A Blueprint for Transformation in Mental Health Rights

VOICES

ANJALI

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START UP!
The First Step in Social Change

Research, Writing, Editing and Design by

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The First Step in Social Change

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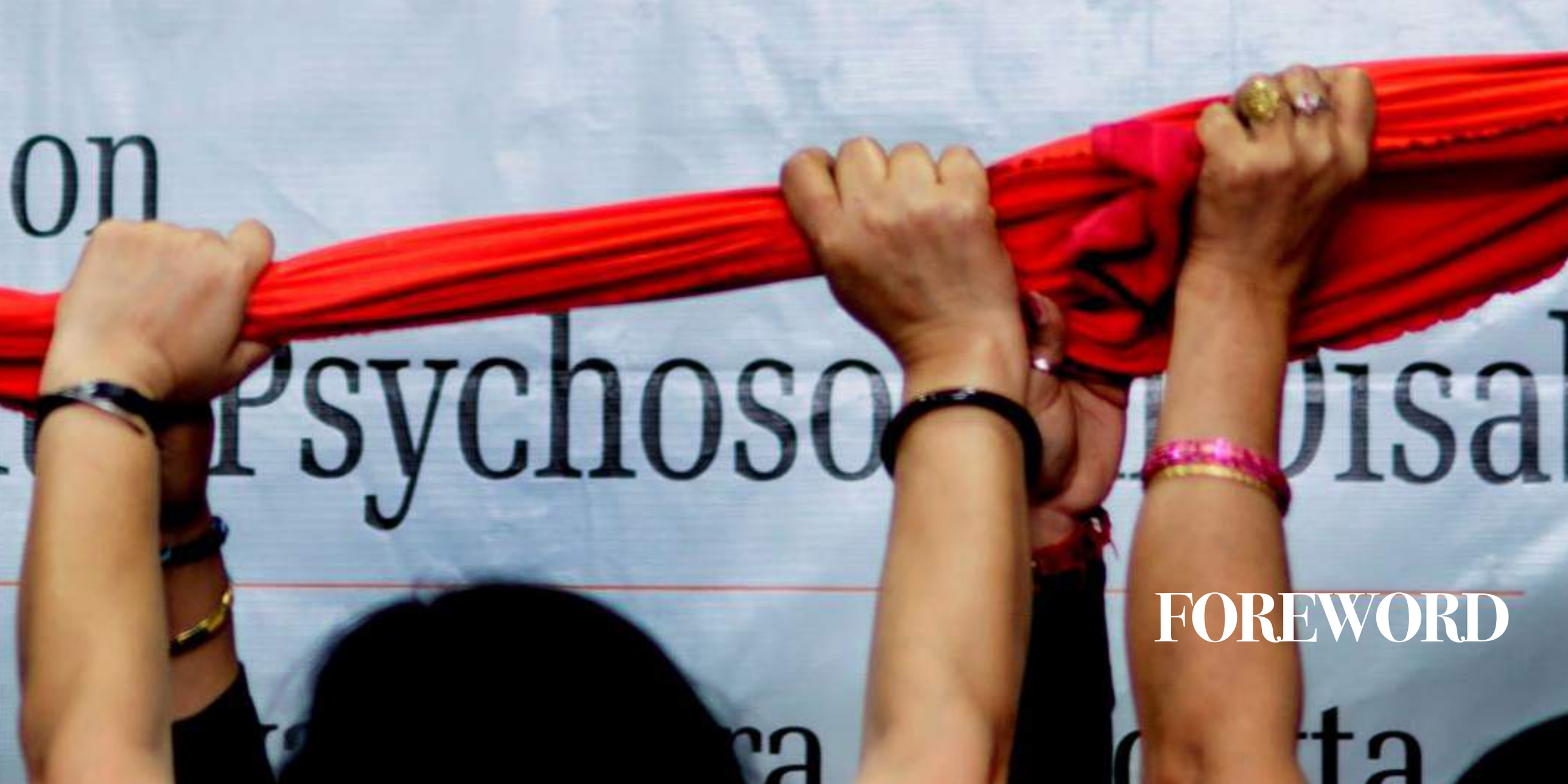


FOREWORD

FOREWORD

Several years ago, I had a breakdown – that's what my employer and a psychiatrist called it. I called it a breakthrough. I took my experience and built connections to others facing discrimination. I created Anjali.

Anjali was born from my tryst with mental illness and institutional care. From then to now, our fearless team has walked on unknown paths to transform policy and the provision of institutional care in government mental hospitals of West Bengal.

Every day for 20 years, we have put the rights, agency, and personhood of individuals with psycho-social disabilities at the center of all our programs and activities. This has been our way of nudging our participants (read: persons living in mental health hospitals) to find, claim, and amplify their 'voice'. This was also our reason for naming our flagship program in state mental hospitals, Voices.

Enabling Voice and Choice

In two decades of shaping and scaling Voices, thousands of persons with psychosocial disabilities have shown us that when they find their voice, they get the courage to exercise choice. They determine their choices related to their lives, home, relationships, livelihoods, and community, even as they navigate a world that is designed to intentionally exclude them. The exercise of voice and choice becomes their inflection point, the point at which they cross the threshold: from being invisible and excluded to being seen, heard, and included in families, neighborhoods, communities, and institutions.

A Minefield of Learning

Voices grew organically. Just like our participants, we navigated our minefields. There were many things that we could have done differently; many times where we did not exercise patience; many moments when we lost tempers and hope. But every day, Voices threw up new challenges, urged us to revisit our constructs, and check our levels of comfort and discomfort. We learned through trial and error. We built our knowledge and knowing from the narratives of the people we work with.

In 2010, different components of the Voices program started to replicate outside of Bengal. We started to be called upon to 'transfer' our blueprint. From that time on, we have asked ourselves a few questions:

- ***Could emerging practitioners in the mental health and human rights field be interested in, and draw value from what we had learned over 20 years?***
- ***Could organizations working inside mental hospitals be able to navigate the terrain better if we could share with them our failures and mistakes; if we spoke to them about the fingers we burnt and the lessons we learned?***
- ***Could organizations and individuals working at the intersection of gender, sexuality, rights, citizenship, and mental health be able to strengthen their impact through a knowledge-sharing exercise with us?***
- ***And finally, could sharing our learning across the mental health sector help us to dialogue, learn, and acquire knowledge that we do not as yet have, from mature organizations?***

An Offering of Gratitude
This manual is our way of responding in the affirmative to all these questions. I hope it can be our bridge to the world of thinkers and doers in mental health, human rights, gender, sexuality, and other related fields. It captures two decades of learning of the Voices program. It is inclusive of many voices — those from within our team, to those in the hospitals, families, and communities that we work with and most critically, those of our participants.

This manual is also our offering of gratitude to the mental health sector that has held us, taught us, challenged us, and let us grow on our terms.

Going Back to Go Forward
The process of creating this manual was a process of learning and re-discovery. So much of what is useful gets forgotten under the press of time and the pressure of implementation. This exercise created the space for us to clear the dust and relive stories, anecdotes and milestones, re-read critical reports and revisit our journeys of growing with Voices. By going back to the past, we were able to build a more future-facing understanding of Voices.

Ultimately, the aim of Voices is to make persons with psychosocial disabilities become self-advocates and chart their journeys of citizenship and social inclusion with confidence and dignity. The mandate is huge and Voices continues to be a work-in-progress model.

So far it has been a collective journey and we hope that this manual will open up many new friendships, partnerships, insights, conversations, and knowledge exchange.

Acknowledgements
This manual would not have been possible without the spirit, energy, and generosity of several co-travelers. We would like to thank our funders, team members, individuals who have contributed to our growth story and the StartUp! team who have enabled the coming together of this manual.

— *Ratnaboli Ray, Founder & Managing Trustee, Anjali*

GUIDE FOR USERS

GUIDE FOR USERS

This document is a comprehensive blueprint and operations manual of Voices, India's first mental health program to run inside government mental hospitals.

Voices was launched by Anjali in 1999, in the Pavlov Mental Hospital of Kolkata, West Bengal. The goal was to demonstrate how mental health institutions could be transformed into humane, inter-sectional and inclusive spaces for person with psycho-social disabilities.

Voices started with the focus on rehabilitating and re-integrating recovered individuals. Over two decades, it has evolved into a program that empowers and builds capacities of persons with psychosocial disabilities to lead lives of full potential and active citizenship. Operational in four mental hospitals of West Bengal, Voices has significantly transformed government mental health policies and practices of the state.

Why this manual?

The purpose of this manual is two-fold. First, it captures the 20-year growth journey of Voices. Second, it delineates clear and (to the extent possible) standardized structures, systems, processes, mechanisms, tools and protocols deployed by Voices.

Through these twin objectives, StartUp! has endeavoured to create a blueprint for the effective replication of Voices to other geographies.

Methodology for Developing the Manual

The key methodology employed by Start Up! to develop the Manual comprised:

- *Backroom research on institutional mental health care initiatives*
- *Literature review of the Voices curriculum, process documents, available tools, and communication templates for critical stakeholders*
- *In-depth interviews with organizational and program leaders, therapists, counsellors, and partners, as well as re-integrated participants*
- *Design clinics and follow-up consultations with the Voices team to finalize process maps*

Navigating Components of the Manual

The manual begins through an exploration of nuanced challenges within the mental health sector from the perspective of Anjali's work and the framework used for its Voices program. These include social stigma and discrimination, the mental health care gap, and a problematic pathologized approach to mental health. Next, the manual moves to an overview of Anjali's work and a snapshot of the Voices program. Both these sections give users a 'big-picture' view of the organization as a whole, and the Voices program model. The last section of the manual unpacks the Voices program—how it has evolved over the last two decades, innovations unique to the program, incorporated framework, milestones, and impact.

Who can use it?

This manual is a robust blueprint and toolkit for NGOs, mental health professionals, and government officials, to replicate the Voices model. The users can be either from organizations that are already working in the field of mental health or from organizations working in other-related domains (such as general health, gender, human rights, etc). In particular, those working within mental health institutions or within government-run/aided mental health programs will benefit from insights on how Voices fosters collaborations with the government and transforms institutional care.

"It is my deepest hope that this manual finds its way into the hands of those working in institutional settings, those within the mental health sector at large or those engaged in social justice programs. I believe that the insights, processes, and protocols provided here, if leveraged, can transform mental health hospitals across the country."

– Manidipa Ghosh, Deputy Director, Anjali

Using Process Maps

A key component of this manual is the set of process maps, which are visual tools through which an entire process can be seen from start to finish on a single page. Each map includes what inputs are necessary for each step and the output at the end of each activity. Process maps help in:

- *Planning deliverables and timelines by providing the framework for building work plans and project trackers;*
- *Delegating roles and responsibilities;*
- *Understanding linkages between the different components of the program; and*
- *Analyzing and improving the process.*

Using Templates

The manual also includes detailed templates or worksheets for various program processes. The templates are tools to help carry out the activities in the process maps. They are suggestions for creating required documents, as well as for collecting, documenting, and evaluating information in a standardized format. These templates can and should be adapted and modified as the processes/activities organically change and mature over time.

Anjali is a leading non-governmental organization, working in the field of mental health and human rights. Based in Kolkata, Anjali works to secure large-scale systemic changes in the mental health field, by making mental health institutions, systems, and communities— intersectional and inclusive.

ANJALI |

I

SETTING CONTEXT

Mental Health Framework

Mental Health Care in India is rife with nuanced challenges. Foremost among these are social stigma and discrimination that perpetuate violence and human rights violations against persons living with psychosocial disabilities. Furthermore, the mental health sector receives a bare minimum of resources and funds, expanding a significant care gap—especially within mental health institutions. A pathologized approach to mental health care adds further complexity to these challenges, compounding discrimination, perpetuating stigma, and widening the care gap.

This section discusses these challenges from the perspective of Anjali's work and the framework used for its Voices program.

Discrimination: An Unresolved Global Crisis

Mental illness is a poorly understood issue, marked by ingrained misconceptions and false beliefs—including perceiving persons living with mental health conditions to be 'violent, dangerous or unpredictable', or in common language 'insane'.

Research indicates that this ignorance—held not only by the general public but also by health professionals and policymakers—perpetuates large-scale discrimination of persons with psychosocial disabilities. Human Rights Watch (2014) reported rights-violations in 24 mental health hospitals and state-run residential care facilities across India. Unfortunately, coercion, involuntary treatment, and violence often constitute the legacies of most mental health institutions worldwide.

"I had just completed doing my rounds at the hospital, when one of the residents came running towards me," Ratnaboli Ray remembers. "She was crying bitterly. 'They have cut my hair', she sobbed, 'look at how short it is, they have cut it.'"

Residents of mental health hospitals are routinely subjected to archaic practices such as shaved heads and uniforms. Often, women, residents are denied sanitary napkins. Till recently, some hospitals ran weekly public showers where residents would take a bath in the full force of water from hose pipes held by ward caregivers. Mental health hospitals and institutions have been historically modeled on prisons. The treatment meted out to patients here is reminiscent of the surveillance, policing, and dehumanization that prisoners are subjected to.

Most state mental hospitals resemble a prison-like environment characterized by dark long corridors, heavy metal locks, and iron collapsible gates, and fans with metal grids to prevent suicides, wherein patients are forced to sleep on the floor, urinate and defecate within the cell owing to the lack of toilets. They lack the human or financial infrastructure to support therapies, conduct rehabilitation, re-integration or community follow up visits. These institutions on several occasions have been grounds for severe human rights violations.

What is missing is a comprehensive regulatory mechanism that can maintain minimum standards at private and public residential mental health institutions.

Persons living with a mental health condition, particularly those with long-term, severe mental health conditions often, voluntarily or involuntarily, end up being ‘institutionalized’ in mental hospitals. Their everyday behaviors, social interactions, self-identity, and even their view of the future end up being severely regulated by the prevailing norms, practices, and general environment of their hospitals.

Unsurprisingly, stigma, and discrimination are more debilitating than their mental health condition itself. A survey by Hans Foundation (2019) of patients in mental health institutions indicated that over 93% of them had not stepped outside during their stay and over 86% had never had a visitor. Over 11% of those surveyed had been in long-term care in a mental health hospital for over a quarter of a century. Mental health institutions become receptacles for persons living with psychosocial disabilities who have been abandoned by family members on account of stigma.

casestudy

When Pradeep (a young adult at the time) began to experience distress, his younger brother—eager to keep the condition under wraps—diagnosed and treated Pradeep for Schizophrenia without consulting any mental health professional. The diagnosis was a mistake and the medication had severe side effects. Pradeep became bed-ridden.

Cases like these are not uncommon in India. Family members of persons living with a mental health condition often delay seeking treatment and care, primarily because of misconceptions about the condition or social stigma. They also mistakenly believe that the mental health condition of the individual is permanent. So, when the family does seek treatment, it is often to incarcerate persons with a mental illness within institutions.

Pradeep was admitted to Pavlov Hospital and has been languishing there for many years. His family, including his younger brother, haven’t visited him even once during this time. Realizing that Pradeep had been shunned by his family, hospital staff took advantage of his circumstances. Pradeep was made to do laborious tasks around the hospital in exchange for a few bidis and tobacco.

Like Pradeep, persons with mental health conditions experience daily violations around consent, participation, and decision-making on matters related to their own lives and general incapacitation. Once a person is deemed to be ‘of unsound mind’, all authority related to their life is handed over to a family member or guardian, or a service provider. This process of reducing persons with psychosocial disabilities into persona non-grata is played out with impunity across homes, health care centers, the legal system, and the world of work.

The Care Gap
Research reveals glaring shortfalls in service delivery, huge gaps between the need for, and availability of, mental health professionals, and shortcomings in the quality of services delivered. If one goes by statistics, then one in four of us will at some point be affected by a mental health issue in our lifetime.

India's National Mental Health Survey (2016)—the latest and most comprehensive survey of mental illness in the country—shows that around 10.6 percent of people in India have a mental health condition which requires treatment. That's nearly 130 million people in the country. However, 80% of those living with psychosocial stressors or mental health issues remain without support for over a year, due to a lack of access to quality, accessible, affordable mental health care.

India spends less than 1% of its budget on mental health (National Health Profile Data, 2019). Low budgetary prioritization translates into insufficient care facilities at primary, secondary, and tertiary levels. India boasts of less than 4000 mental health professionals, 1000 psychologists, and 3000 social workers to cater to this growing need. There are currently only 47 government-run mental health institutions in India with approximately 18,307 hospital beds.

Here is an illustration of how the care gap plays out in the mental hospitals that Anjali works in:

- ***With 200 beds, Calcutta Pavlov hospital accommodates 650 residents.***
- ***The mental hospital in Behrampore has 695 residents on its register but only 400 beds.***
- ***Lumbini has 200 beds and 209 patients. Purulia has 200 beds and 212 residents.***
- ***Often a bed is shared between 2/3 residents.***

The mental health 'care gap'—reflected in a shortfall of trained mental health professionals, poor availability of medication to treat major mental illness, low government budgetary allocations towards mental health services across the country, discriminatory mental health care services, and human rights violations—severely impacts the 130 million Indians living with mental health conditions.

casestudy

Jayanti's story illustrates how oppression based on gender and economic status impact mental health.

Being born into poverty, Jayanti was further stripped of agency on account of her gender. Male members of her family married her off when she was merely 20 years of age to a man living with a physical disability. Unprepared for this role and forced to become a caregiver to her husband at such a young age, resulted in acute levels of distress for Jayanti. After the birth of her child, Jayanti had dual caregiving roles—looking after her baby as well as her bed-ridden husband. Although Jayanti was experiencing exhaustion, frustration, and helplessness on account of these multiple stressors—it was interpreted as a 'breakdown' by her in-laws. Such interpretations are typical of how mental health is viewed. Lack of agency, loss of decision-making power, caregiver exhaustion — aren't recognized as factors that enhance distress. The individual is seen as solely responsible for their mental health. Consequently, Jayanti's in-laws shunned her and sent her back to her family.

Again, myths about mental illness and prevalent misconceptions about recovery influenced how Jayanti's family responded to her distress. She was taken to quacks, local godmen and Ojhas for treatment. Jayanti was socially isolated and stigmatized on account of her condition. Her in-laws refused to allow her back into her marital home. On her way back to her family, she was trafficked to Jammu and Kashmir and pushed into commercial sex work.

Fortunately, she was rescued by a police officer and was brought back to West Bengal. Jayanti's families refused to take her back. No one had even thought of tracing her when she went missing for months. Her husband had moved on and had started living with his sister-in-law. These traumatic events left her deeply disturbed. She was found wandering the halls of a government hospital by the police and was admitted to Lumbini Hospital.

Read the full story of how social inclusion strategies, which sit at the heart of the Voices program, reunited Jayanti with her family and enabled her to find her feet again – in Chapter 3, Voices].

Pathologizing Mental Health
Mental health care services lean heavily towards a biomedical model. A medicalized, pathologized lens denotes all mental health conditions as manifestations of a physical issue—something that is located in the brain—that can only be fixed through an 'expert-led', 'institutional-based', medication and treatment-based intervention. This approach ignores the cognitive, emotional, behavioral, and social determinants of mental health.

Anjali's founder, Rantaboli Ray, emphasizes the crucial role that ***"our past, relationships, and circumstances"*** play, and how they "***shape how we think, feel, and behave."*** Implied in Ratna's preference for the term 'psychosocial disability' over 'mental disability', is her belief that a "person's mental state is greatly influenced by life experience."

For example, gender, poverty, and ethnicity can coalesce to impact a person's mental health. A single woman from a marginalized community, working in the informal sector as a domestic help to eke out a living for her family, keep her children in school and pay the rent for the roof over their head might experience extreme distress (anxiety, fatigue, worry, depression, etc.). For her and her children, the pathways to building resilience would require more than just medication.

Given the nuances of and interplay between challenges described in this section, working in the mental health sector is like running a race in an obstacle course. But new ideas, players, organizations are emerging. Voices exemplifies a person-centric, user-survivor, rights-based approach to mental health in institutional settings.

"I am a die-hard optimist. In our lifetimes, we have seen a transformation in women's rights and LGBTQ+ rights. Full personhood for people with disabilities is the next frontier. We are limited only by our ability to see all people as truly human."

- Ratnaboli Ray

2

ANJALI: A SNAPSHOT

"Anjali was the name of the first woman whom we integrated, almost twenty years ago. We have since enabled hundreds of others, living with psychosocial disabilities, who were languishing in mental health institutions across West Bengal to find their voice, exercise their rights, and make their way back to their communities"

– Ratnaboli Ray, Founder & Managing Trustee, Anjali

Anjali's vision is a world where the right to positive mental health is secured for all.

Forerunners in Mental Health

Anjali addresses the full terrain of mental health challenges discussed in the previous section by foregrounding the voices and rights of persons living with psychosocial disabilities. Pioneering innovations in the mental health sector, Anjali is the first Civil Society Organization in India to partner with the government to make state-run mental hospitals inclusive and humane. Anjali is also one of the earliest to launch community mental health programs that addressed social stigma, discrimination, and exclusion—establishing a new discourse around mental health within families, communities, and institutions.

Anjali strives to make mental health a developmental priority in the country. By amplifying marginalized voices, in particular, the voices of those incarcerated in mental health institutions— Anjali holds the government and society at large accountable. Anjali's work is grounded in the principles of the Rights of People with Disability Act, India (2016), and the United Nations Convention on the Rights of People with Disability (2006). It employs the language of disability and a feminist perspective within its practice.

Framing Anjali's Approach

Anjali works towards making mental health less about bio-medicine and more about fundamental human rights – to ensure everyone has full membership in the human family: the right to self-determination — to own property; vote; choose a partner, marry, have children, manage money and hold a job.

Anjali is guided by the belief that all persons with psychosocial disabilities must realize their personhood, rights, and citizenship. They must be empowered to not only claim their 'voice' but also to exercise choice. However, for them to witness this transformation— their homes, institutions, communities must also be transformed.

In keeping with this framework, Anjali empowers hospitals and health systems to become democratic institutions that promote care, respect, commitment, and excellence. Furthermore, Anjali's community programs strive to alter social perceptions that stigmatize, discriminate against, and violate the rights of those living with psychosocial disabilities. ***Anjali aspires to influence change at three levels: 'Self', 'Systems' and 'Society'.***

Focus Area	Goals
Self Determination	Build the capacities of individuals with mental illness living in government mental health institutions to develop a strong sense of personhood, value their role in society, and understand and claim their rights as citizens.
Systemic Change	Work within government mental health institutions and in partnership with the government to develop systems, structures, laws, and policies that protect the rights of residents and create inclusive environments for their well-being.
Society without Discrimination	Build awareness and dialogue to end social stigma and discrimination against persons with mental illness, and foster inclusive communities.

Through a combination of rights-based programs and policy initiatives, Anjali works to secure three long-term objectives:

1

To establish mental health within mainstream health and development discourse in India.

2

To build new identities for people with psychosocial disabilities so that they are perceived as 'full citizens', by ensuring progressive shifts in the dignity and quality of their lives within institutions, families, and communities.

3

To foster training, networks, and collaborations between individuals and organizations in criminal justice, health and rights-based CSOs, thereby encouraging new talent, perspectives, and leaders to emerge in the mental health sector.

Anjali implements innovative programs to build citizenship and personhood of persons living in mental hospitals by building capacities, collaborating with the health system, and catalysing policy change.

Over 20 years, Anjali has developed a continuum of interventions that address the critical lifecycle needs of persons with psychosocial disabilities.

VOICES

An institution-based capacity building program.

- Building agency of participants living in mental hospitals
- Transforming institutions and communities
- Providing livelihood opportunities

JANAMANAS

A community mental health program.

- Creating eco-systems that promote mental well-being
- Empowering women to become bare-foot mental health professionals
- Shifting the focus from a biomedical to social model

ARC

Advocacy, research, and alliance for policy shifts.

- Fighting stigma through public opinion and discourse
- Conducting research to identify gaps in services and policies in mental health
- Advocating for rights of persons living with psychosocial disabilities

VOICES

First launched in Pavlov Hospital (Kolkata), Voices is now an ongoing, hospital-based, capacity building program, with 280 residents in four government-run facilities. Its chief objectives include: redesigning all hospital-based services, while centering a human-rights approach; and developing a replicable model that can be adopted by different state governments. The focus is to deinstitutionalize participants and relocate them back to their communities, while ensuring their participation and consent in all decisions related to their lives.

Voices is implemented in partnership with the government and operates within West Bengal State's mental hospitals, utilizing state infrastructure, (including psychiatrists, caregivers, and counselors), rather than creating parallel systems. This strategy optimally uses available resources and ensures that the state does not abdicate its responsibility toward health, especially for the most marginalized communities.

Voices implements a comprehensive curriculum that focuses on building communication and leadership skills of participants.

Pivotal program components include:

•building the agency and capacity of residents

• empowering residents to speak up for their rights

• advocating for social inclusion of participants as rightful citizens within their communities and society at large

• enabling gainful engagement for participants, thereby breaking the prevalent notion that people with severe mental illness are unemployable

• safeguarding the rights of residents through advocacy and legal aid

JANAMANAS

While Voices deinstitutionalizes residents of Anjali's program and relocates them back in their communities, the transition is not easy. Families and communities continue to be hostile, and violent, and to perpetuate stigma.

To counter this, Anjali has developed Janamanas (collective mind), a model of community-based mental health care in partnership with urban municipal wards – which envisions working in coordination with government bodies to mainstream mental health services within the public health service delivery system.

Janamanas demonstrates the possibilities of empathetic, community-owned care, and the integration of persons with psychosocial disabilities, in ways that are affordable and accessible for the most marginalized sections.

Janamanas was initiated in three municipalities, where women from resource-poor urban localities operated Community Mental Health Kiosks. The project includes counseling of family members, and advocacy by community workers for the inclusion of those with psychosocial disabilities in municipal planning, services, and facilities. It entails continuous capacity building, training, and workshops for community workers, and awareness camps. Additionally, it works towards the reintegration of formerly institutionalized women with their families and communities.

Janamanas collaborates with the local Municipal Corporation, police officials, panchayat members, and community leaders — to create support networks for clients. It is led and managed by women from rural and semi-urban localities, thus encouraging community agency, and centering community narratives. Janamanas has been recognized as a "best practice model" both by the Government of India and in a documentation study by the Institutional Review Board.

ARC

Often, people who are marginalized, oppressed, and resource-poor, are unaware of social services and welfare options available to them. Or, these services are unavailable and inaccessible. Access to knowledge, information, and services can encounter social barriers, social inequalities, and structural challenges.

Anjali works with a population that is resource-poor, oppressed, marginalized, and disenfranchised. Thus, a significant proportion of Anjali's efforts go into fulfilling their clients' basic needs for survival: access to water, food, shelter, sanitation, and medical care. Anjali also aims to build social capital in communities and leadership in hospitals by advocating for equal opportunities, equal status before the law, meaningful employment, social justice, and human dignity. In this way, Anjali's initiatives—both within hospitals and communities—are directly related to advocating for the advancement of persons living with psychosocial disabilities.

On a macro level, Anjali's advocacy efforts include legal and institutional policy reform — foregrounding the rights and agency of persons coping with mental health challenges — through research, and governmental/institutional engagement.

Anjali also leverages 'collective power' for its advocacy efforts and is an active member of various forums, coalitions, and campaigns, including:

- Disability Activists Forum (DAF),
- Maitree, a women's network in West Bengal promoting awareness and advocating against violence against women,
- Dash theke Dash Hajar (Ten to ten thousand), a network of NGOs/CSOs documenting cases of sexual assault, and advocating against sexual violence towards women, lesbians, and the transgender community.
- 'RAKSHA', a regional network platform of organizations, activists, and practitioners advocating issues related to child protection and rights.

ANJALI A SNAPSHOT

78,564
People that Anjali has reached out to in the community

14,522
People that Anjali has provided psychosocial support

611
Individuals reintegrated

288
Self Help Group members Anjali has trained

35
Wards covered

301
Clients engaged in work

35
Barefoot mental health professionals

894
Young people engaged

Over the last two decades, Anjali has influenced paradigm shifts in the mental health sector, which include:

- Humanizing government health institutions and securing progressive policies through partnerships with the state and local governing bodies.
- Enabling patients in government hospitals with information, training, and a distinct 'voice' in matters about their care and treatment.
- Partnering with citizens (especially youth) to build new allies and new change agents for the field of mental health.
- Shifting the existing paradigm of mental health care and treatment from institutionalization, to community-based models of care and healing.
- Securing progressive policies through partnerships with local and state governments

Critical Milestones

1999
- Conception of Anjali, as an idea
- Ratnaboli Ray, (Founder & Managing Trustee, Anjali, receives the Ashoka Fellowship

2001
- Anjali is registered as a charitable trust
- Anjali, the organization, reintegrates its first participant of Pavlov hospital named Anjali

2002
- Anjali launches operations in Lumbini Mental Hospital, Kolkata
- Anjali integrates a rights-based approach into its model
- Order for LOA (Leave of absence) for patients secured - a policy win

2003
- Prohibition of direct administration of ECT in government mental hospitals secured
- Anjali launches operations in Behrampore Mental Hospital, West Bengal

2005

2008
- Anjali reintegrates its 100th participant

2009
- Anjali wins the Edelweiss - Kubera ~ Social Innovation Awards in Health

2010
- Dance Movement integrated into the curriculum through partnership with Kolkata Sanved

2013
- MAD (Make a Difference) Summit launched
- Inception of Cha Ghar - a livelihoods program inside mental health hospitals

2016
- Significant policy win achieved -
a) Demolition of isolation cells
b) Direct re-admission in case of re-lapse
c) Inclusion of Anjali in RKS of the mental health hospitals
- Launch of a Dhobi Ghar - non-traditional livelihood enterprise (an automated commercial laundry at Pavlov Mental Hospital
- Ratnaboli Ray awarded with the International award Alaison Des Forges award
- National conclave on Community Mental Health

2017

- Design and development of a rights, dignity, and citizenship curriculum for hospital participants
- A National Conference on Pleasure, Politics, and Pagalpan (desire, politics, and mental health) launched

2018

- Anjali secures voting rights for its participants of Pavlov mental health hospital
- “Love in the time of Madness”, a documentary by Anjali, gets published
- Anjali launches a bakery as a livelihood initiative at Pavlov Hospital and other new livelihoods opportunities like block printing and kantha stitching
- Anjali gains participation in the diet committee of mental hospitals
- Anjali’s thematic paper on ‘Sexual Rights of Women with Psychological Disabilities: Insights from India’ is published
- Partnership secured with Sangath for International Conference on community mental health
- Anjali launches operations in Purulia Hospital, Kolkata

2019

- Anjali is included in the rule framing committee on the Mental Health Care Act by the department of Mental and Family Welfare
- Invitation by the Chhattisgarh Government (department of health and family welfare) to initiate a rehabilitation and reintegration program
- Anjali reintegrates its 1000th participant

2020

- Atasi, a film on mental health, wins the best documentary in International Mumbai Film Festival
- Anjali has reintegrated 1200+ participants over the past two decades
- Anjali has launched and executed 5+ livelihood programs across mental health hospitals in West Bengal
- In the face of pandemic, peer leaders emerge among Anjali participants in the hospitals for conducting sessions on behalf of Anjali’s staff

3

VOICES

- AN OVERVIEW
- A HISTORY OF INNOVATIONS
- PILLARS
- PROGRAM ARCHITECTURE

Freedom, Rights and Citizenship for all

On August 15, 2015, the participants of Baharampur Mental Hospital marked India's 68th Independence Day by displaying their flags, each with a symbol that represented the notion of freedom from the perspective of their lives within the institution. For some freedom was a ray of light that illuminates lives, others drew spectacles, to emphasize the responsibility of citizens to take a better look at reality.

The installation initially received a lot of opposition from the hospital superintendent who felt that raising multiple flags would demean the tricolor and its history. However, the Anjali team escalated the issue to the Department of Health and received their full support. Dr. Subhashish Saha, Chief Medical Officer of Health, and one of the delegates present at the event noted the significance of this gesture, ***"I have observed at least 50 Independence Day celebrations in my 29 years of work but here we are exploring the meaning of this day in a different light. We are free from British rule but our freedom fighters wanted more. They had a vision of an independent country where the voice of each person is heard."***

Anjali's Voices program is built on the hope of achieving a vision of independence and citizenship for every individual, especially for people living with psychosocial disabilities in government mental health institutions who are unable to claim their basic rights and freedoms. To fully understand the audacity of this vision one must consider that institutionalized individuals with psychosocial disabilities have historically been denied their right to vote, marry, have a child, or hold a passport.

Giving Voice to those on the Margins

Voices is the flagship program of Anjali. It predates the formal registration of Anjali. Launched as a field pilot in 2000 in Pavlov Mental Hospital of Kolkata, West Bengal, Voices was the first program in India to work inside government mental health hospitals in partnership with the health ministry of a state government.

Anjali strives to foreground the voices of those living with psychosocial disabilities. By integrating the voices of those with lived experiences of mental illness, prioritizing agency, and leveraging social capital—Anjali's Voices program has transformed institutional care provision within government-run mental health hospitals in West Bengal—spaces that were notorious for rights violations and ridden with apathy. A long-standing goal of the program is to create peer leaders of the residents and enable their transition from 'patienthood' to personhood. Residents of these institutions become agents of transformation, ushering in change both within the institution and outside in the community.

For over 20 years, Voices has sustained and strengthened its partnership with the government to scale to four mental hospitals of West Bengal. Its model has been replicated and is now in the early stages of launching in Chhattisgarh.

Framing Voices

To ensure person-centric systems in government mental health hospitals that are rooted in a rights-based approach, Voices incorporates a 4-C framework:

Collaboration
Care
Capacity Building
Citizenship

Collaboration: Collaboration with the state government has been the strategic inroad for Voices to work inside the mainstream health system; to transform the system through small, slow, steady wins; and to take forward all players in the system as part of its core success. This systems-thinking approach has enabled Voices to influence and change government policy and programs at various levels.

Capacity Building: Starting with the purpose of rehabilitating recovered persons living inside mental health hospitals, Voices has grown roots inside hospitals through care and capacity building of its participants. It recognizes these two Cs as critical processes of empowerment.

Care: The participants of Voices are individuals who would have been relegated for years to the wards and corridors of a mental health hospital, with minimum or no word from families. To be heard, to know that someone is committed to your well-being, to have someone speak up for you, and then to teach you to speak up for yourself; these elements of care have healed, nurtured, and then fired up the dormant personhood of hospital residents.

Care forms the bedrock on which Voices builds the Capacity of its participants. Institutionalized for years, participants are encouraged to stretch outside their skin and unlearn their regulated behaviors. It builds their capacities for successful re-integration into homes, communities, and society at large. This ranges from managing daily chores, everyday communication, managing relationships, problem solving and negotiation. More importantly, Voices nurtures participants' abilities for self-advocacy, making decisions, independence, and interdependence.

Citizenship of persons institutionalized inside mental health hospitals is a goal as well as a strategy of Voices. It is also the core criteria on which Voices selects its participants.

"Before inducting participants, we work with individuals for almost 30-45 days to assess their motivation for joining Voices," Sukla Deb Baruah, Program Manager, Voices says. ***"We seek answers to two critical questions : Are they in a great hurry to get home? Do they see Voices as their fastest, most assured route out? Or are they willing to put themselves in a discomfort zone, confront and challenge their own constructs, and become the key driver for reclaiming their rights and citizenship. This can be a lot of hard work, a lot of responsibility. But it is also the path to long-term rehabilitation."***

Taken together the 4-C framework forms the matrix on which Voices drives the long-term social inclusion of its participants.

Impact at a Glance

participants who have been in the Voices program over the last 20 years

1280

10% of total no. of hospital residents

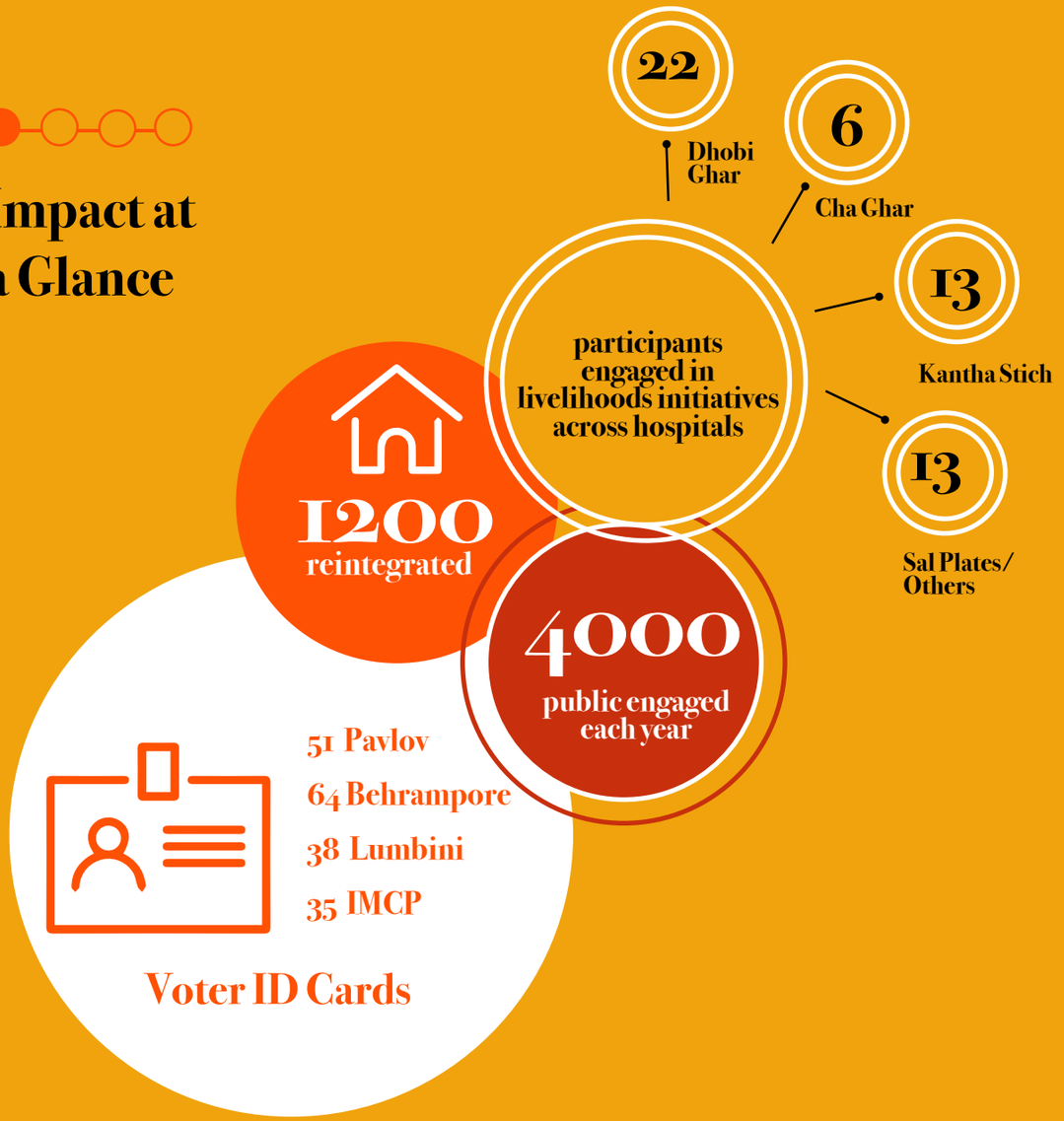
49% male

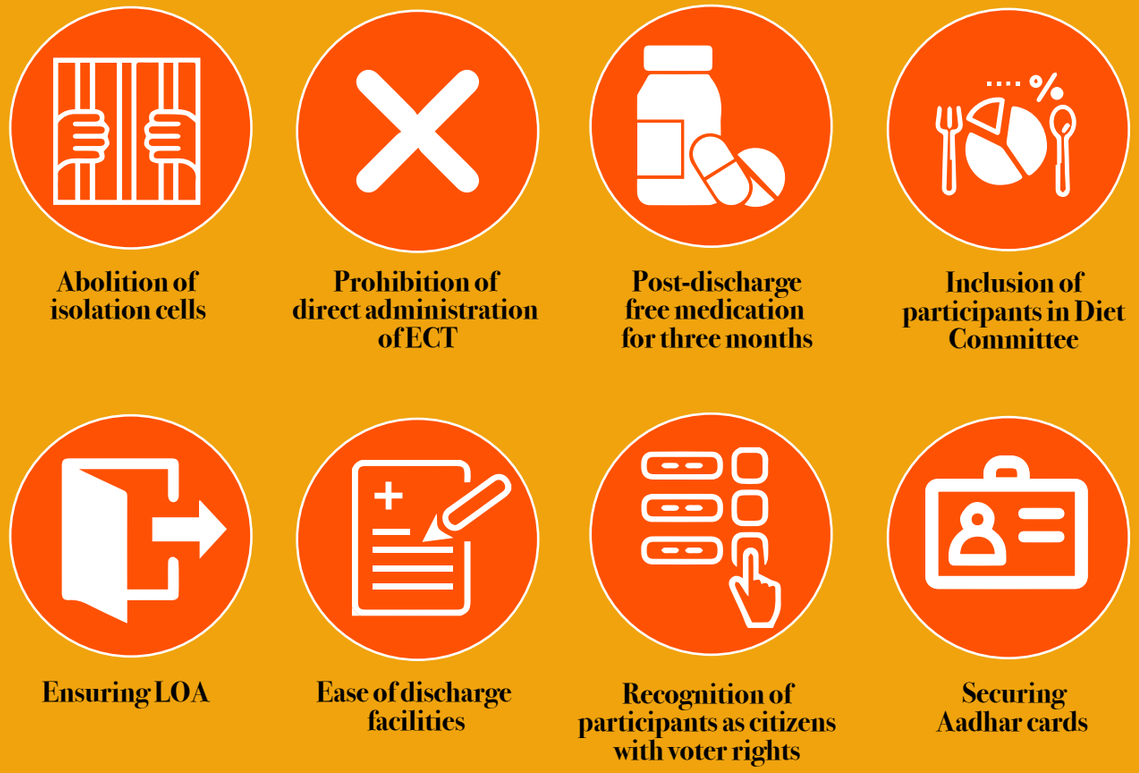
51% female

~ 80% within the age group of 32-45 yrs

majority of participants come from West Bengal State

Impact at a Glance





A HISTORY OF INNOVATIONS

Breaking Ground

The evolution of Voices marks the evolution of Anjali. In 1999, Voices was an idea in Ratnaboli Ray's mind. It was contoured on the belief that government mental hospitals could transform; from holding cells for persons with mental illnesses, they could turn into humanized spaces of care and treatment, offering safe pathways to recovered individuals to go back to their families and communities. Ratnaboli Ray approached the Human Rights Commissioner of West Bengal for permission to test this idea inside a government mental health hospital. The matter took more time than anticipated. Every day for three months, she trudged to the office of the Commissioner and waited in the corridors.

Ratnaboli did not have an organization to back her; and her identity as an individual social worker did not give her the heft to seek the offices of the Commissioner. Her path continued to be blocked by the Commissioner's Assistant. In the fourth month, the Assistant acquiesced. Ratnaboli was granted a brief meeting with the Human Rights Commissioner, Kamlakar Mishra. He endorsed her idea immediately. Within a week, she was granted space in the outer ward of the Pavlov Mental Hospital. She could work with a few recovered women patients. "***What will you do with them there?***" the state health secretary had asked her. "***Have conversations, tell stories, do some art perhaps,***" Ratnaboli responded.

In the same year, Ratnaboli received a fellowship from Ashoka: Innovators for the Public – a global organization that recognizes and supports social entrepreneurs with the vision of creating systemic change. The validation propelled her to take the path for which there were no maps.

Anjali's Voices program broke ground in mental health institutions, innovating at every turn and creating roadways into institutional care that was previously uncharted terrain. These innovations drew from Anjali's core beliefs in the power of personhood, the ability of institutions to be inclusive and intersectional, and the role of communities in preventive mental health care.

Enhancing Agency through Storytelling

"Storytelling and story-sharing are about listening and listening to. There is an intellectual side, an imagination side, and a facilitative side to storytelling. That someone is listening to our stories; that our stories matter- this was the aspect of storytelling that we exploited. Our participants understood that they had the right to be heard."

- Ratnaboli Ray

Story-telling marked the start of Voices's innovations. "***I started by asking my participants what they would like to do and gave them options. We could cook, draw, stitch and tell stories,***" Ratnaboli recalls. They were open to all but voted resoundingly for stories.

Long years of isolation in a hospital ward, of staring vacantly at blank hospital walls, and the expanse of empty hours had blunted the women's abilities to converse, respond, and communicate. Conversations with Ratnaboli stimulated them in new ways.

"***We used to talk a lot***," Ratnaboli remembers. "***Sitting on straw mats in the corridors of the hospital, we would have seemingly banal conversations. We would talk about food, exchange recipes, share memories of festivals, recall favorite games, and remember the rush of the giant wheel in village fairs***." The chit-chat jogged their memory and sharpened their cognition.

Slowly, the informality of conversations gave way to deeper narratives and Ratnaboli's work started to take the shape of a social change intervention.

Shaping new identities

In these sessions, every time an individual introduced herself, she would state her first name, state the hospital as her place of permanent residence and state her primary identity as a mental health patient. "***All their narratives were built around the body and pathology.***"

Ratnaboli recalls, "'Here is my liver; here is my heart', they would tell me. "I started to coax them to say, 'I am also a woman, a citizen'. But they struggled to understand this." Then it was decided that all individuals who gathered to work with Ratnaboli would call themselves 'participants' not 'patients'. A new identity made women talk in new ways.

Listening actively, with a rights lens

Soon, fantastic 'coming-of-age' hospital stories started to tumble out. Women began narrating incidents of ECT as stories of heroism, stories of growing up and graduating into 'real' patients. "Oh! I have had 15 ECTs so far," a participant would boast. Another would say, 'Then three of my teeth fell off after the electric shock, but I got to drink milk after that.' Ratnaboli started turning up the right's radar as she noted these stories.

Sharing new conceptual frameworks

"Stories helped me to share new conceptual frameworks with the participants," Ratnaboli explains. "I told them about persons living with diabetes and pointed out that their illness did not appropriate their identity. Pat came their response, 'But the people with diabetes stay at home. We stay in a hospital. That is why our illness frames who we are.'

When pushed to talk of relationships, the participants' stories would quickly give way to questions and resignation. 'When will I be discharged? Why does my family not visit me?'" In many ways, their stories mirrored their stoic acceptance of their long-term confinement in hospitals.

A channel for mining informal data

Through stories, Ratnaboli collected information on families, home addresses, villages, and towns of the participants. Within one year, she and her team of volunteers and friends had rehabilitated 15 women participants back into their families. Many of these were cases of inter-state integrations. Soon, the number of participants attending Ratnaboli's sessions swelled. Doctors and psychiatrists started visiting her and her group. From a small stretch on the veranda of the hospital, her program now occupied six rooms near the doctors' quarters.

Voices had demonstrated that collaborating with a civil society organization could be an agile route for government mental hospitals to unclog its rehabilitation bottleneck.

Integrating a Rights-Based Approach in Service Delivery

In 2000, with proof of concept established, Ratnaboli registered Anjali as a Kolkata- based non-profit organization. Anjali's mandate was to professionalize and humanize government mental hospitals, and to demonstrate speedy and dignified routes for the re-integration of recovered patients back into their communities.

But soon Ratnaboli and her team of three would add another innovation into the mix. Between 2002 and 2003, a set of serendipitous events unveiled the human rights sector for Anjali and Voices. Ratnaboli Ray attended the Institute of Rights, Advocacy, and Development (IRAD), organized by an Indian non-profit CREA. She later attended a ten-day, Ford Foundation-funded course on human rights at the Harvard School of Public Health. The two courses opened up multiple windows into the approaches taken by human rights activists across South Asia.

The Voices team quickly started to see how basic mental health services in a government hospital could be designed, delivered, and critiqued from a human rights lens. "We took the stance that rehabilitation was the right of all persons living in mental hospitals. But not surprisingly, this confused the government," Ratnaboli says. "The government did not understand why we, with our focus on rehabilitation, were demanding clean bed sheets for all patients; because the government viewed clean beds as an administrative issue! This prompted us to strengthen our rights-based messaging, even as we delivered a service inside the hospital.

"We said if the hospital is not clean, how will the participants internalize the concepts of cleanliness at home?" Ratnaboli pointed out. ***"If our participants are not allowed to bathe and groom with dignity, how would they learn the basics of grooming?"*** The Voices team started to integrate these conversations into the daily rhythm of its hospital work.

Much to the chagrin of the hospital staff, the patients adopted the rights and entitlement narrative into their vocabulary. This incensed the hospital labor union. They mounted a negative campaign against the Voices program. But daily harassment, foul language, the destruction of signboards, and negative deputation to the hospital superintendent failed to knuckle down the Voices team.

One day, a member of the Group D hospital staff tricked Ratnaboli into a desolate corner of the hospital and locked her up in a room. She remained incarcerated there for up to eight hours, till a passer-by heard her calls for help and unlatched the door from outside.

Building social capital as protective armour

There were many such flashpoints. But Voices could not be dislodged from the government mental hospital, due to three key reasons:

1. The teams are embedded inside the hospital system. The everyday connection and access to Voices strengthen the 'voice' of participants and seeds the culture of dialogue in the hospital. By being in the system, Voices could escalate and diffuse crises and reign-in miscommunication across official levels promptly. By being inside the hospital, Voices also demonstrated its skin-in-the-game.

2. Whatever the animosity between hospital staff and Voices, the participants continued to stream into and demand sessions. This ground-up endorsement built the social capital of Voices and Anjali.

3. Whatever the spanner was thrown in Voices's way, the team continued to think, write, talk, negotiate, discuss, and facilitate the rehabilitation of hospital patients with full dignity and respect. The more indefatigably Voices walked on this straight and narrow path of purpose, the more the government trusts its intention.

Sometimes extremely adversarial episodes also flipped in Anjali's favor by these three factors. For example, when Anjali worked outside the patient wards, one participant escaped from its session, slipped out of the hospital campus, and disappeared. This was a huge liability for Anjali. Overnight, its work got suspended and all operations were shut down for four months. Quick to seize the moment, Ratnaboli made a powerful appeal to the government to not only restore Anjali's program but to ensconce it inside the patient wards. The Superintendent agreed. And Anjali returned to the hospital, on a stronger wicket.

Nurturing Collaboration as a Behaviour

Anjali has sustained and deepened its partnership with the government for over 20 years. For Ratnaboli and her team, collaboration is not a strategy, but the core organizational behavior of Anjali. This behavior has been shaped by the values of inclusion, commitment, and integrity.

"We constantly watch the field, and the field watches us constantly," Ratnaboli says of the continuous checks and balances that Anjali and the hospital systems maintain on each other. ***"For example, the more transparent that Anjali is with the government, as transparent will the government be with Anjali".***

What has nurtured such behaviors of collaboration? Ratnaboli lists the following principles, belief, and purpose: Anjali works with the deep-seated belief that government systems are responsive and they do transform for the benefit of its people. This is a robust, affirmative belief – not a servile position. It enables Anjali to purposively and positively critique government systems.

• **Participation:** All initiatives and solutions are co-created by Anjali with all its stakeholders. This consultative approach gives the organization the strength and pragmatism of the collective.

• **Safety:** The participants need to be safe; the hospital needs to be safe; the government system needs to be safe; the Anjali team needs to be safe. Ratnaboli and her team never take a decision that can potentially jeopardize all or any stakeholders.

• **Capacity:** All decisions and actions of Anjali are geared towards building positive capacities of all stakeholders.

"Earlier, the hospital team used to view us as stark enemies. Now, over time, they understand that our intention is only the well-being of patients. Often doctors and nursing staff tell us, that if we ask for certain provisions we may be able to move change faster than people like them who are within the system."

- Sukla Das Barua,
Senior Program Manager

PILLARS

Building blocks of social inclusion—pillars of the Voices program

a. CITIZENSHIP CURRICULUM
b. LIVELIHOODS
c. REHABILITATION
d. ADVOCACY

a.

CITIZENSHIP BUILDING

A Voice of My Own

"When we started, our curriculum was focused on creative therapy, but we realized that we cannot determine what counts as therapy for our participants. Even the notion of rehabilitation and recovery is specific to each individual. Hence the focus of our curriculum moved from therapy to citizenship building where we address multiple enablers and barriers for participants to lead lives of dignity and enjoy their rights."

- Aditi Basu, Program Manager, Voices

Anjali's Voices program rests on a Citizenship Building curriculum that is implemented in three phases across a two-year period. In keeping with the program's rights-based approach, the curriculum is designed to enable residents to know, own, enjoy and defend their rights as citizens. To enable this, the curriculum works to enhance resilience, participation and ownership among participants.

Woven into the fabric of the Citizenship Building Program are values of self-determination, flexibility and empowerment. Anticipating the diversity of participants' needs, the curriculum employs a flexible structure that allows residents to choose the duration of their participation, the themes they want to explore and the pace at which they want to proceed.

Involving all stakeholders—right from the Superintendent, to hospital authorities, to doctors and nurses— is another critical component of the Voices curriculum. This strategy speaks to Anjali's belief that transformation of the individual cannot happen without a transformation in their environment.

Voice's Citizenship Curriculum endeavours to tear down virtual walls inherent in institutions — those between residents, between residents and hospital staff and between residents and the world outside.

Several themes are incorporated and explored over the course of the program, through workshops, exposure visits, training sessions, peer-learning activities, and group discussions.

Curriculum themes include:

- ***Understanding Self:*** Yoga; Art; Drama; Financial literacy; Dance Movement Therapy
- ***Mental Health:*** Diary for self-assessment; Theatre; Music; One-on-one discussions
- ***Rights:*** Drama; Group sessions; Performing art
- ***Leadership:*** Performing arts; Art; Drama; Peer leaders/peer groups
- ***Livelihood:*** Participant-led assessments to identify skills and interest areas

Given the program's long-term goal of sustainability, Team Voices piloted and then incorporated a 'Training-of-Trainers' (TOT) module within the curriculum for residents who complete the 2.6 year capacity building program and express an interest in working as program trainers/facilitators. The TOT module includes communication /facilitation skills and a thorough exploration of mental health, gender, rights and sexuality. The module uses peer-learning and expert-led sessions to train selected participants over a 5-day period.

The Voices Curriculum is based on both the ARC (Self-determination theory) and CHIMES Framework that focus on one's innate psychological needs and the ways these can be shaped — to lead to personal recovery and development, specifically adapted for persons with mental health conditions.

Self-Determination Theory: ARC Framework

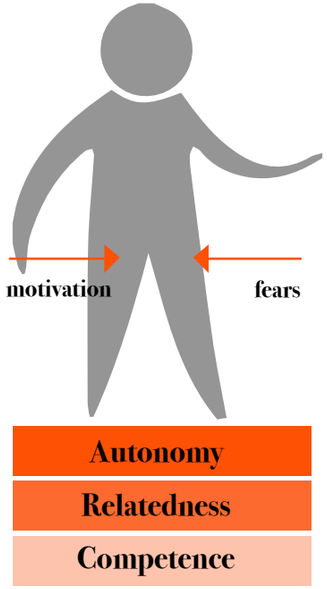
The Self-determination theory suggests that people are able to become self-determined when their needs for competence, connection, and autonomy are fulfilled. The theory grew out of the work of psychologists Edward Deci and Richard Ryan in 1985.

According to self-determination theory, people need to feel the following in order to achieve psychological growth:

Autonomy: Individuals need to feel in control of their own behaviours and goals. This sense of being able to take direct action plays a major part in helping people feel self-determined.

Relatedness: Individuals need to experience a sense of belonging and attachment to others.

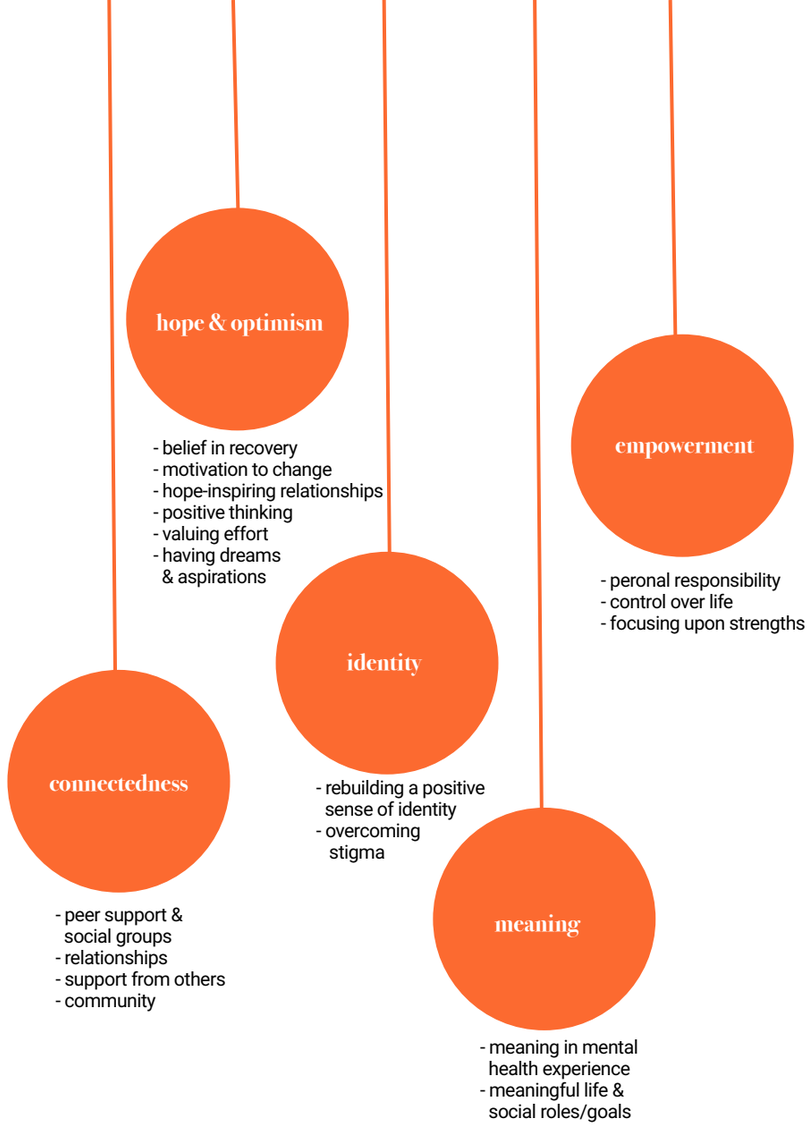
Competence: Individuals need to gain mastery over tasks and learn different skills. It is when they feel they have the skills needed for success that they take action to help them achieve their goals.



CHIME Framework

In its most basic form, the CHIME framework has five main themes: Connectedness, Hope and Optimism, Identity, Meaning and Empowerment. These themes make recovery understandable and attainable for people. It was developed through a systematic review and narrative synthesis of the existing literature on personal recovery frameworks and definitions by Mary Leamy (PhD) in 2011.

This framework can be easily adapted to fit programs that focus on mental health and personal recovery.



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Shakuntala's story—although initially marked by abuse and neglect—illustrates the importance of interventions that enhance agency and promote social inclusion. When Shakuntala, an orphan and destitute, began displaying symptoms of schizophrenia, people in the area labelled her as a witch and tortured her frequently.

She would often be severely beaten to the point of unconsciousness. She was admitted to Pavlov Mental Hospital and spent seven years as a resident there without uttering a single word. Hospital staff assumed she was mute. After three months of participating in Anjali's Voices program, Shakuntala began to tell her story. Through the process of storytelling and articulating her lived experiences of trauma, Shakuntala was able move beyond these narratives. This marked the start of her recovery.

Shakuntala completed the Voices program curriculum and was discharged from the hospital. Through her participation in Voices, she had rediscovered not only her voice, but also her ability to weave beautifully. Through Anjali's social inclusion initiative, Shakuntala opted to live in a short-stay home in Kolkata. She now earns a living as a skilled weaver.

b.

LIVELIHOOD

Dhobi Ghar is a livelihood program that utilizes a laundry service model. The service is run entirely by long-stay residents of a mental health hospital. Residents are trained to master all processes within the laundry service: washing, steaming, ironing, and folding.

'Patienthood' to Personhood: Shaping New Identities

Recasting Employment as a Win-Win

In 2013, as Anjali's Voices program made inroads into institutional care and brought a systemic change in its wake—Dr. Achaal Bhagat, a leading voice in mental health rights, gave the team a suggestion. ***"What about starting a livelihood program?"***, he asked. Dr. Bhagat's prod would soon become a pivotal moment for the Voices program.

Could a new role, a new identity beyond that of being a resident of a mental health institution, advance agency among their clients? Would having a source of income foster independence? Could products and services delivered by those within institutional care become a leaver to overturn social stigma? As Team Voices pondered the potential of this new initiative, they also struggled with the logistics of carrying it out. It took three years to secure government buy-in and the required permissions to launch the first of Voice's livelihood initiatives: Dhobi Ghar. In 2016, the Government of West Bengal completed the infrastructure required for Dhobi Ghar and green-lighted all the permissions needed for the initiative to launch.

At the heart of these negotiations was Team Voices premise that Dhobi Ghar was an asset to the institution. The laundry service would be free of charge for Pavlov hospital initially, and later on, services would be provided at a heavily discounted rate. Framing Dhobi Ghar as a win-win for the institution was a key strategy for securing buy-in from both the government as well as the hospital staff.

Once more, Team Voices encountered barriers of stigma and discrimination among hospital staff. That residents of the mental health ward were going to do laundry for the rest of the hospital became a sore point and one that Anjali took head-on.

Ratnaboli remembers how they openly "***spoke about the uncomfortable correlation between people living in mental hospitals and dirt, grime and untouchability. Unless these conversations are had,***", she emphasized, "***we cannot expect to achieve any form of justice for disenfranchised people like Anjali's constituency.***"

Employment as Empowerment

In keeping with Anjali's inclusive approach to all its initiatives, the Voices team first began to have conversations with residents to enquire if this was something that interested them. Their response was resounding "yes". Residents were excited at the prospect of taking on a new role, earning an income, having access to a bank account, providing a service to others, learning new skills—and most significantly, going beyond their identity as 'residents of a mental health institution'.

Team Voices understood that the training process itself could be leveraged to empower residents. Trainers worked not just on building technical skills directly related to the laundry service but also on those required for life outside the institute: discipline, responsibility, negotiation, communication, time-management, teamwork, and self-belief. Transferring these soft skills to residents is in keeping with the program's broader goal of social inclusion.

To ensure a smooth transition into these new roles, Team Voices ensured that each participant has the opportunity to visit other laundry service centers, and intern at Dhobi Ghar for six months prior to officially being employed. Participants are also supervised and supported throughout the initial process, to enable them to succeed in their new roles.

That employment breeds empowerment is evident in feedback from participating residents. Moushumi who has been working at Dhobi Ghar since 2014, shares how she enjoys the work "not only because it is an opportunity to leave the ward for a couple of hours every day", but also because she gets to feel like a working woman, and this small but critical role has been pivotal to her recovery process. Asha, another participant, shares that it has given her "the confidence to be able to find and keep work outside the hospital". Having a bank account and a steady source of income also significantly contributes to participants' recovery.

Alam Da, a Dhobi Ghar trainer illustrates the transformative process that training and employment have on residents. ***"When they first join, most of them have quivering lips and shaking hands***", he says, ***"but then we show them how to operate the iron box — and over time as they build confidence in themselves, their hands become steady."*** Alma Da's observation mirrors that of other trainers who not only witness this transformation in participants but similarly notice a shift in their own perceptions of and personal biases towards the residents.

On the Upswing

Through partial funding from Hans Foundation, Dhobi Ghar scaled to accommodate increasing demand and in 2020, the initiative became a completely self-sustainable business, providing participants with a steady source of income.

In 2013, Anjali expanded its livelihood initiative to include 'Cha Ghar' a rustic café that serves comfort food items—tea, ghugni toast, chowmein—at an affordable price. Their customers are usually the hospital staff or family members of participants of the hospital.

In keeping with Anjali's goal to end social stigma and discrimination towards persons living with psychosocial disabilities, Cha Ghar allows the public to closely interact with and be served by residents working at the cafe. A daily load of over 200 customers–which includes hospital staff, patients, or their family members —witness other roles that residents can play, if allowed to do so. In this way, Cha Ghar quietly builds social inclusion into its structure.

Riding on the success of these two livelihood initiatives, Voices launched several other livelihood activities in 2018: Kantha stitching, Ceramic pottery, Block printing, and handicrafts. These products are sold on Byloom and also through the Anjali website, and many of its partners.

Today, over 40 long-term residents are engaged in the program's livelihood activities and a significant percentage of residents have benefitted from training and livelihood opportunities.

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Regardless of our age, we are always deeply influenced by the people who raise us. These influences include not only the genes inherited from biological parents, but also the behaviours, habits, values, and communication styles that we learn from our adult caregivers. Research indicates that children who grow up in households where substance abuse prevails, are more likely to experience poor performance in school, emotional and behavioral issues, a higher risk of developing anxiety or depression, and a greater chance of becoming addicted themselves. These children live with the tremendous emotional and mental stress of having to care of themselves and for an intoxicated parent.

Rohima was born and brought up in Baruipur to a father living with an addiction. In addition to living with the stress of an addicted parent, she also grew up in a low-income family plagued by unemployment. Unemployment compounds existing stressors. Rohima was already shouldering this double burden of an addicted parent and poverty, when she failed her final exams in grade nine. This failure increased her levels of distress to the point where she experienced a mental health condition. Rohina's trauma manifested in bouts of rage and periods where she didn't recognize those around her. Unaware of how to provide support, Rohima's mother took her to a doctor who recommended hospitalization. The doctor's pathologization of Rohima's mental health condition and recommendation of a purely medicalized approach to treatment is indicative of mainstream mental healthcare models. This biomedical, expert-driven approach puts the onus of both the experience of a mental health condition and recovery from the same—squarely on the individual. This approach discounts the socio-cultural/environmental factors that enhance distress.

Rohima was admitted to Pavlov hospital where she stayed for a period of three months. During her stay Rohima met staff members from Anjali's Voices program who invited her to participate in the annual 'MaD' (Make a Difference) summit. Anjali conceived MaD (Make a Difference) Summit 2013 as a day-long meeting with persons with mental illness/ psycho-social disability who had lived in government mental health hospitals in West Bengal and later were reintegrated into their families or the community by Anjali. The summit is also an opportunity for persons living with psychosocial disabilities to hear stories from others that mirror their own experiences.

Involving family members and caregivers of those living with a mental health condition, fosters a deeper understanding of factors that enhance distress, builds perspective among those providing care and support and helps reduce social stigma. It is a step towards fostering social inclusion.

Rohima learned about Anjali's various livelihood programs and enquired further about Cha-Ghar. She began travelling to the hospital on her own and has been employed at Char-Ghar for many years. Char-Ghar is a medium to social inclusion. It enables residents to perform a role that goes beyond the all-pervasive, stigmatizing label of living with a mental illness.

Participants employed at Cha-Ghar share that it instils a feeling of being valuable, and "this knowledge that 'I am valuable' — is essential to mental health." For Rohima the opportunity to work at Cha-Ghar provides not only a source of income but also an avenue towards self-reliance and social acceptance.

C.

REHABILITATION

Social inclusion goes beyond simply sending residents back home. Navigating social exclusion requires an array of strategies and interventions. Right from reclaiming voter rights, to reclaiming public spaces, to make a place for residents at the table of their families & communities—Voices strives to build a more inclusive world.

Reclaiming A Place at the Table

"Being part of the electorate is perhaps the most conventionally significant way of being acknowledged as a citizen, whose interests the State must not disregard.

- Adrika Sengupta, Head Programs, Anjali

It was February 2019. India was gearing up for its 17th general elections. Campaigning by political parties had begun at full speed. During conversations about the impending elections, one resident said, "***I am a citizen of this country but have no certificate to prove it. Isn't it my basic right?***" Another participant added, "***Just because I suffered from mental illness at some point, it doesn't make me any less human or any less of a citizen of India!"***

Under Section 16 (b) of The Representation of the People Act (1950), a person of unsound mind, who stands so declared by a competent court may be disqualified as a voter. For years, this clause has thwarted the right that residents of mental health institutions have to vote—and by default other rights intrinsic to the voting process: the right to freedom from discrimination, freedom of opinion and expression, and freedom of movement.

Taking cues from the sentiments voiced by residents, Anjali's team set out to ensure that all residents of mental health hospitals, under its watch, were allowed to vote. In 2019, ahead of the National elections, Team Voices visited residents to conduct an orientation on political parties and the current political scenario.

Navigating exclusion in legal, civic and societal systems

For Voices, the Voter ID Card was an instrument they could use to navigate exclusion at multiple levels. However, for residents of a mental health institution, having a permanent ID card that mentioned the name of the hospital as their place of residence, would result in ongoing discrimination even after their discharge.

Therefore, Team Voices advocated strongly for voter identity cards that did not mention the mental health hospital. This took lengthy negotiations with relevant law enforcement entities and the Election Commission. But for Anjali, this was a crucial step towards fulfilling its vision of destigmatization and deinstitutionalization.

Anjali is also familiar with how social stigma creeps into and finds a place within all attempts to build social inclusion. The team, therefore, rejected suggestions made by hospital authorities, doctors, even government departments to place voting booths within hospitals.

Although this was portrayed as an effort for the convenience of residents, Team Voices knew that allowing this would further narratives of stigma, invisibilization, and social exclusion. Residents also rejected an offer to form a separate line so that they could complete their voting process quicker. Waiting their turn along with everyone else, was their way of subtly countering 'othering'.

For Team Voices voting became an instrument by which they were able to make visible an ever-disenfranchised population, enable them to reclaim citizenship, and take one step further towards social inclusion.

Celebrating Inclusion

Social inclusion sits at the heart of the Voices Program. Efforts to build agency among residents and transform systems culminate in reintegrating residents back into the communities they came from. For this, both the resident and the community need to be prepared.

A few years into the Voices program, residents expressed their desire to celebrate Durga Puja. For years, while the rest of the city was embellished in grandeur, residents had to contend with passing their time within the gloomy walls of a hospital. Thus began an annual tradition of taking residents pandal hopping on Panchami.

Soon, other activities: picnics, Basanta utsav, and puja parikrama were added to the mix. These outings not only give participants an opportunity to escape the monotony and drudgery of hospital life but also allow for mingling and engaging with the outside world.

"Being able to go out and spend a day among all the celebrations makes us feel less left out", shares a resident, after returning from a day of pandal hopping.

Bringing residents out into social spaces during festivals is a rebellious act. When asked about the significance of this initiative, Ratnaboli emphatically says "***While the whole world looks the other way from people living in mental hospitals, we at Anjali wear them like a cape of pride***", During Durga Puja, as people pour in the streets, celebrating the festival, lost in their bubbles, they encounter residents and they are reminded of those who society has forgotten. And similarly, standing together in a crowd with hundreds of others, gives residents a sense of belonging, acceptance, and the knowledge that there is space for everyone.

Team Voices thus leverages social excursions to subtly sensitize the community at large.

Preparing Families and Communities

Excursions, celebrations, voting—while significant—constitute only a small part of Anjali's efforts towards social inclusion. Given the depth of social stigma and ingrained misconceptions about persons living with psychosocial disabilities, sensitizing and preparing family members and communities takes most of the team's efforts.

At Voices, the re-integration process begins in the third month after a participant joins the program. Through conversations about their journey, memories of home, and some probing questions, Team Voices can glean basic information about where a resident comes from. "We first start talking about the house", says Ratna, "how it looks, landmarks, and we create a visual picture." This visual picture is what guides the team in locating the resident's home and family.

Team Voices sets out to search for the resident's home, using this visual picture and basic background information. They leverage connections with the police and Panchayat leaders to uncover the family's whereabouts. Over the years, the team has also worked towards sensitizing police officers. For example, on account of these efforts, police officers dress in civil clothes to not intimidate family members during the re-integration process.

Context building is extremely vital in the re-integration process and also to ensure that the family and the community is the right place for the participant to go back to. Anjali, therefore, involves the local Panchayat in initial conversations. ***"We've discovered that if the Panchayat leader is convinced, it is much easier to set-up other processes such as collaborating with local dispensaries to send the needed medication,"*** explains Ratnaboli. Here, the use of accessible mental health language helps to build understanding and perspective among family members. Additionally, to build good-will and credibility, Team Voices assures support for other community members living with mental health conditions.

The re-integration process is unpredictable. In some cases, participants are re-integrated with just a few phone calls and one visit. But with others, it takes a minimum of a year, multiple conversations, several phone calls, and home-visits.

Successful reintegration is contingent on family, education, economic conditions, and social milieu.

Most often, the team receives a disappointing response from the family if the participant lives within West Bengal. Re-integration with extremely poor families is not as difficult as with low- to middle-income families. Speaking to this, Ratnaboli shares: ***"I believe this could be due to the fact that in that strata, social capital means everything to the family, low to middle-class families view having persons with mental disabilities within their home as a sign of losing respectability."*** Other barriers to reintegration include issues of caste, class, employment, and a lack of resources.

In the initial days, Team Voices would write letters to family members, but over time, they use video calls as a means of establishing the first contact. Through videos, photos, and over phone conversations, family members are given a glimpse into the lives of the resident. They see how happy their son/daughter is and what he/she has made in workshops. Family members are also invited for a visit which gives them a chance to witness how participants live and see indicators of their recovery firsthand. Families often carry misconceptions about mental illness—these steps help to rebuild bonds of attachment and love.

As a first step, the resident is allowed to take a 'leave of absence' which constitutes time off from the hospital, enabling them to stay with family members and allowing Anjali to see how responsive both sides are to the re-integration process. Leave of absence serves as a litmus test and is a good indicator of what outcome to expect.

Once re-integrated, Team Voices stays in touch with the participants over 3 years—the intensity of this overseeing depends upon the case. It can vary from just a monthly phone call to monthly visits. If complications arise, the team mitigates by way of counseling sessions. If mitigation fails, the participant is brought back to the hospital. Anjali has a standing arrangement with the hospital that allows for a participant who has relapsed to be readmitted.

casestudy

Being born into poverty, Jayanti was stripped of all agency on account of her gender. Male members of her family married her off when she was merely 20 years of age to a man living with a physical disability. Unprepared for this role and forced to become a caregiver to her husband at such a young age, resulted in acute levels of distress for Jayanti. After the birth of her child, Jayanti had dual caregiving roles—looking after her baby as well as her bed-ridden husband. Although Jayanti was experiencing exhaustion, frustration and helplessness on account of these multiple stressors—it was interpreted as a 'breakdown' by her in-laws. Such interpretations are typical of how mental health is viewed. Lack of agency, loss of decision-making power, caregiver exhaustion — aren't recognized as factors that enhance distress. The individual is seen as solely responsible for their mental health. Consequently, Jayanti's in-laws shunned her and sent her back to her family.

Again, myths about mental illness and prevalent misconceptions about recovery influenced how Jayanti's family responded to her distress. She was taken to quacks, local godmen and Ojhas for treatment. Jayanti was socially isolated and stigmatized on account of her condition. Her in-laws refused to allow her back into her marital home. On her way back to her family, she was trafficked to Jammu and Kashmir and pushed into commercial sex work. Fortunately, she was rescued by a police officer and was brought back to West Bengal. Jayanti's families refused to take her back. No one had even thought of tracing her when she went missing for months. Her husband had moved on and had started living with his sister-in-law. These traumatic events left her deeply disturbed. She was found wandering the halls of a government hospital by the police and was admitted to Lumbini Hospital.

Without any enquiry into the traumatic events that had impacted her mental health, Jayanti was given a blanket treatment for psychosis and Schizophrenia. She began to attend Anjali's Voices program and participate in some of the creative sessions that focused on personhood, active citizenship and agency.

Thus began her slow journey to recovery. Jayanti found herself and her voice. She shared her story with Anjali's team who then set out to contact her family. After multiple efforts, Jayanti's family was located and informed. However, they refused to take her back. Such is the depth of mental health related stigma that Jayanti's mother was willing to look after her grandchild but not her own daughter.

Leveraging community leaders in the process of social inclusion is a strategy that Anjali uses effectively. A meeting was organized with local leaders and neighbours. Many conversations later, Anjali's team was able to sensitize both her community members as well as her family. It was discovered that Jayanti's husband was chronically ill with tuberculosis. Jayanti offered to become his caregiver once more and was allowed back into her marital home. Jayanti's greatest joy comes from being around her children. Through Anjali's support she secured a job as a cook at a Government Primary School and was able to support her family.

After her husband passed away from TB, Jayanti continued to be the primary caregiver for both her son and her daughter. Having lived with a mental health condition and experienced life within an institution, Jayanti is now a mental health advocate. She speaks at public forums on the double burden of gender discrimination and poverty—and their impact on mental health. She also advocates for the rights of those living with mental health conditions and the crucial role that family members as well as the community at large have to play in the recovery process.

Jayanti is now seen as a community leader. Her own lived-experience stands testimony to the need for humane systems of care and the power of social inclusion.

d.

ADVOCACY

Safeguarding the rights of residents is a key component of the Voices program.

Safeguarding Rights

In October 2014, Anjali intervened in the case of a human-rights violation in Pavlov Hospital, Kolkata. A 26-year-old woman had been locked up in a tiny solitary cell for more than 10 days and made to eat, sleep as well as defecate inside that cell. According to the nurses, her 'violent and unpredictable' behavior warranted her confinement.

Anjali advocated strongly against these violations using every avenue available at the time. In a ground-breaking decision by the State Government, three senior-most authorities of Pavlov Hospital, including the Superintendent, Deputy Nursing staff, and Medical Officer were suspended and replaced. On account of Anjali's advocacy efforts, isolation cells at Pavlov Hospital and Baharampur Mental Hospital were demolished three months later.

Safeguarding the rights of residents is a key component of the Voices program. Program staff identify participants who need legal aid and with their permission, a lawyer is engaged. Anjali's lawyer visits twice a month, identifies problem areas, secures supportive evidence/ documents, develops the case, and represents the participant through proceedings.

Legal cases vary from ancestral property disputes, child custody disputes, divorce negotiations, and employment contract negotiations. A large majority of these cases can be divided into four main themes: Property Law, Family Law, Basic Criminal Law, and Employment Law.

Thorough and detailed record-keeping and documentation are central to Anjali's work and it begins as soon as a participant joins the Voices program. This diligence proves helpful in safeguarding the rights of residents.

In 2018, when the new Mental Health Care Act came into effect, Team Voices facilitated legal training sessions for participants to build their understanding of their rights and protective measures under the law.

casestudy

Prior to India's Mental Health Care Act 2017, incarcerating persons within mental health hospitals was used extensively as a strategy to deal with persons found homeless or loitering on streets. It was relatively easy to admit a person believed to be mentally ill without their consent or any accountability for their treatment and discharge. This lack of accountability manifested within institutions as well, and oftentimes residents were left to languish for years together in institutions without any contact with their families.

Hasan's story is one of incarceration and human rights violations. He was pursuing an ITI Diploma in Assam when he decided to take a vacation with his friends to Puri. A series of chance events resulted in him losing both his friends and his belongings during the journey. Experiencing acute fear and anxiety from being in an unfamiliar place, Hasan was found wandering the streets of Paragana by the police who mistook his distress as signs of a mental health condition. Thus began his incarceration at Lumbini hospital and his subsequent long struggle to freedom.

During his hospitalization, Hasan was introduced to Anjali's Voices program. He shared this story of incarceration and his longing to go back to his family in Assam. Although he was showing no signs of a mental health condition, the stringent discharge policy of Government Mental Hospitals kept him hospitalized. Prior to MHCA 2017 a patient's discharge could only be authorized by their legal guardians. In Hasan's case, his family in Assam was unwilling to take on this responsibility and refused to authorize his discharge.

With Anjali's support, Hasan initiated his own discharge process by writing to the hospital Superintendent. As expected, his application was rejected. Through legal support from Anjali, Hasan appealed this decision in the lower court, hoping to get justice. After several months, the court assigned a date for his plea. Yet again the verdict was disappointing; it was declared that he should be released only to his family.

Unwilling to give up, Hasan then re-appealed to Shashta Bhawan. They agreed to allow his discharge but only on the absurd condition that Anjali would adopt him as their ward. Undeterred by this apathy from both the hospital and legal system, Hasan appealed to the High Court.

The High Court judge was appalled that a person of Hasan's capacity could be confined in a mental hospital for so many years. He demanded that the hospital justify this treatment by showing Hasan's medical records, only to realize that the diagnosis was extremely superficial. He authorized an independent assessment of Hasan's mental state by a private doctor. The results proved that Hasan was fit for discharge.

Hasan's case was not just a personal victory for him and Anjali, but a landmark judgement. For the first time in West Bengal, a resident had petitioned for his own discharge, and won the case. Hasan's story also underscored the importance of providing legal support to residents within institutional settings and using the law to ensure accountability of all those within the system.

Advocating for his own freedom was the first step of Hasan's journey towards reclaiming his life. With Anjali's support he developed his ancestral property and launched a ready-made garment business and an eatery. The success of both businesses gave him the opportunity to provide employment opportunities within his community. Over time, Hasan has rebuilt his credibility in his community and is now an advocate for those living with mental health conditions.

Having experienced incarceration first-hand and the stripping away of liberties and human-rights, Hasan advocates for more humane institutional care and greater accountability by those within these systems.

Transferring Ownership: Building a Network of Peer Leaders

In 2020, as the global pandemic restricted access into mental health institutions, Anjali's work in the four mental health hospitals came to a standstill. In the initial phase of lockdown restrictions, Program team members were not able to visit the hospital and no sessions were held. The lack of information unnerved participants. Team Voices began to worry that the lockdown would derail years of progress that residents had made towards their recovery. To their surprise, peer leaders emerged among residents. These peer leaders facilitated counseling sessions, arranged storytelling groups, and literary classes. A few went further and took it upon themselves to ensure that levels of personal hygiene were in-keeping with pandemic-related guidelines and social distancing norms were being adhered to.

The pandemic became an opportunity for program staff to transfer ownership of the Voices Program to the residents themselves. By encouraging a network of peer leaders to oversee program activities and take on more responsibility, the program inched towards its ultimate goal of diminishing its role.

Voices' long-term goal is to become smaller and smaller as people with mental illnesses become bigger, more vocal, more entitled, more active as citizens. "***As they start to represent themselves; understand their needs and claim their rights and negotiate with the governments, Anjali's role will diminish. That is our North Star***," says Ratnaboli.

PROGRAM ARCHITECTURE

PROCESS MAPS & FRAMEWORKS

Change Process: The Big Picture

This section presents an overview of the processes implemented by Voices.

Recovered Resident referred to Anjali:
• By Medical Officer & Psychologist or
• Identified by Anjali itself

Participation in capacity building session:
• 15 days orientation
• Anjali's Voices as a program is introduced
• Willingness of participation is assessed

Willing to participate

Induction of participant:
• Profile of the participant is generated
• Case history is prepared by the APM/Psychologist

Continued capacity building session:
Efforts to ensure movement of participant from patienthood to personhood through:
a. Continued interaction with APM & Psychologist
b. Continued participation in various training sessions

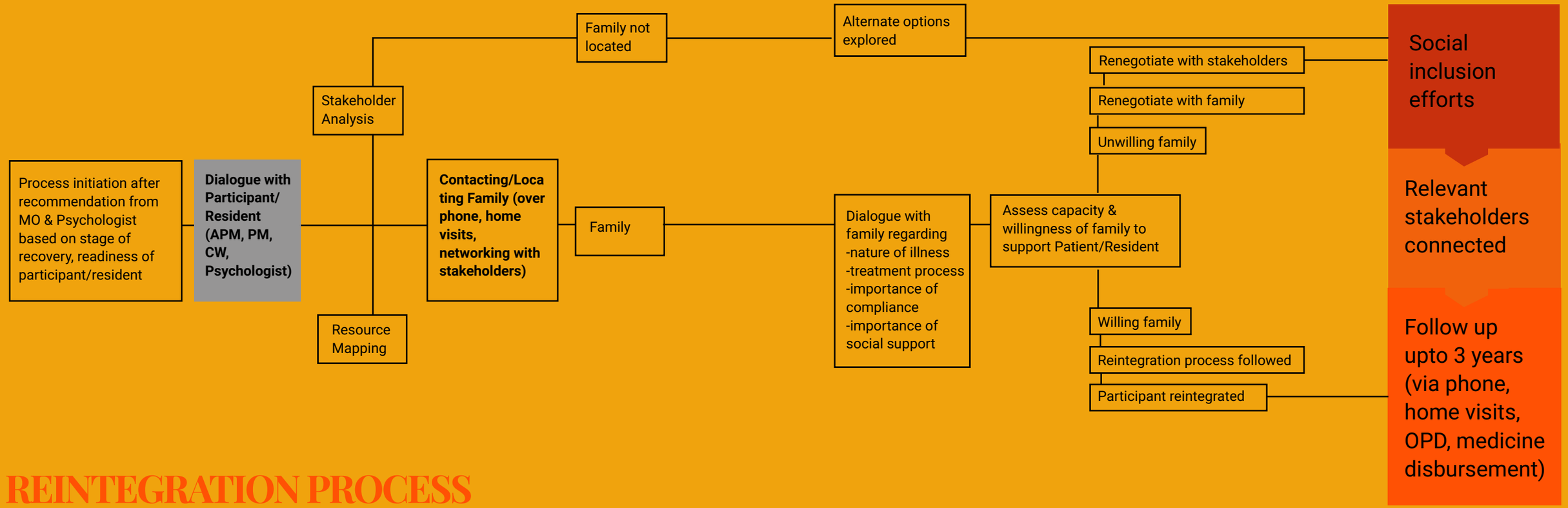
In case of non-participation, livelihood training is introduced based on the stage of recovery & willingness of participant/ resident

Livelihood:
• 3-4 months of training provided
• Selection based on performance post training
• Functional literacy and professional grooming
• Role assigned; wages provided as per the present labour laws

Social Inclusion/ Reintegration:
• Based on the stage of recovery
• Based on readiness, participant/resident and of the family to accept
• Social inclusion also includes other stakeholders viz community members, local governance
• Efforts to link up with existing government schemes
• Regular follow-up to ensure physical, mental & social well being through phone calls and home visits

CAPACITY BUILDING

REINTEGRATION PROCESS



Process map of a participant's journey

- Initiating the program in a new hospital
- Identification & induction of new participants
- Capacity building of participants
- Advocacy & campaign based processes
- Counselling of participants
- Legal awareness/access to justice
- Case-work documentation

Process map for reintegration of participants

- Contacting/locating family of the respective participant
- Begin dialogue with family regarding nature of illness, treatment, compliance, social support and facilitating discharge
- Explore alternate options such as long-term stay, old-age home, etc.
- Follow-up (via phone, home visits, OPD, medicine disbursement)

Process map of a participant's journey

**Process Holder: Deputy Director & Head of Program*

***Process Supervisor: Program Manager & Associate Program Manager*

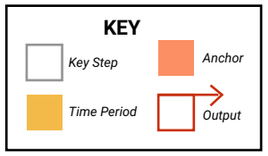
Primary Stakeholders: Participants, Government Hospital staff

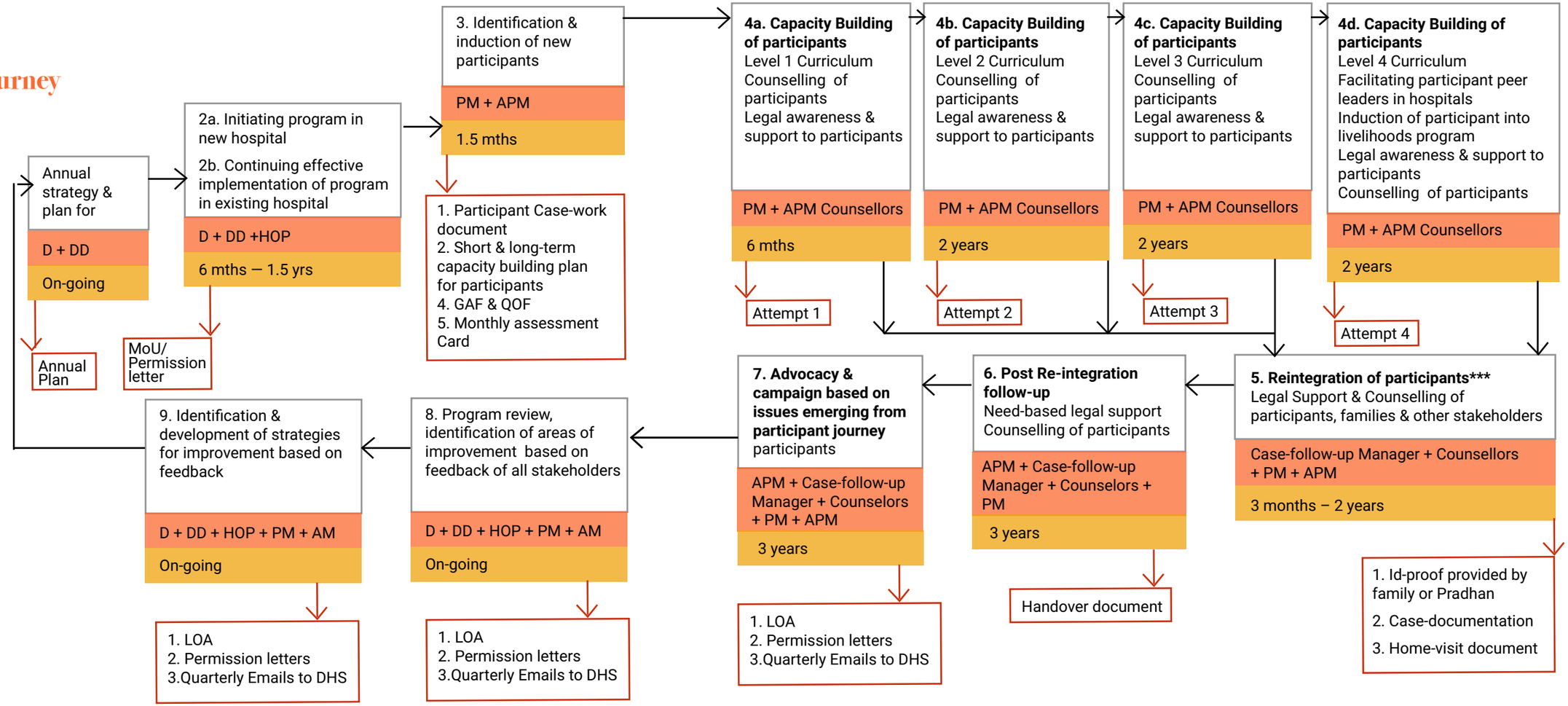
Secondary Stakeholders: Department of Healthcare Services, Mental-health Sector, Families of Participants,

Process Outcomes: Successful social inclusion/rehabilitation of participants: development of personhood & the capacity to make choices and act on them by participants

Process Inputs: Annual strategic plan: Government relationship; timely and effective planning, management, and execution by Voices team

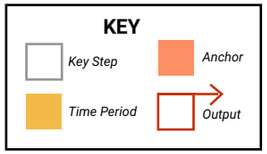
Process Map: (All sub-processes have been mapped below)



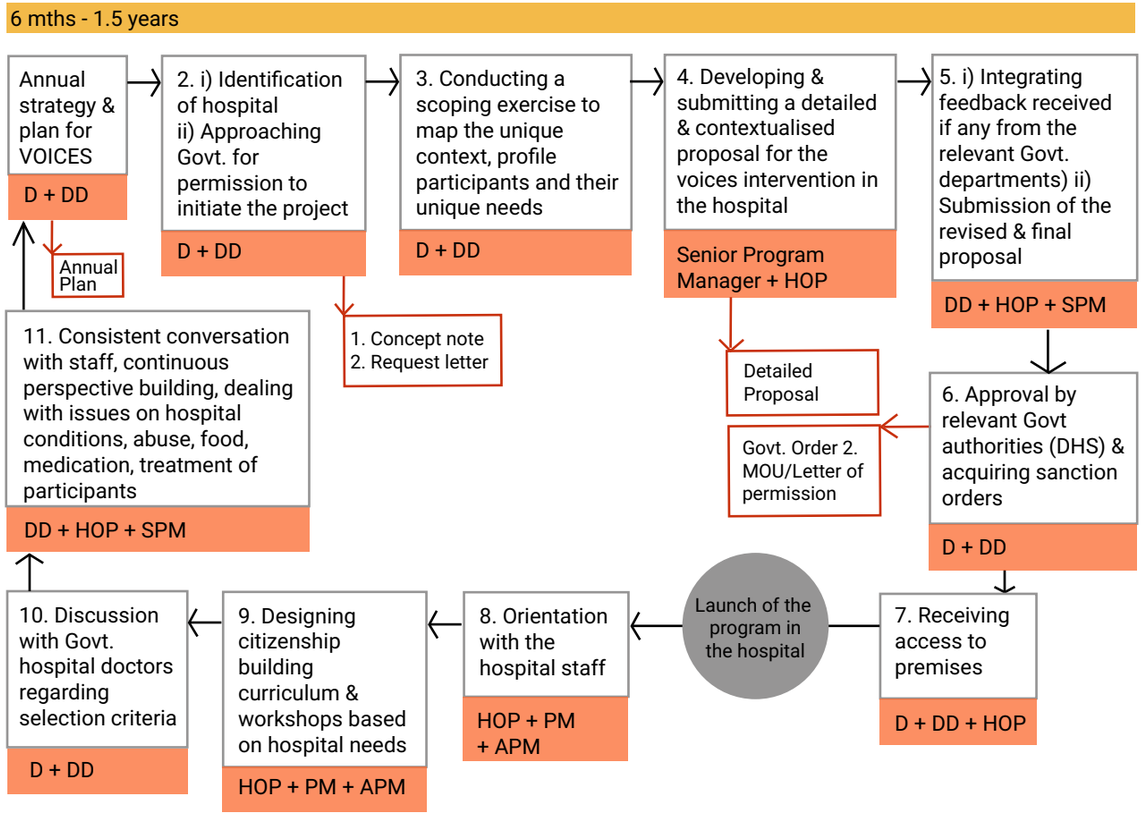


**Process holder is responsible for strategic decisions and overall outcome/impact of the process*
***Process supervisor is accountable for timely and effective implementation of the process*
****Families may not be open to taking participants into their homes but would want to facilitate the process. In those cases, Anjali facilitates the process of reintegration into alternate spaces of stay (short-stay home, paying guest, old-age home), the payment of which is borne by families.*

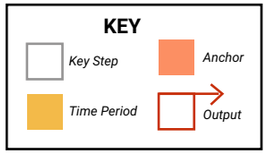
2a&b. Initiating program in a new hospital



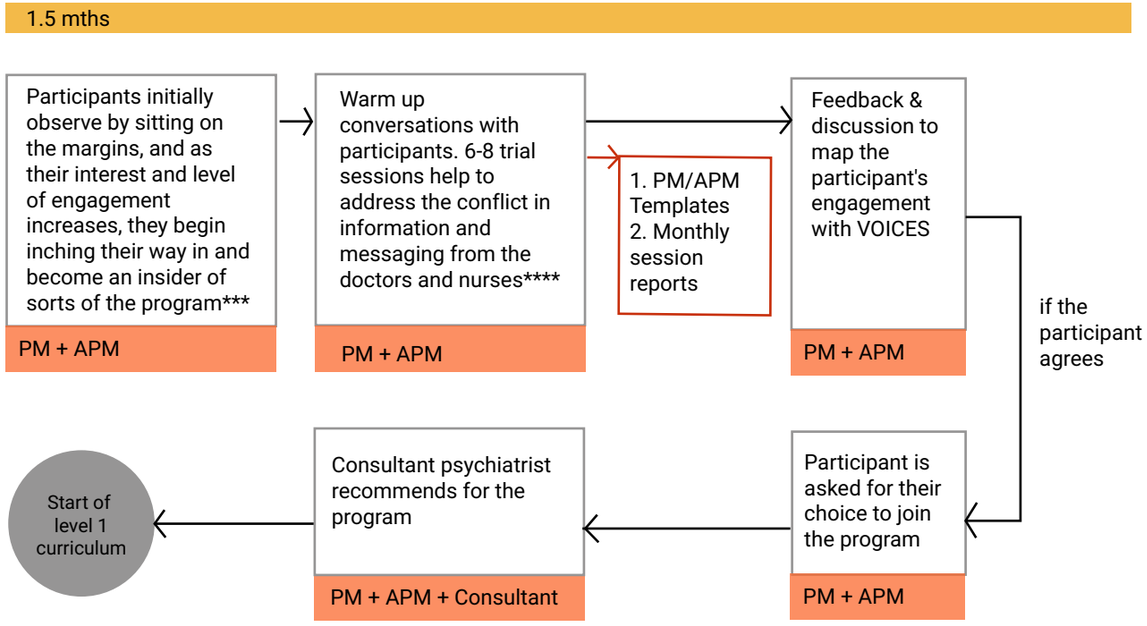
**Process Holder: Director & Deputy Director*
***Process Supervisor: Head of Programs & Senior Program Manager*
Primary Stakeholders: Participants, Government Hospital staff
Secondary Stakeholders: Department of Healthcare Services, Mental-health Sector, Families of Participants,
Process Outcomes: Successful partnership with hospital and continuous relationship building
Process Inputs: Annual strategic plan: Government relationship; timely and effective planning, management, and execution by Voices team
Process Map:



3. Identification & induction of new participants



**Process Holder: Deputy Director & Head of Program*
***Process Supervisor: Program Manager & Associate Program Manager*
Primary Stakeholders: Participants, Government Hospital staff
Secondary Stakeholders: Department of Healthcare Services, Mental-health Sector, Families of Participants,
Process Outcomes: Successful induction of the participant into the program
Process Inputs: Government relationship; timely and effective planning, management, and execution by Voices team
Process Map:



Process holder: responsible for strategic decisions and overall outcome/impact of the process
***Process supervisor is accountable for timely and effective implementation of the process*
****Participants find out about the program from peers, by observing on-going sessions, or by doctor's recommendation*
*****This is a process where both the participant and Anjali are assessing to understand if the other can be trusted and should be engaged with*

4a. Capacity Building of Participants – Level 1 Curriculum

A fast-track capacity building program for all participants who join the Voices program focusing on rights, self-care and livelihood, in order to prepare participants for a safe and secure life after reintegration

No. of sessions: *4-6 per day (Monday to Friday)*
No. of participants: *Average size of participants for every session is 35, across the male & female ward*
Duration of curriculum: *6 months*

Key Focus Areas

Personhood building - Understanding of self - Self-preservation - Right to dignity - Right to independence - Building confidence - Self-advocacy - Self-acceptance - Relationship building	**Understanding mental health & illness** - Concept of wellness - Understanding discrimination - Understanding mental illness and Compliance to medication - Crisis management - How to navigate education	**Understanding rights and entitlements** - Concept of rights and entitlements - My sexual and reproductive rights - My body, my rights - Right to livelihood - Right to property and accommodation
Community Relationship - Communication: verbal, non-verbal, assertiveness and negotiation - Managing interpersonal relationships - Designing daily activities - Problem solving, resilience, & critical thinking	**Community and Mental Health** - What is a responsive community - Skills to make community responsive towards me - Skills to identify, seek support, address triggers in community impacting my mental health - Participation in community - Inclusion in community	**Livelihoods** - Identifying basic skills, - Workplace grooming - Mapping local resources - Personal finance management - Time management - Importance of accountability & delivery

Weekly Workshop Sessions

Creative, participatory, activity-based sessions based on the key focus areas of the curriculum

Creative Projects

A theatre production, Mural project and other group based activities for creative expression

Excursions and Events

Creating an interface between participants and non-participants through cultural events, debates, picnics, Durga Puja Outings etc. that are held at regular intervals throughout the year

Co-design and evaluation

Planning participation and reviewing process monthly to create an individual roadmap

4b. Capacity Building of Participants – Level 2 Curriculum

After six months, participants begin an in-depth capacity building process, where the key areas of learning are delivered through a range of different methodologies such as workshops, projects, events and trainings. Participants can define their own learning path based on the methodologies they prefer. This phase of the curriculum creates a platform to develop a strong sense of self, build an understanding of their rights as citizens, and become advocates for people with mental illness in their communities.

No. of sessions: *4-6 per day (Monday to Friday)*
No. of participants: *Average size of participants for every session is 35, across the male & female ward*
Duration of curriculum: *2 years*

Key Focus Areas:

	Self	*Mental Health*	*Rights*	*Leadership*	*Livelihood*
SELF-DEVELOPMENT	*1.Self-concept* *2.Self-preservation* *3.Dignity ** *4.Independence* *5.Confidence* *6.Self-care* *7.Self-acceptance* *8.Assertiveness* *9.Sex, gender & sexuality* *10.Relationship building**	*1.Understanding mental health & illness** *2.Wellness** *3.Compliance** *4.Understanding discrimination** *5. Crisis management**	*1.Understanding rights and entitlements** *2.My sexual and reproductive rights** *3.My body, my rights** *4.Right to livelihood** *5.Addressing discrimination vis-à-vis my rights**	*1.Understanding leadership* *2.Initiative* *3.Assertiveness* *4.Negotiation* *5.Decision making* *6.Problem solving* *7.Identifying strengths, overcoming weaknesses* *8.Building risk taking capacity*	*1.Understanding Livelihoods** *2.Skills training-* *a. Beauticians course* *b. Accounting* *c. Spoken English* *d. Computer* *e. Gardening* *d. Tailoring*
COMMUNITY SUPPORT	*1. Communication-verbal, non-verbal, assertiveness, negotiation** *2. Realistic understanding of community** *3. Interpersonal relation** *4. Participation in community** *5. Designing daily activities **	*1. Discrimination** *2. What is a responsive community** *3. Skills to make community responsive towards me** *4. Skills to identify, seek support, address triggers in community impacting my mental health**	*1. Legal capacity* *2. Right to reasonable accommodation** *3. District mental health program* *4. Right to recreation* *5. Right to property** *6. Right to marriage* *7. Right to adoption*	*1. What is advocacy?* *2. How do we advocate?* *3. Negotiation skills* *4. Documentation skills* *5. How to provide crisis management support in community*	*1.Skills training* *2.Understanding the value of money* *3.Understanding the importance of saving* *4. Personal Finance management**.
IMPACT IN SOCIETY	*1. Envisioning my role as an active citizen after reintegration* *2. Exercising choice*	*1. Countering, coping with, and overcoming social discrimination* *2. Understanding social dimensions of mental health*	*My citizenship responsibilities*	*1. Initiating, organizing and leading mental health advocacy* *2. Motivating others* *3. Conflict resolution* *4. Strategic planning & project management*	*1. Overcoming discrimination at the work space.* *2. Media and facilitator training to become a mental health advocate.*

4c. Capacity Building of Participants – Level 3 Curriculum

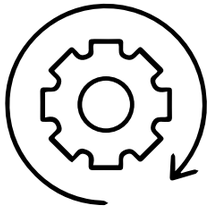
The Training-of-Trainer Curriculum is at a pilot stage, designed for participants who complete the 2.5 years capacity building program and wish to work as trainers for the program. Through this third phase of the curriculum they well each develop and design their own module, adapting existing content and methodologies, and facilitate the module for other participants

No. of sessions: *5 days*
No. of participants: *Average size of participants for every session is 35, across the male & female ward*
Duration of curriculum: *2 years*

Key Focus Areas

Understanding Mental Health, Gender, Sexuality and Rights

Communication and Facilitation Skills



Module Design Processes

Documentation Processes

TOT Workshop

5 days, 30 hours
Expert presentations, Peer learning, Co-design Sessions, and Prototype testing to develop training modules

4d. Capacity Building of Participants – Level 4 Curriculum

Anjali's Cha Ghar (Tea Room) launched in 2015 and Dhobi Ghar (Laundry Room) launched in 2016 at Pavlov Hospital, Kolkata, employ several participants enabling them to earn and lead their lives with dignity within the institution.

No. of sessions: *Post the initial training, participants work daily hours at Dhobi Ghar (3-hour shifts daily) & Cha Ghar (8 hours/day)*
No. of participants: *Average size of participants for every livelihood programs differs based on demand.*
Duration of curriculum: *2 years*

Key Focus Areas
1. Cha Ghar
2. Dhobi Ghar
3. Block printing
4. Kantha stitching

Audience analysis
Team Voices conducts an audience analysis to understand the needs, and demands of the market as well what the participants want.

Training (hard & soft skills)
All participants receive training in both soft and hard skills. These include training in discipline., negotiation. cooperation , competition, grooming, financial transactions, communications etc.

Exposure visits
Participants are taken on exposure visits to similar workspaces as a learning and training opportunity. For example, Cha Ghar participants are taken to the Park hotel to learn from others in the hospitality sector.

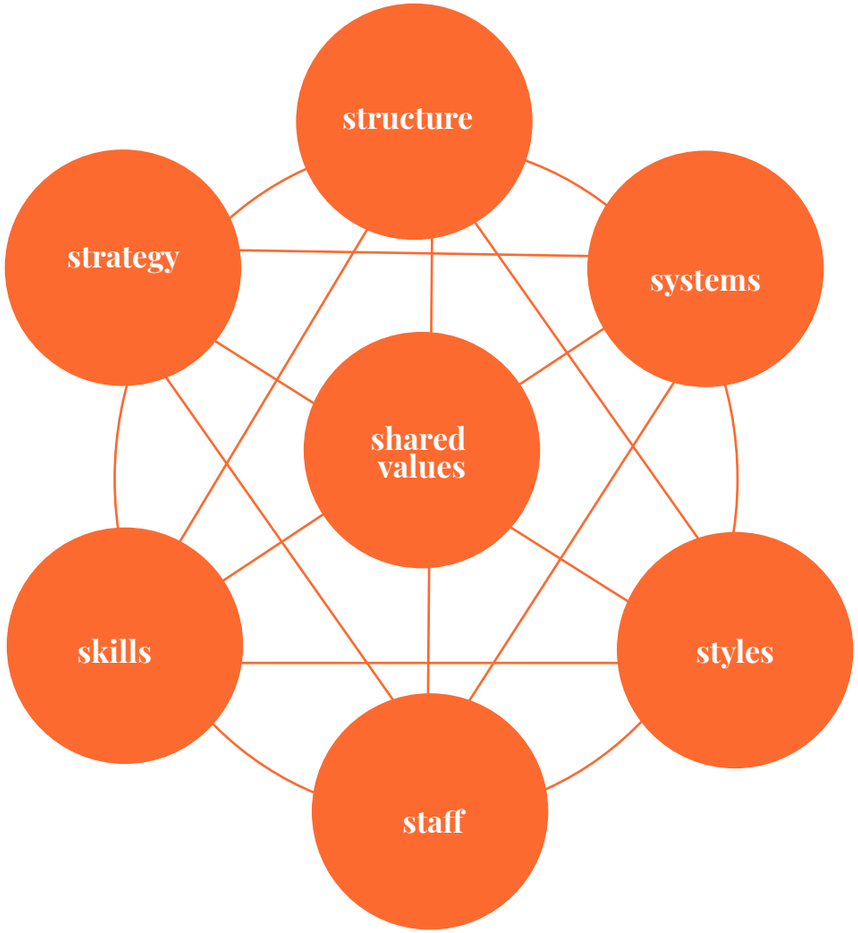
Apprentice training
Apprentice training is mandatory with a supervisor post training.

Supervision
Post the probation period, participants are divided into batches/shifts and are supervised by a trained professional who is responsible for the smooth functioning of the program.

Curriculum Framework

7S Framework

Voices incorporates 7 key elements: Structure, Strategy, Systems, Shared values, Style of Leadership, Skills and Staff (drawing from the McKinsey 7S framework).



Shared Values
Shared values represent the ethos and belief system of the model. They provide an insight into the core values that are shared across stakeholders and drive their collaboration. Shared values for the Voices program include Autonomy, Freedom, Trust, Commitment, Creativity and Accountability.

Strategy
Strategy delves into the long-term direction and scope of the model. Voices deploys the 4-C strategy (Capacity Building, Care, Collaboration, Citizenship) to generate the aspiration, culture, voice, and practice of self-determination in institutions that have been historically violent towards people with psycho-social disabilities.

Structure
The structure of the Voices Program spans across designations, with many team members juggling multiple roles and responsibilities.

Staff
Anjali works as a dynamic and cross-functional team with many of the roles and responsibilities divided amongst the different levels of the organization.

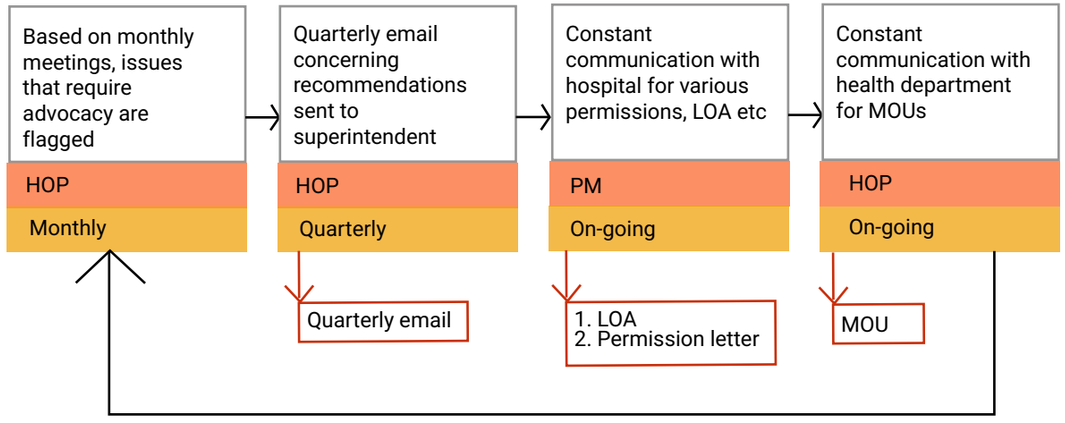
Skills
Skills are the core competencies that exist within the model and the program-wide competencies identified among the staff include:
• Problem Solving
• Counselling
• Effective Communication
• Critical Listening & Reasoning
• Fearless response and action
• Resilience to continue daily work in dark and stubborn environments
• Relationship-building

Style of Leadership
Anjali is composed of an unstoppable team and leadership that is centred on the participants. The style of leadership can be hence summed up to be:
• Consultative: This style enables everyone to be a part of the decision-making process, bringing together theory and practical insights from the field to arrive at solutions most beneficial to the participants.
• Facilitative: Anjali believes in creating ownership among its team members to enable them to grow as decision-makers, planners, and organizers.
• Non-hierarchical: Anjali's organizational structure is non-hierarchical; thereby ensuring that all voices of the team members are heard and incorporated in the strategy of the organization.

Systems
These include formal and informal processes that control everyday activity/program execution. The process maps in this section outline systems within the Voices program.

7. Advocacy & campaign based issues

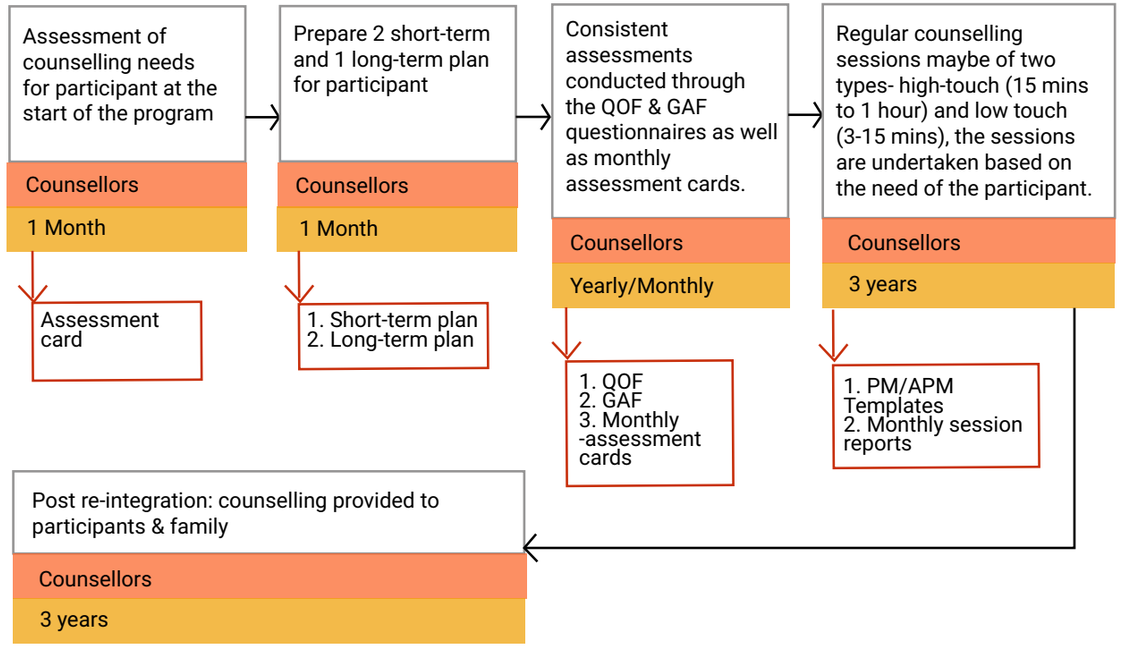
**Process Holder: Head of Programs*
***Process Supervisor: Program Manager & Associate Program Manager*
Primary Stakeholders: Participants, Government Hospital staff
Secondary Stakeholders: Department of Healthcare Services, Mental-health Sector, Families of Participants,
Process Outcomes: Successfully flagging & solving of issues needing advocacy based interventions
Process Inputs: Government relationship; timely and effective planning, management, and execution by Voices team



**Process holder: responsible for strategic decisions and overall outcome/impact of the process*
***Process supervisor is accountable for timely and effective implementation of the process*

Counselling of participants

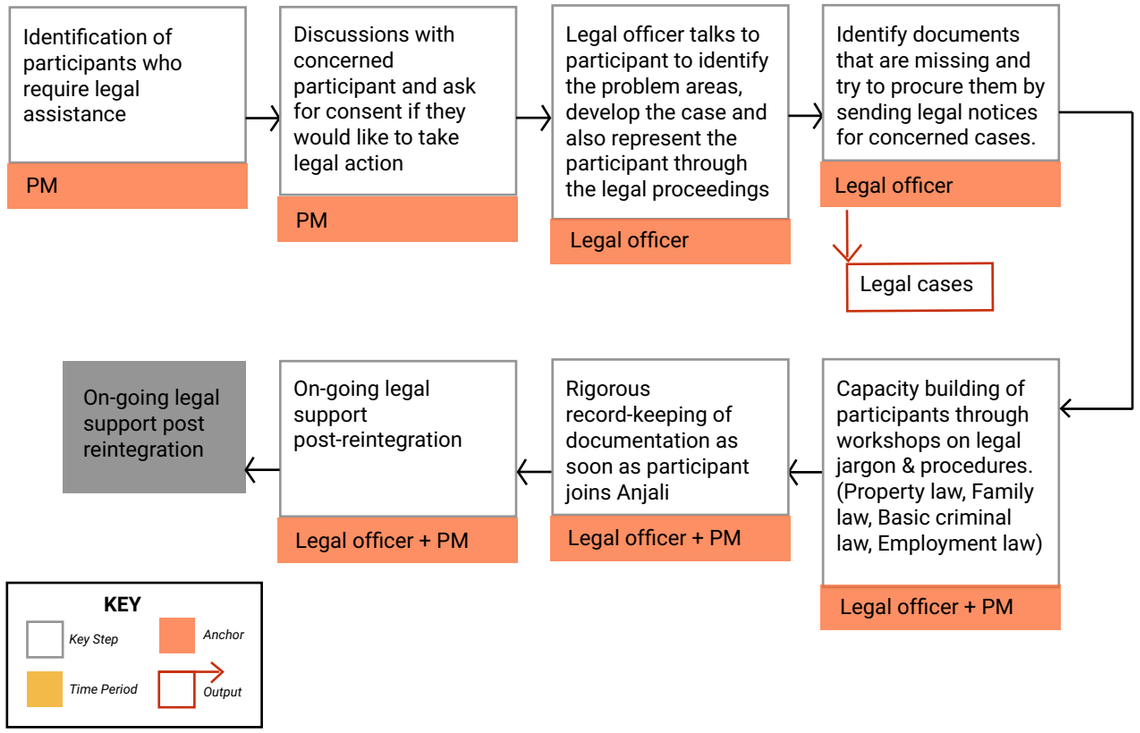
**Process Holder: Program Manager + Assistant Program Manager*
***Process Supervisor: Counsellors*
Primary Stakeholders: Participants, Government Hospital staff
Secondary Stakeholders: Department of Healthcare Services, Mental-health Sector, Families of Participants,
Process Outcomes: Successful counselling of participants over the course of their participation
Process Inputs: Timely and effective planning, management, and execution by Voices team



Legal awareness/ Access to justice

**Process Holder: Head of Programs*
***Process Supervisor: Program Manager & Legal Officer*
Primary Stakeholders: Participants
Secondary Stakeholders: Department of Healthcare Services, Mental-health Sector, Families of Participants,
Process Outcomes: Consistent legal support to help participants be able to fight for their rights
Process Inputs: Timely & effective planning, management, and execution by Voices team

On-going

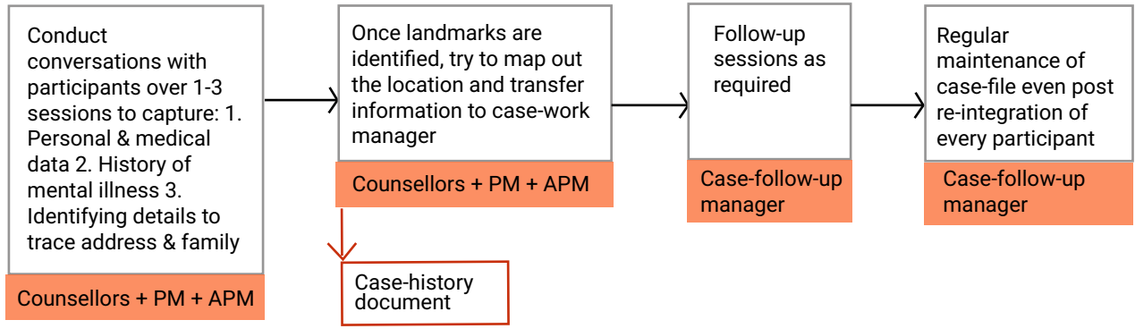


**Process holder: responsible for strategic decisions and overall outcome/impact of the process*
***Process supervisor is accountable for timely and effective implementation of the process*

Case-work documentation

**Process Holder: Deputy Director & Head of Program*
***Process Supervisor: Program Manager, Associate Program Manager & Case-follow-up manager*
Primary Stakeholders: Participants, Government Hospital staff
Secondary Stakeholders: Department of Healthcare Services, Mental-health Sector, Families of Participants,
Process Outcomes: Proper documentation of participant's history, journey & identification of own's family home
Process Inputs: Timely and effective planning, management, and execution by Voices team
Process Map:

On-going



Process map for Reintegration in Voices Program

**Process Holder: Program Manager, Head of Programs & Deputy Director*

***Process Supervisor: Case history Manager & Assistant Program Manager*

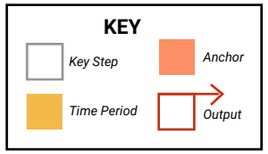
Primary Stakeholders: Participants, Anjali Staff, Families of Participants

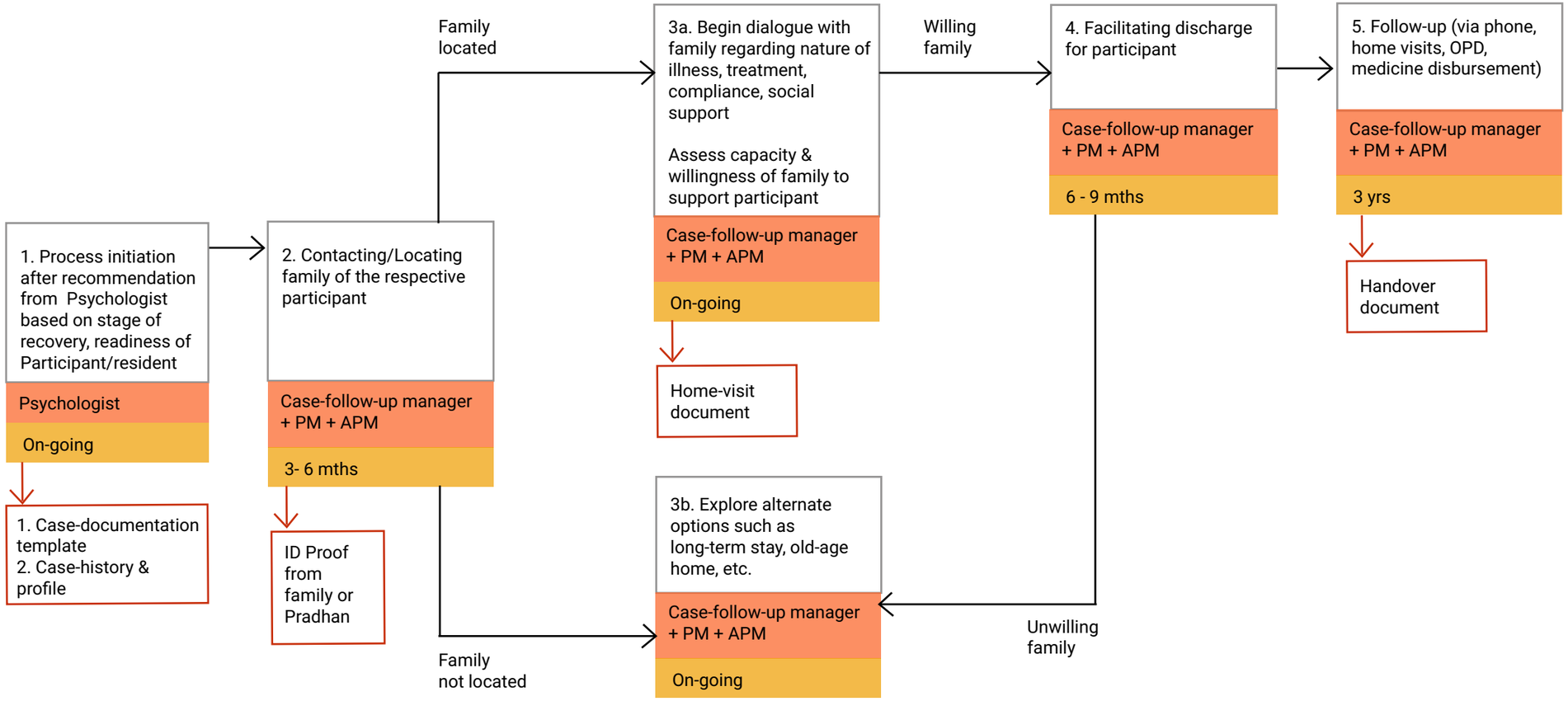
Secondary Stakeholders: Ministry of healthcare, Hospital Staff, Civil-society agencies

Process Outcomes: Successful social inclusion/rehabilitation of participants: development of personhood & the capacity to make choices and act on them by participants

Existing Inputs: Government relationship; timely and effective planning, management, and execution by Voices team

Process Map: (Sub process are mapped below)

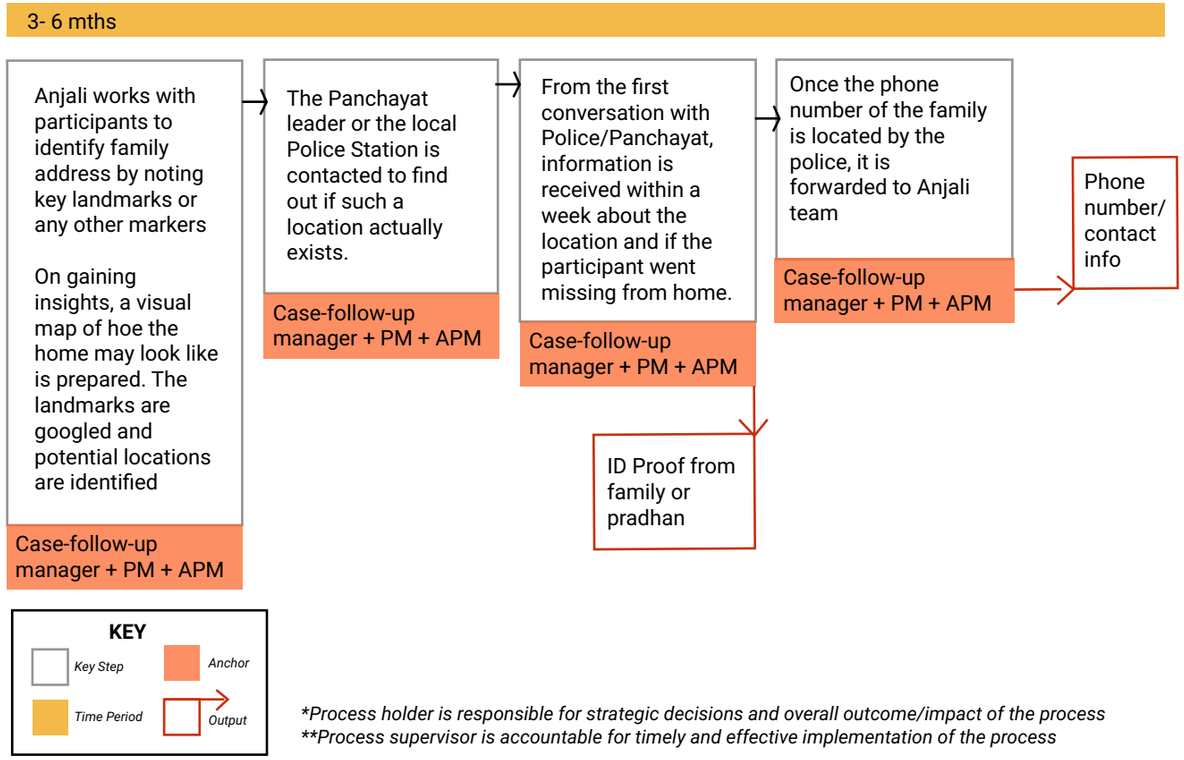




**Process holder is responsible for strategic decisions and overall outcome/impact of the process*
***Process supervisor is accountable for timely and effective implementation of the process*

2. Contacting/Locating family of the respective participant

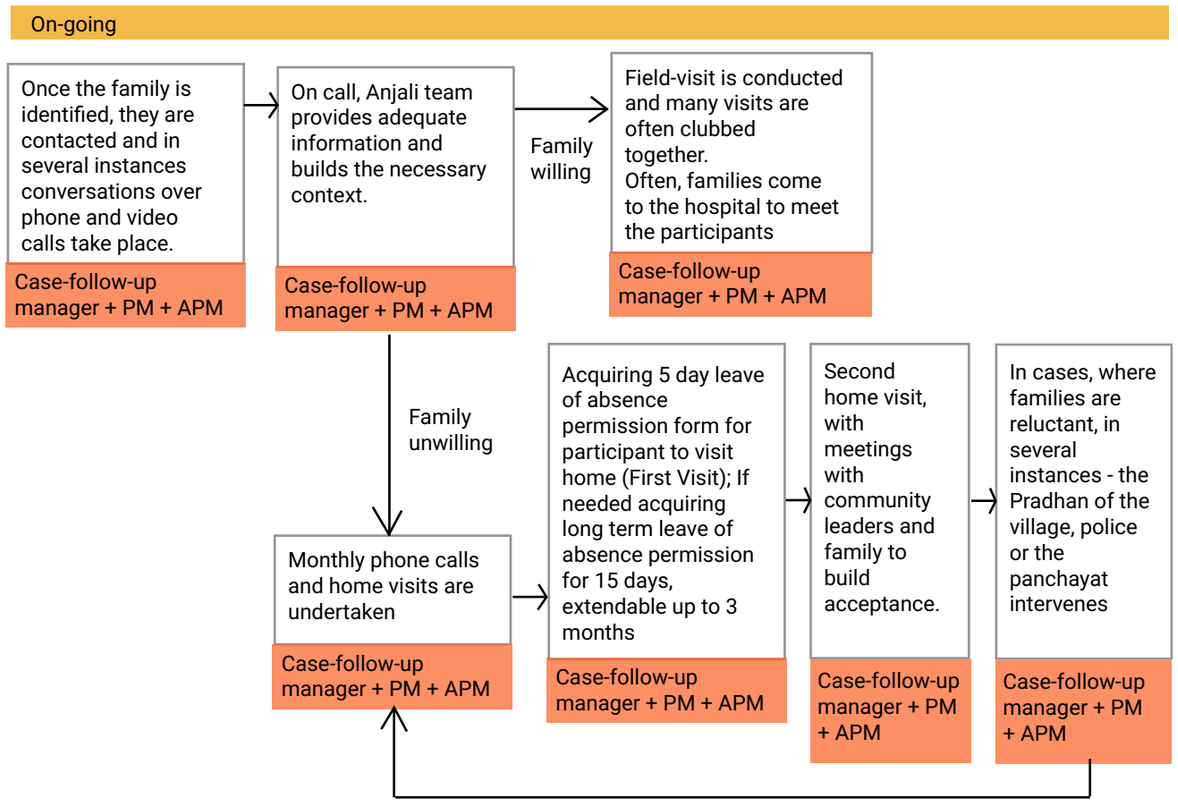
**Process Holder: Head of Programs*
***Process Supervisor: Program Manager, Associate Program Manager & Case-follow-up manager*
Primary Stakeholders: Participants, Government Hospital staff
Secondary Stakeholders: Department of Healthcare Services, Mental-health Sector, Families of Participants,
Process Outcomes: Successful identification of family home & contact information of participant
Process Inputs: Government relationship; timely and effective planning, management, and execution by Voices team
Process Map:



**Process holder is responsible for strategic decisions and overall outcome/impact of the process*
***Process supervisor is accountable for timely and effective implementation of the process*

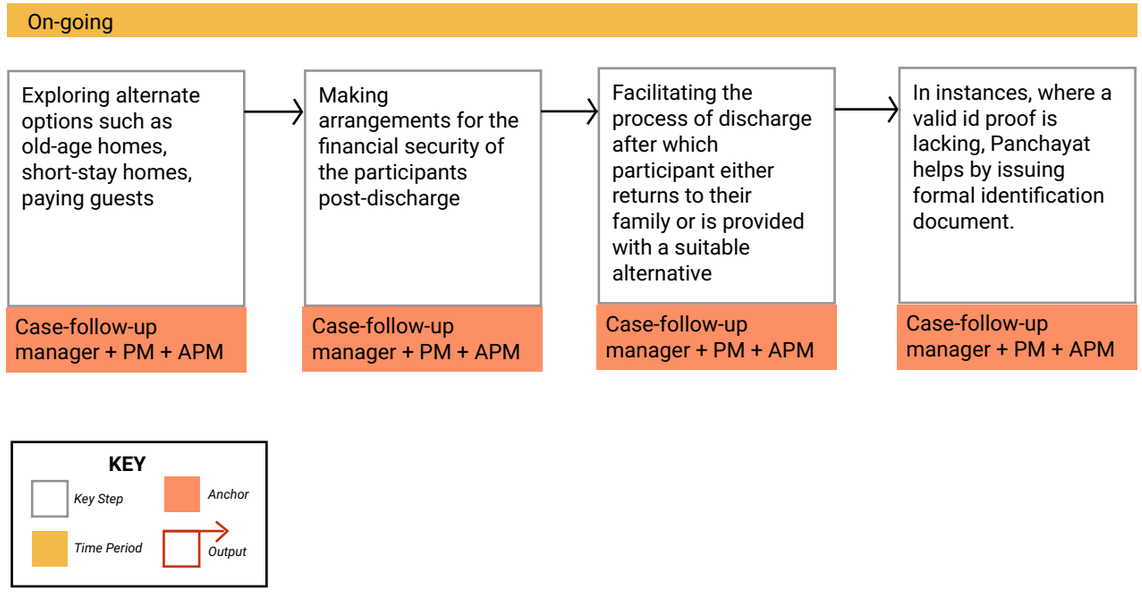
3a & 4. Begin dialogue with family regarding nature of illness, treatment, compliance, social support & facilitating discharge

**Process Holder: Head of Programs*
***Process Supervisor: Program Manager, Associate Program Manager & Case-follow-up manager*
Primary Stakeholders: Participants, Government Hospital staff
Secondary Stakeholders: Department of Healthcare Services, Mental-health Sector, Families of Participants,
Process Outcomes: Successful social inclusion/rehabilitation of participants: development of personhood & the capacity to make choices and act on them by participants
Process Inputs: Government relationship; timely and effective planning, management, and execution by Voices team
Process Map:



3b. Explore alternate options such as long-term stay, old-age home, etc.

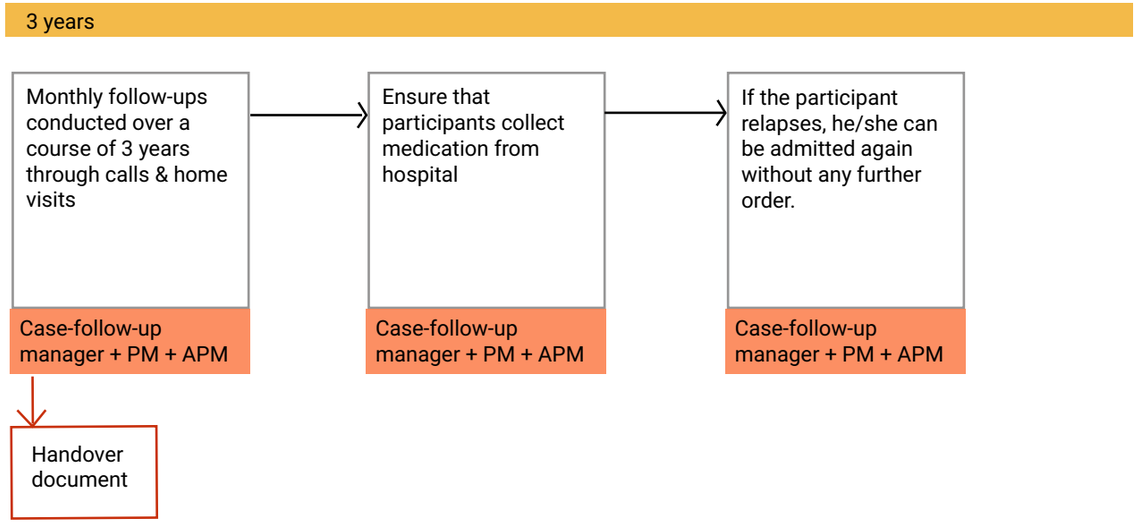
**Process Holder: Head of Programs*
***Process Supervisor: Program Manager, Associate Program Manager & Case-follow-up manager*
Primary Stakeholders: Participants, Government Hospital staff
Secondary Stakeholders: Department of Healthcare Services, Mental-health Sector, Families of Participants,
Process Outcomes: Successful social inclusion/rehabilitation of participants: development of personhood & the capacity to make choices and act on them by participants
Process Inputs: Government relationship; timely and effective planning, management, and execution by Voices team
Process Map:



**Process holder is responsible for strategic decisions and overall outcome/impact of the process*
***Process supervisor is accountable for timely and effective implementation of the process*

5. Follow-up (via phone, home visits, OPD, medicine disbursement)

**Process Holder: Head of Programs*
***Process Supervisor: Program Manager, Associate Program Manager & Case-follow-up manager*
Primary Stakeholders: Participants, Government Hospital staff
Secondary Stakeholders: Department of Healthcare Services, Mental-health Sector, Families of Participants,
Process Outcomes: Successful social inclusion/rehabilitation of participants: development of personhood & the capacity to make choices and act on them by participants
Process Inputs: Government relationship; timely and effective planning, management, and execution by Voices team
Process Map:



VOICES

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