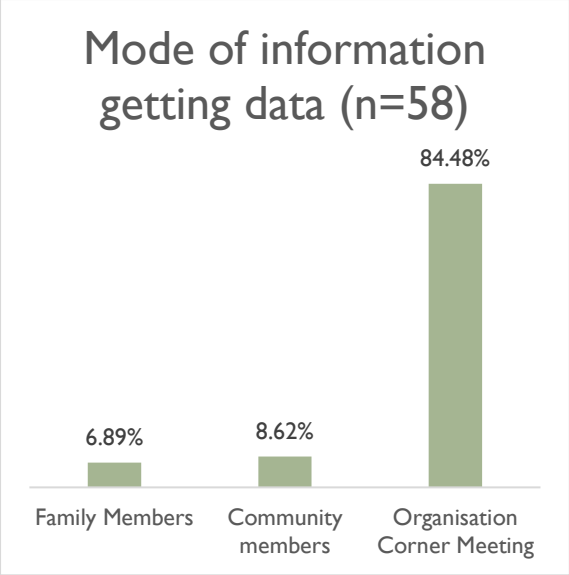
Figure 3: Marital Status



Rapport building

Figure 4: Source of information about organizations services; Table 4:

Name of orgnisation	Family Members	Community members	Corner Meeting	Total
Agricon	1	2	21	24
GASVS	0	2	10	12
Samaan Society	3	1	18	22
Total	4	5	49	58



Data shows that the client approached the organisations through awareness activities like corner meeting 84.48%(n=49/58)

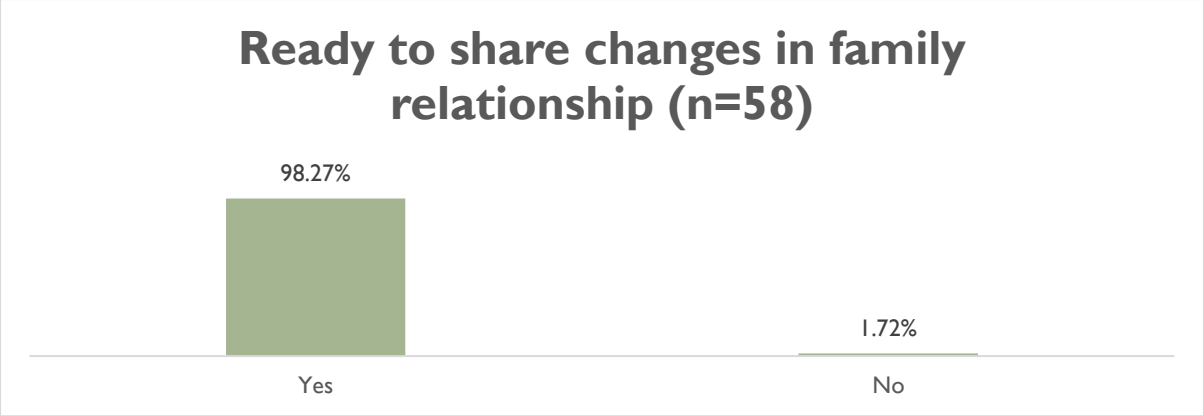
Table 5: Organizations service use.

Name of the Organisation	Before 2 years n (%)	Between 1 and 2 years n(%)	Less than 1 year ago n(%)	I don't remember n(%)	More than three years n(%)	Total
Agricon	9 (37.5)	8(33.33)	5(20.83)	1(4.16%)	1(4.16)	24
GASVS	5(41.66)	6(50)	0(0)	0(0)	1(8.33)	12
Samaan Society	9(40.90)	3(13.63)	9(40.90)	0(0)	1(4.54)	22
Total	23(39.65)	17(29.31)	14(24.13)	1(1.72)	3(5.17)	58

70% of clients used organisation's services within one to two years (39.65%; n=23/58) and the remaining, less than 2 years (29.31%; n=17/58)

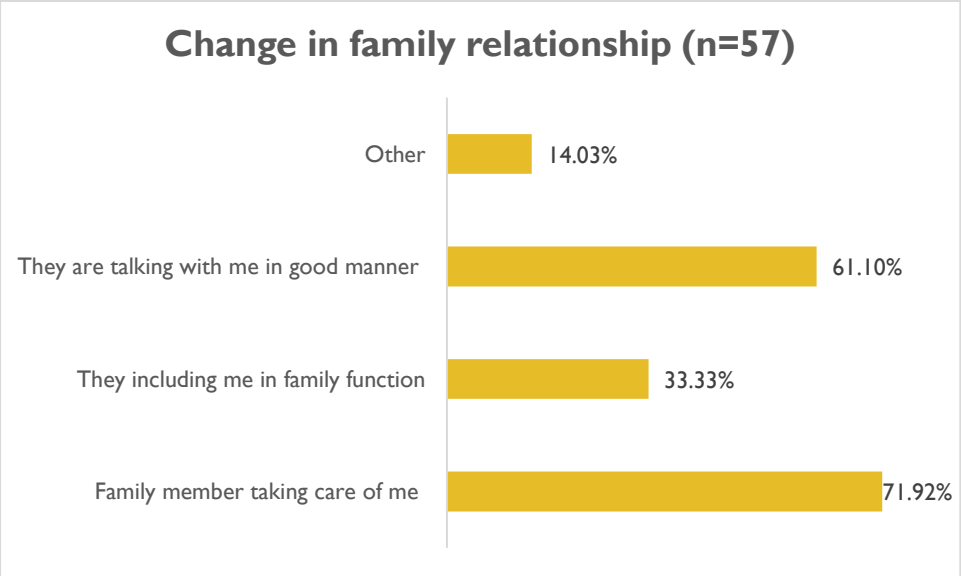
Present Status of client

Figure 5: Ready to share change in relationship with family due organisations innervation.



98.22%(n=57/58) clients were open and ready to share any changes in family relationships.

Figure 6: Changes in family relationships



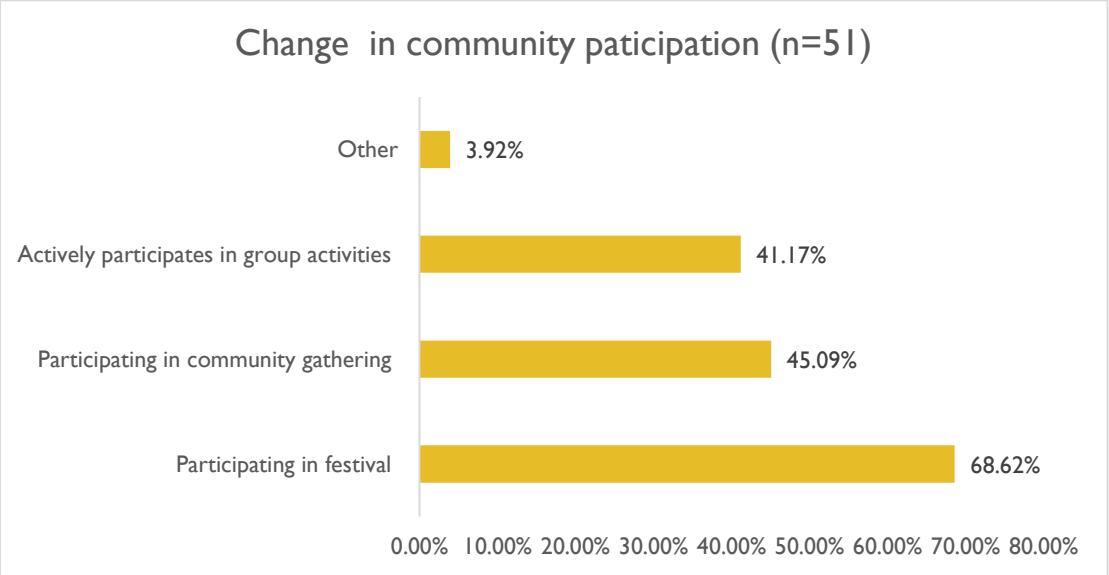
Data shows that, 72% (n=41/57) of the clients reported their family was taking care and 61.40%(n=35/57) clients reported their family members are talking with them in good manner. Also, 33.33% (n=19/57) clients reported that family members are including them in any family functions. Findings show that, after organisations' intervention family attitude has changed. It has brought positive changes in the family. Data shows that family is willing to take responsibility of their relatives. Its shows in all partner sites. Only one client reported no particular change is family attitude.

Table 6: Ready to share change in community participation due to partners' intervention

Name of the organisation	Yes n (%)	No n (%)
Agricon	21(87.5)	3(12.5)
GASVS	12(0)	0(0)
Samaan Society	18(81.8)	4(18.2)
Total	51(87.9)	7(12.1)

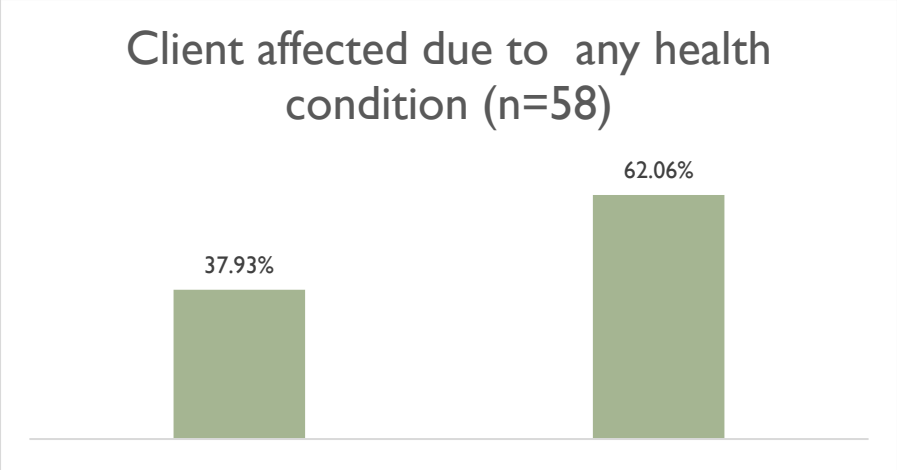
Responses show that 87.9% (51/58) of clients reporting increase in community participation due to the intervention. All clients of GASVS reported increase in community participation.

Figure 7: Community Participation



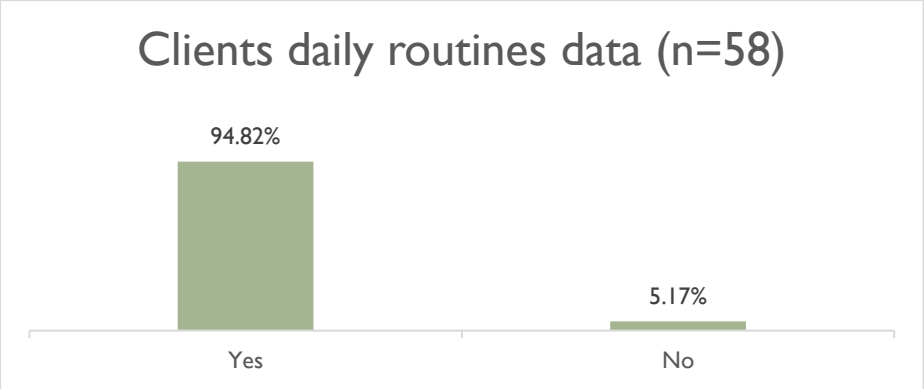
Data shows that community participation has increased due to partners interventions. 68.62%(n=35/51) clients reported increased their participation in festivals, 45.09%(n=23/51) clients reported increased their participation in community gatherings and 41.17%(n=21/51) clients reported their actively participation in group activities. Because of partners intervention clients are actively involved in community festivals. Clients feel more included in the community.

Figure 8: Client affected due to specific health condition



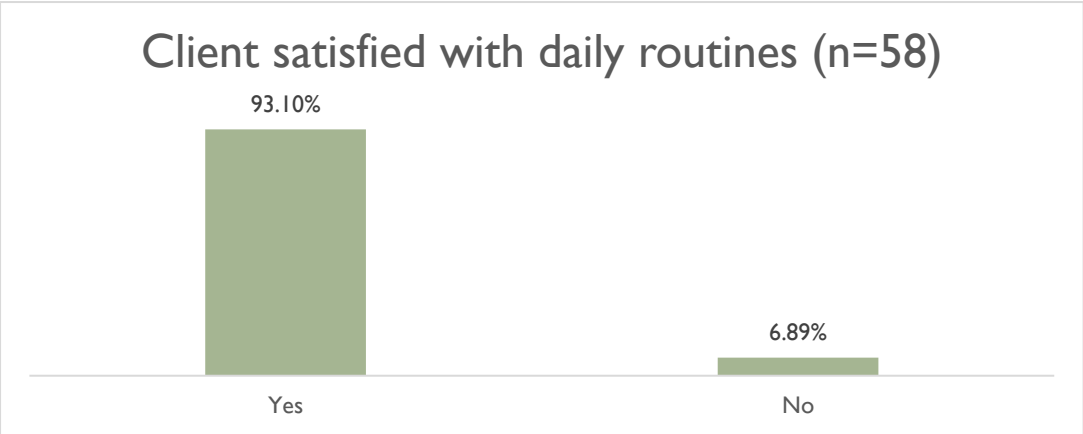
Data show (37.93%; n=22/57) clients were affected by BP, Sugar, thyroid, brain issue, heart issue, body pain, kidney etc. A majority of the clients reported BP problems and body pain.

Figure 8: Client adopts some daily self-care routine



Data shows that 94.82%; n=55/58 clients have some daily routines.

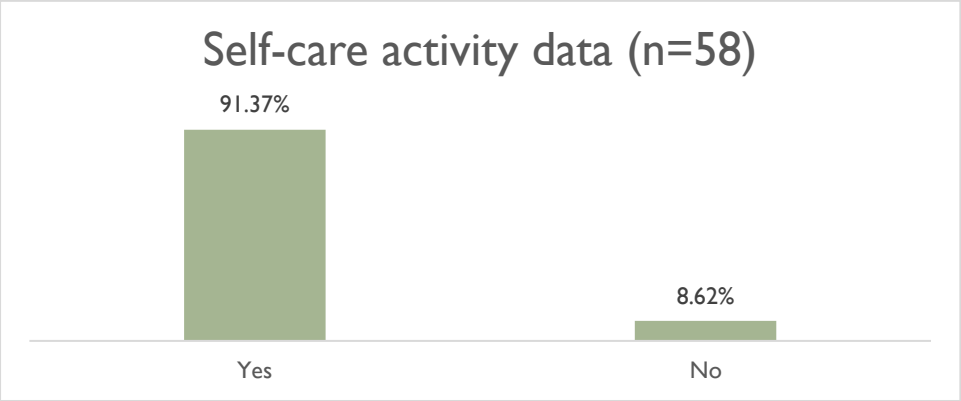
Figure 9: Client satisfaction with daily routines



Data shows 93.10%; n=54/58 clients were satisfied with their daily routines

Data shows 6.89% (n=4/58) clients were not satisfied with daily routines, where clients reported reasons such as child being at home, not interested to do anything and death of elder son.

Figure 10: Self-care activity



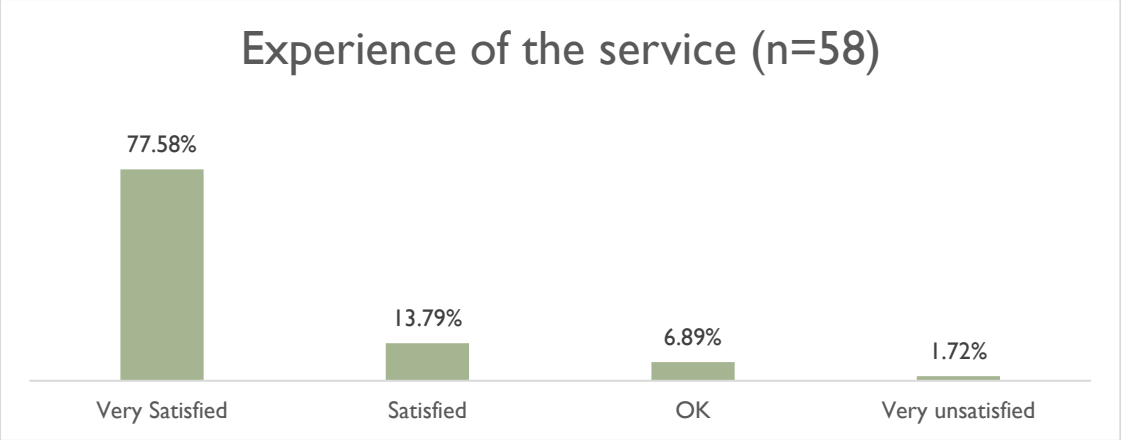
91.37% (n=53/58) clients reported that they are doing at least one selfcare activity in a day. Clients reported that they were doing yoga, breathing activity, chanting of Om, walking, deep breathing, meditation, red balloon activity etc. Most of clients reported meditation, breathing and body movement activities helped them.

Experience of partner's service

Table 7: Experience of services

Name of organisation	Very Satisfied n(%)	Satisfied n(%)	OK n(%)	Very unsatisfied n(%)	Total n(%)
Agricon	20(83.33)	4(16.66)	0(0)	0(0)	24(41.37)
GASVS	7(58.33)	4(33.33)	1(8.33)	0(0)	12(20.68)
Samaan Society	18(81.81)	0(0)	3(13.63)	1(4.54)	22(37.93)
Total	45(77.58)	8(13.79)	4(6.89)	1(1.72)	58(100)

Figure 11: Experience of services



Data show that most of the clients were very satisfied (77.58%; n=45/58) and satisfied (13.79%; n=8/58) with services they got from partner NGOs. Clients of Agricon has more satisfied with services as compared to other two organisations' clients. Only one client of Samaan Society organisation reported being unsatisfied with services.

Table 8: Convenience of time for session convenient

Organisation name	Never n(%)	Rarely n(%)	Sometimes n(%)	Often n(%)	Always n(%)	Total n(%)
Agricon	0(0)	0(0)	2(8.33)	3(12.5)	19(79.16)	24(41.37)
GASVS	1(8.33)	1(8.33)	0(0)	3(25)	7(58.33)	12(20.68)
Samaan Society	1(4.54)	0(0)	2(9.09)	2(9.09)	17(77.27)	22(37.93)
Total	2(3.44)	1(1.72)	4(6.89)	8(13.79)	43(74.13)	58(100)

74.13%; n=43/58 clients reported that session time were convenient for them. Data shows almost 80% clients of Agricon and Samaan Society reported their staff was maintaining the time as per their convenient time schedule.

Table 9: The place of the session feel safe and comfortable

Organisation name	Rarely n(%)	Sometimes n (%)	Often n(%)	Always n(%)	Total n(%)
Agricon	0(0)	0(0)	3(12.5)	21(87.5)	24(41.37)
GASVS	1(8.33)	1(8.33)	2(16.66)	8(66.66)	12(20.68)
Samaan Society	0(0)	2(9.09)	0(0)	20(90.90)	22(37.93)
Total	1(1.74)	3(5.17)	5(8.62)	49(84.48)	58(100)

84.48%; n=49/58 clients reported that the place of the session were always safe and comfortable. Data shows almost 90.90% clients of Agricon and Samaan Society reported the place of the session s were always safe and comfortable.

Table 10: Able to share your story private without fear.

Organisation name	Never n (%)	Sometimes n (%)	Often n (%)	Always n (%)	Total n(%)
Agricon	0(0)	2(8.33)	3(12.5)	19(79.16)	24(41.37)
GASVS	0(0)	4(33.33)	0(0)	8(66.66)	12(20.68)
Samaan Society	1(4.54)	1(4.54)	1(4.54)	19(86.36)	22(37.93)
Total	1(1.72)	7(12.06)	4(6.89)	46(79.31)	58(100)

79.31%; n=46/58 clients reported they are always able to share their story private without fear. Data shows almost 85% of Agrico and Samaan Society's clients reported they can share their story privately without fear. One client of GASVS reported they could not share his/her story privately without fear.

Table 11: Service is relevant and useful in client's life

Organisation name	Never n (%)	Rarely n (%)	Sometimes n (%)	Often n (%)	Always n (%)	Total n(%)
Agricon	0(0)	0(0)	1(4.166)	1(4.166)	22(91.66)	24(41.37)
GASVS	1(8.33)	0(0)	2(16.66)	2(16.66)	7(58.33)	12(20.68)
Samaan Society	0(0)	1(4.54)	0(0)	2(9.09)	19(86.36)	22(37.93)
Total	1(1.72)	1(1.72)	3(5.17)	5(8.62)	48(82.75)	58(100)

82.75%; n=48/58 clients reported this service is useful and relevant in their life. Data shows almost 90% clients of Agricon and Samaan society reported this service was always useful and relevant in their life. 58.33%; n=7/12 clients of GASVS reported this service is always useful and relevant in their life. Only one client of GASVS reported this service is never useful and relevant in his/her life.

Table 12: In interactions with team members, did you feel that you were understood by them

Organisation name	Never n (%)	Rarely n (%)	Sometimes n (%)	Often n (%)	Always n (%)	Total n(%)
Agricon	0(0)	0(0)	2(8.33)	1(4.16)	21(87.5)	24(41.37)
GASVS	1(8.33)	0(0)	3(25)	1(8.33)	7(58.33)	12(20.68)

Samaan Society	0(0)	0(0)	2(9.09)	2(9.09)	18(81.81)	22(37.93)
	1(1.72)	0(0)	7(12.06)	4(6.89)	46(79.31)	58(100)

79.31%; n=46/58 clients reported in interaction with team members, they always felt that they were understood by them. Data shows that almost 90% clients of Agricon and Samaan Society reported that they always felt that they were understood by them. 58.33%; n=7/12 clients of GASVS reported that they always felt that they were understood by them. Only one client of GASVS reported that he/she never felt that he/she were understood by them.

Table 13: Clients felt that they could share whatever they wanted without any pressure.

Organisation name	Never n (%)	Rarely n (%)	Sometimes n (%)	Often n (%)	Always n (%)	Total n(%)
Agricon	1	0(0)	1(4.1)	3(12.5)	19(79.16)	24(41.37)
GASVS	0(0)	1(8.33)	0(0)	4(33.33)	7(58.33)	12(20.68)
Samaan Society	0(0)	1(4.54)	0(0)	1(4.54)	20(90.90)	22(37.93)
Total	1(1.72)	2(3.44)	1(1.72)	8(13.79)	46(79.31)	58(100)

79.31%; n=46/58 clients reported interaction with team members. They always felt that they could share whatever they wanted without pressure. Data shows that almost 80% to 90% clients of Agricon and Samaan Society reported that they always felt that they could share whatever they wanted without any pressure. 58.33%; n=7/12 clients of GASVS reported that they always felt that they could share whatever they wanted without any pressure. One client of Agricon reported that he/she never felt that he/she could share whatever him/her wanted without any pressure.

Table 14: Team members take client consent to conduct the sessions

Name of orgnisation	Never n (%)	Rarely n (%)	Sometimes n (%)	Often n (%)	Always n (%)	Total n(%)
Agricon	0(0)	0(0)	0(0)	0(0)	24(100)	24(41.37)
GASVS	1(8.33)	0(0)	1(8.33)	0(0)	10(83.33)	12(20.68)
Samaan Society	1(4.54)	0(0)	1(4.54)	0(0)	20(90.90)	22(37.93)
Total	2(3.44)	0(0)	2(3.44)	0(0)	54(93.10)	58(100)

93.10%; n=54/58 clients reported that team members are always take client consent to conduct session. One client from GASVS and one from Samaan Society organisations reported that team members never take consent while conduct the session.

Did client feel under pressure to continue with the sessions?

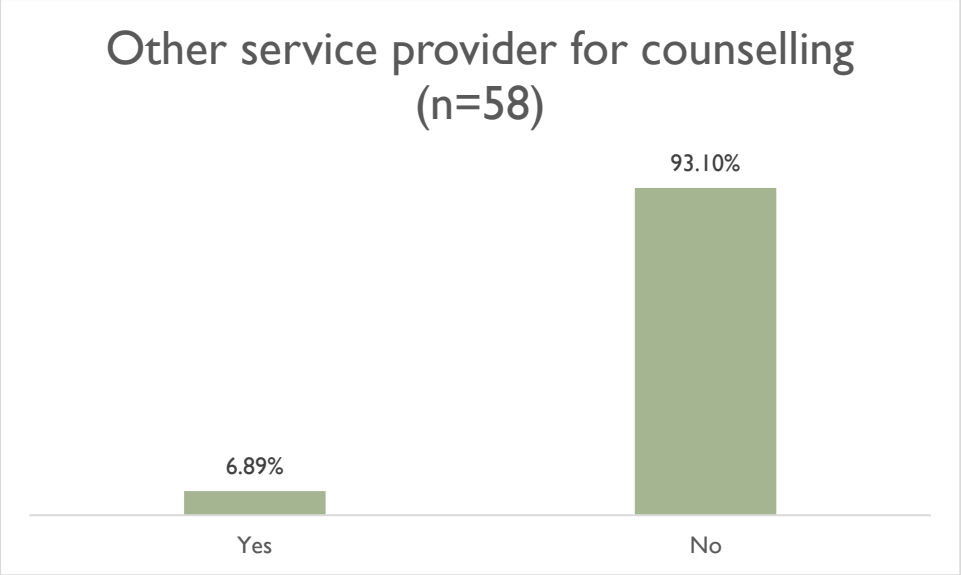
All clients reported that they never felt any pressure to continue with the sessions.

Figure 12: Partners field staff attitude

82.75%; n=48/58 clients reported that counsellor treated them with respect, 68.86%; n=40/58 clients reported that they felt understood by them, 44.82% clients reported that counsellor always spoke with maturity and positive thoughts to them. 27.58%; n=16/58 clients reported that they felt that someone was present to listen to them. 25.86%; n=15/58 clients reported that they felt that someone was there to care for them. Data shows that overall attitude of staff was always good.

Cost of services

Figure 13: Client goes to other service provider counselling or treatment



Data shows 6.89%; n=4/58 client reported they had gone to other service provider for counselling treatment. These clients used to go private psychiatrist, Ayush practitioner, etc.

Table No.15: Cost for counselling or treatment in the last 1 year

Expenditure	Percent	Respondents(n=4)
<500 INR	0	0
Between 500 – 2000 INR	0	0
>2000 INR	100%	4
0	0	0
Total	100.0	4

All four clients who sought other services reported that they spent more than 2000 rupees for counselling in one month. They did not mention any break-up of the amount.

Cost for accessing partners services was mentioned for the last 6 months:

All clients reported that they did not spend a single rupee for accessing service from the partner NGOs.

After recovery:

Table 16: After recovery, clients are able to share experiences of mental health services with others in the community.

Organisation name	Yes n(%)	No n(%)	Total n(%)

Agricon	21(87.5)	3(12.5)	24(41.37)
GASVS	9(75)	3(25)	12(20.68)
Samaan Society	12(54.54)	10(45.45)	22(37.93)
Total	42(72.41)	16(27.58)	58(100)

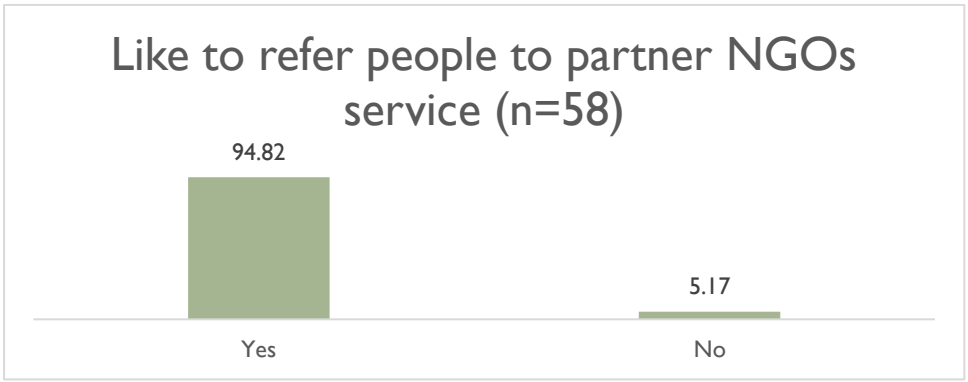
Data shows 72.4%; n=42/58 reported they could share their experience of mental health service with others in community. 87.5%; n=21/24 clients of Agricon and 75%; n=9/58 clients reported that they could share their experience of mental health services. But 45.45%; n=10/22 clients of Samaan Society reported that they were not able to share their experience of mental health. Samaan society works in urban areas and other two organisation work in rural area.

Table 17: Client referred people to organisations services

Organisation name	Yes n(%)	No n(%)	Total n(%)
Agricon	16(66.66)	8(33.33)	24(41.37)
GASVS	2(16.66)	10(83.33)	12(20.68)
Samaan Society	20(90)	2(9.09)	22(37.93)
Total	38(65.51)	20(34.48)	58(100)

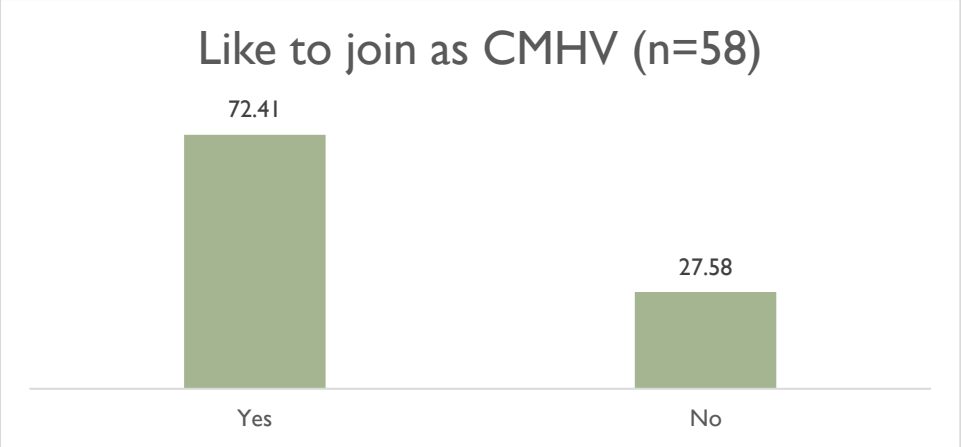
Around (65.51%; n=38/58) reported they referred client to organisations' services. It shows that most of clients liked the services. 90%; n=20/22 clients of Samaan Society & 66.66%; n=16/24 clients of Agricon reported that they referred people to organisations services.

Figure 14: Like to refer people to organisations services



Data shows 94.10%; n=55/58 client like to refer people to partners services.

Figure 18: Interest to join as CMHV(Community Mental Health Volunteer)



Data shows 72.41%; n=42/58 client reported were ready to join as a CMHV.

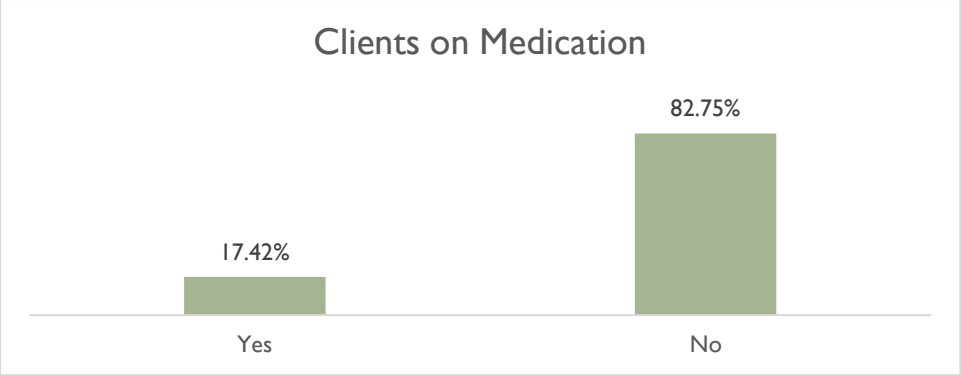
Table 18: Other than counselling services received

Other services received	Percentage	Responses (n=58)
Nutrition help	32.75%	19
Homeopathy Medicine	0%	0
Job	3.44%	2
Financial support	3.44%	2
Documentation (aadhar, etc.)	5.17%	3
Health services	8.60%	5
SHG, group support, social support	10.34%	6
No other service received	41.37%	24

41.37%; n=24/58 clients reported they received only counseling services but 58.62%; n=34/58 clients received at least one service other than counseling. Data shows 37.75%; n=19/58 clients reported they received nutrition help, 3.44%; n=2/58 clients reported they get financial support & 10.34%; n=6/58 clients reported they get SHG, group support, social support service. 8.6%; n=5/58 clients reported they get health service.

Partners need to improve in develop other social network services for fulfilling the clients' psychosocial needs.

Figure 19: Client on medication



Data shows 17.42%; n=10/58 clients on psychiatric medication. Out of these 10 clients, 6 clients of GASVS and 4 of Samaan Society partners. Out of 10 clients 2 clients are wanting to withdraw from the medications.

Suggestion from clients for partner organisations service improvement:

- For Agricon
  - Most of clients suggested to make doorstep availability of awareness activities to increase the reach
  - Explain people about the work of organisation
  - Provide homeopathic medicine services
  - Reach out to more people facing tension and mental health issue
- For GASVS
  - Enroll more disable people in the program
  - Provide gender wise counsellor. For example, for woman provide only female counsellor.
  - Provide government schemes to clients
  - Provide disability pension
  - Counsellor should meet at client's home
  - Start yoga classes again for community people
- For Samaan Society
  - Help poor and needy people who may not have mental health issue
  - Do more awareness activity and reach more people
  - Nice service, keep continue in future
  - Provide government schemes to clients
  - Strat support group for client in area

Discussion and Recommendation

Based on the impact study research with 58 clients who were beneficiaries of partners NGOs (Agricon, Samaan Society & GASV) conducted under the community mental health program data shows that:

- 84.48% of clients reach organisation through awareness activities. It shows that organisation is well understood the awareness program
- 98.22% & 87.9% clients are comfortable sharing their changes with family members & change in community participation respectively which shows reduce the stigma about mental health.
- 37.93% clients reported they have BP, Sugar, thyroid, brain issue, heart issue, body pain, kidney such kind of health issues.
- 94.82% clients reported they have some daily routine & 93.10% clients were satisfied with their daily routine.
- 91.37% clients reported they do yoga, deep breathing, walking, body activity, meditation such kind of as a self-care activity. Data shows self-care awareness increase due to intervention.
- 77.58% & 13.79% clients reported they are very satisfied & satisfied with partners services. Almost 90% clients of Agricon and Samaan Society reported they are satisfied with services. 58.33% clients of GASVS reported they are satisfied with their services.
- 74.13% clients reported session time were always convenient for them. 79.16% clients of Agricon and 77.27% clients of Samaan society reported session times were always convenient for them. 58.33% of clients of GASVS are reported session time were always convenient.
- 84.48% clients reported the place of the session were always feel safe and comfortable. 90.90% clients of Samaan Society, 87.5% clients of Agricon and 66.66% clients of GASVS are reported they are felt safe and comfortable at place of session.
- 79.31% clients reported they are always able to share their story private without any fear. 86.6% clients of Samaan society, 79.6% clients of Agricon & 66.66% clients of GASVS are reported they are always able to share their story private without fear.
- 82.75% clients reported this service is always useful and relevant in their life. 91.66% clients of Agricon, 86.36% clients of Samaan Society and 58.33% clients of GASVS are reported this service is always useful and relevant in their life.
- 79.31%; n=46/58 clients reported in interaction with team members, they always felt that they were understood by them. 87.5% clients of Agricon, 81.81% clients of Samaan Society and 58.33% of clients of GASVS reported in interaction with team members, they always felt that they were understood by them.
- 79.31% clients reported in interaction with team members, they always felt that they could share whatever they wanted without pressure.
- 93.10% clients reported that team members are always take client consent to conduct session.
- All clients are reported that they never came under pressure to continue with the session.
- Partners team member attitude:
    - 82.75% clients reported that counsellor was treated them with respect.
    - 68.86% clients reported that they felt understood by them.
    - 44.82% clients reported that the counsellor always spoke with maturity and positive thoughts to them.
- 6.89% clients reported they gone to other service provider for counselling or treatment.
- Clients reported when they took treatment from partners they never spent on treatment.

- 72.4%; clients reported they are able to share with others their experience of mental health services in the community. Its shows that stigma is reducing. But 45.45%; n=10/22 clients of Samaan Society reported that they are not able to share their experience of mental health.
- 65.51% clients reported they referred people to organisations for service. It shows that most of clients liked services. 94.10% clients reported they are like to refer people to organisations for service.
- 17.42% clients reported they are on medication.
- 20% clients reported they are ready to withdraw from medication.

Findings from qualitative interviews:

We conducted focus group discussion and in-depth interview with partner organization leaders, staff and community stakeholders.

1. Result findings from FGDs and KII interviews

In-depth interview with leaders of the organizations

Overall experience of the Program:

The leaders shared that the program was good, and useful for people. Their staff had developed a unique perspective about mental health, learning new skills. The counselling taught is very easy to execute at the community level. The leaders realized the connection between their own work in Development and mental health: If we work on the root causes then already some mental health work is done, and we can support better. Earlier, they did not know about 'first aid' for mental health work, and now they have some modules in this area. They also shared how their perspectives changed. Earlier they were judgmental, but now when they see a mental health issue in a person, they consider, 'what happened to that person'. Previously, they believed that a person with mental health needs only medication, but with the program experience, they learnt that without medication, and by addressing the root cause, a person can become better. The program is also cost effective.

Impact of this project on the leader, their staff and the organization as persons:

The program has changed staff behaviour. They understand each other better. They understood the importance of self-care, and are doing it on a regular basis. The staff are more empowered because of this program. Earlier they would be irritated easily, but now their response is different, to an irritating situation. They also support each other. Empathy has increased among the staff. One of the leaders shared that he used to frequently get angry, but now that has reduced considerably.

Share community experiences about this program, as leader of the organization

We see people doing self-care activities like Yoga, breathing, pranayama, etc. Their community quarrels and crises are much improved because of this program. Because of awareness activities people have understood the mental health issues. Some people are ready to work as volunteers. The common messages of the program are reaching to people, they are understanding mental health issues.

Challenges faced during the implementation period

Initially, the organizations faced a big problem concerning how to name the program, because of the stigma associated with the words 'mental health' in the community. People were related to come to the program. One organization decided to change the name, calling it the *Khushali* program. There were also cultural issues, as the senior officers were not acceptable to communities to talk about personal topics. They hired local field workers for the program to make the subject acceptable and more everyday. Other development programs are easy to implement, but implementing a mental health program was more challenging. We started this program step by step. At the community level, initially, people were not coming together to talk about mental health, so the organizations started with fun games and activities. Their own perceptions caused barrier sometimes: They were not doctors, so how can they treat mental health issues. Then they realized that an expert was not needed for this program. Every person's need is different, so one has to learn to talk and connect differently with each person. Some organizations had plans, but no funding.

Any plans for scaling up the program

Organizations are trying to get funding for the program. One of the leaders shared that they have a plan to run this program sustainably for a long time. So they are in conversation with another partner organization regarding this. Some organizations are developing a volunteer cadre, now they have 10 volunteers for this. One of the organizations started a helpline service for mental health issues. One organization does not plan on scaling, but going deeper into their current areas.

Focused group discussion with staff

The overall experiences of implementing the community mental health program was good. They well understood the program now. Initially, they had anxiety and fear how they would work with 'mentally ill' people. When they started their work, they realized mental health is about everybody, but people did not pay attention or give priority to this topic. When they started work, people did not listen to them, so they started with fun activities, games, etc. They gradually saw the change in the people. In one organization, people believed in medicines, so initially it was difficult to convince them about alternative community therapy.

Bapu Trust program is in urban settings, and organizations had the scope to innovate and adapt to their working context. They had to do a variety of activities in the community to see what

was acceptable. They started a new activity called ‘Assembly’: They conducted assemblies in the community to create a safe place for people to share with each other. A ‘Manmitra’ helpline was started. They adapted the subject of mental health into local activities such as *Langadi, Fugadi, Billas, etc.* Billas was described as a game where if the players came across a mental illness, they have to collect and throw it outside the circle. They developed new games for awareness activities. As in the Bapu Trust experience, awareness can cause change.

The field team shared about the increase in their confidence levels, to engage with people in the community. Now they can take trainings as well for other staff and stakeholders. The program also helped them at the personal level. A few of them were able to manage their own anger. They had worked on their fear and had gained confidence. A few built on their interpersonal relationships. They all expressed that a person has to accept that there are mental health issues, and start to work on that. They have experienced the organization leadership as co operative and ready to support in everything, in improving working skills, etc. They remembered that, in the case of one client, due to limitations of the organization, the staff did not get a chance to work with the client.

Focused Group discussion with stakeholders of partners

Stakeholders who attended the FGD were working in low income settings. They run a 2 wheeler mechanic repairing course for women and a driving course. Additionally, they work on domestic violence, adolescents and also work with farmers. With support of the Bapu Trust, they run a community mental health program.

The group shared that they talk about children’s issues, issues of adolescent girls, domestic violence, different types of worries, tension. They become more aware on women’s rights. They talk about women’s mental health issues, about anger and addictions. They share on relationships and exam pressures. They learnt many wellbeing activities, such as breathing, yoga, songs, pranayama, body activities and story telling.

Because of the activities, they felt good and tension free. The topic of inclusion and mental health issue, in communities became more popular. One of the participants shared that she was not educated, and she managed to complete her education, after reaching this organization. Earlier there was no support from the family, now the family was also supporting. Because of the organizations’ intervention, some children got admission in school. They have positivity and increased hopes. The organization also helped to get disability certificate. That has benefited people. They are able to participate better in the community.

In conclusion, based on the study, all the organizations have a good rapport with their communities. Leaders and staff have well understood the nature of the program. Counselling services are satisfactory. One of the organizations need additional handholding, while others are doing quite well. For all of them, there is a need to improve social service networking on the topic of psychosocial health and inclusion.