Negotiated Care

Rights, Recovery, Partnership

Eight Years Inside Purulia
Mental Health Care Hospital
2017-2026

by

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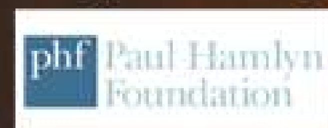


Foreword

Working Within Resistance

Partnership in a High-Control Institutional Setting

The Anjali–Purulia Mental Care Experience

Partnership within state-run mental health institutions is often framed as collaboration and alignment. Our experience in Purulia suggests otherwise. Partnership, in this context, is a continuous negotiation within unequal power structures, shaped by institutional hierarchies, cultures of control, and the pressures of accountability.

A gender lens is essential to this account. Anjali's work at IMC Purulia has engaged both men and women residents, and the experience of women within custodial psychiatric settings carries a distinct and layered character. For women living with mental health conditions and/or psychosocial disabilities, institutionalisation is rarely a singular experience of illness — it is frequently a form of gendered violence. Confinement, loss of bodily autonomy, separation from children and family, exposure to abuse within institutional walls, and the denial of reproductive and relational rights converge in ways that compound vulnerability. Women in such settings often arrive having already survived multiple and overlapping marginalisation — shaped by poverty, caste, domestic violence, and social abandonment. Understanding this is not peripheral to the work. It is central to it.

From the outset, friction was structural, not incidental.

The institutional environment reflected characteristics common to large public mental health facilities: overcrowding, limited resources, entrenched custodial practices, and rigid hierarchies of authority. Anjali's introduction of a rights-based, recovery-oriented approach—foregrounding dignity, consent, and accountability—disrupted these norms. Resistance followed.

Early in the engagement, sections of the medical staff and

Group D employees opposed the work. This resistance intensified after Anjali raised concerns around violence within the institution. Programme activities were temporarily halted, highlighting the operational risks of rights-based engagement in closed settings.

At another point, a serious breakdown occurred involving the then Superintendent and Anjali's project leadership, where professional boundaries were breached. This incident reflected deeper tensions around authority and external scrutiny. In parallel, Anjali used formal accountability mechanisms, including RTIs. These actions were part of a deliberate strategy to engage both within and beyond the institution, though they added to the strain in the relationship.

These moments were not aberrations. They revealed how power operates within institutional settings.

The continuation of the work required deliberate and adaptive strategies.
Anjali maintained its presence despite interruptions, treating continuity as a strategic choice. Engagement extended beyond formal leadership to multiple levels of the system, reducing dependence on any single authority. The organisation combined relational approaches—daily interaction, dialogue, and trust-building with formal mechanisms such as documentation, reporting, and escalation where necessary.

A critical element was the calibration of response. Not all moments required confrontation; not all could be deferred. The ability to assess when to push and when to sustain engagement became central. Documentation served not only reporting functions but also as a tool for protection, continuity, and escalation.

Over time, this approach enabled a form of negotiated coexistence. The work continued not because conflict was resolved, but because it was engaged with strategically.

Institutions are not monolithic. Even within resistance, there were individuals and spaces that allowed the work to move forward. Engagement at the state level, including with Swasthya Bhavan, created additional pathways to address barriers. Sustained presence contributed to familiarity, if not always acceptance.

This experience points to a central insight: in institutional settings, partnership is often extended as permission. The work lies in gradually shifting it towards accountability.

The Anjali–Purulia partnership did not move from conflict to alignment. It moved through phases of resistance, interruption, negotiation, and partial accommodation. The work continues within this tension.

Partnership, in this context, is not the absence of conflict. It is the capacity to remain engaged without relinquishing core principles in the face of it.

Ratnaboli Ray

Health
DAY
Institute for

A note on this document

This report documents eight years of work carried out by Anjali within the Institute for Mental Care (IMC), Purulia, with support from the Paul Hamlyn Foundation. It draws on structured observations, case records, facilitator notes, session documentation, family engagement records, and interviews conducted with residents, staff, and community members across the programme period.

The document is written primarily for practitioners, funders, and policymakers engaged with mental health systems reform in India. It aims to offer both an account of what changed and an honest reckoning with how — and where — change proved difficult.

The documentation also attends, with particular care, to the experiences of women residents — recognising that for women with mental health conditions and/or psychosocial disabilities, incarceration within a psychiatric institution is inseparable from broader structures of gendered harm. Their stories, their struggles, and their capacities for recovery are not footnotes to this report. They are constitutive of it.

A system in transition
then and now

In 2017, the Institute for Mental Care (IMC), Purulia reflected the enduring legacy of custodial psychiatry in India.

The institution functioned with routine efficiency. Systems were in place. Roles were clearly defined. Yet, the organising logic of care was not recovery — it was containment.

Daily life within the hospital was structured around control, predictability, and risk minimisation. Residents wore identical institutional uniforms, reinforcing anonymity and eroding personal identity. Basic activities such as eating were stripped of dignity — breakfast was served directly onto residents' palms, tea was poured into multipurpose mugs, and meals were consumed sitting on the floor. Food was transported in buckets, with little attention to hygiene or nutritional adequacy.

The wards were marked by prolonged inactivity. There were no televisions, no music systems, and no structured recreational opportunities. Residents rarely stepped outside their wards, even within the hospital campus. Life was defined by restriction — both spatial and social.

These conditions bore a particular weight for women residents. Within custodial settings, women's bodies and behaviour are often subject to heightened surveillance and control — not only as psychiatric patients but as women whose conduct is held to specific social and moral standards. Women in long-term institutional care may face additional violations: inadequate attention to menstrual health, absence of gynaecological care, lack of privacy for personal hygiene, and in some cases, exposure to sexual violence or exploitation within institutional spaces. The absence of agency described above was thus not a generic institutional experience for women — it was inseparable from their experience as women within a setting that treated their gender as invisible or, worse, as a problem to be managed.

A seclusion cell existed within the institution — both as a

physical structure and as a symbol of coercive control embedded within the system.

For women residents, the conditions within these institutions carried a specific and compounded weight. Custodial care for women is rarely gender-neutral: it is often shaped by patriarchal norms that define women's 'deviance' from prescribed social roles as evidence of mental illness. Many women in long-term institutional care had been admitted not only due to psychiatric distress but following domestic violence, abandonment by families, widowhood, or social non-conformity. Their institutionalisation was, in many cases, itself an act of confinement — a form of organised abandonment. The institution inherited and reproduced these conditions. Understanding the situation of women within IMC Purulia required attending to this layered reality.

Mechanisms for accountability and participation were weak. Institutional bodies such as the Rogi Kalyan Samiti (RKS) were largely inactive. Residents had no meaningful platforms to express concerns, participate in decisions, or exercise agency over their daily lives.

Long-term institutionalisation was not an exception — it was an accepted outcome.

Eight years later, the same institution presents a markedly different reality. Daily life now reflects a gradual but visible shift toward dignity and participation. Residents wear personal clothing. Meals are served on plates, eaten at tables, and monitored through structured dietary processes. Food is transported through more hygienic systems.

Wards are no longer spaces of silence. Residents interact, participate, and engage in shared activities. They step outside into open spaces within the campus, participate in sports such as badminton and volleyball, and engage in everyday social life.

The seclusion cell has been demolished — not only removing a physical structure, but signalling a broader institutional shift away from punitive practices.
Incidents of violence have reduced significantly, alongside a visible shift toward dialogic and relational approaches to care.

Residents now participate in civic life. They hold voter identity cards, possess Aadhaar documentation, and travel outside the institution to exercise their right to vote.

Most significantly, a growing number of residents have transitioned out of

long-term institutional care.

Across this transformation, Anjali's work has engaged women and men residents alike. A gender lens is essential to reading these changes. Women residents at IMC Purulia carried histories that were frequently shaped by multiple and overlapping marginalisation: gendered violence at home, abandonment by families, the removal of children, caste-based discrimination, and the erasure of identity that accompanies long-term confinement. For women with mental health conditions and/or psychosocial disabilities, institutionalisation is not a neutral experience—it is a continuation of the social violence that often preceded it. The shifts described in this document—in participation, voice, dignity, and reintegration—must be understood in this light.

Between 2017 and January 2026, 170 residents have been reintegrated into families and communities.

This transformation reflects not a singular reform, but a sustained process of systemic change—engaging institutional culture, administrative systems, individual recovery, and community ecosystems simultaneously.

Executive summary

Since 2017, Anjali has worked within IMC Purulia, with support from the Paul Hamlyn Foundation (PHF), to reimagine the role of state-run psychiatric institutions within a rights-based mental health framework.

The initiative was grounded in a central question:
Can long-term custodial institutions become spaces that actively support recovery, dignity, and reintegration into community life?

Over eight years, this work demonstrates that transformation is possible — but only when approached as a sustained, relational, and multi-level process.

Anjali's work has been guided by the principle of deinstitutionalisation — understood not simply as discharge, but as a process through which persons with psychosocial disabilities reclaim identity, agency, citizenship, and belonging.

Approach

The work unfolded across multiple, interconnected levels, recognising that change within the institution could not be achieved through a single point of intervention.

It engaged simultaneously with:

- **Institutional practices,** shifting everyday routines and systems toward dignity and participation
- **Individual recovery processes,** enabling psychosocial engagement, confidence, and agency
- **Rights and citizenship,** supporting access to identity, participation, and decision-making
- **Reintegration pathways,** working with individuals, families, and communities
- **Administrative and systemic interfaces,** building alignment with state systems and structures

Evidence of change

Over eight years, something shifted inside the institution.

- 209 residents engaged in structured recovery processes
- 2,717 structured sessions enabled expression, participation, and decision-making
- 170 people returned to families and communities
- 15 voluntary discharges asserted choice over confinement
- 102 home visits re-opened relationships beyond the hospital

Inside the wards, change became visible:

- Seclusion practices were eliminated
- Recreation, mobility, and everyday freedoms were introduced
- Violence and coercion reduced significantly

This is what institutional transformation looks like when recovery is taken seriously—not as containment, but as rebuilding voice, agency, and readiness.

Evidence of resistance

And yet, people did not leave at the pace they could have. 170 reintegrations out of 209 engaged is not just a number—it is a limit.

If recovery inside the institution were enough, more people would have left. They did not. Because the barriers are not clinical—they are social:

- Families feared return
- Communities carried stigma
- Women, in particular, faced layered rejection—of gender, of disability, of "respectability"
- Care continued to be seen as a private burden, not a shared responsibility

The institution changed. The outside world did not change enough.

Evidence of **system failure**

Some of the most basic acts required extraordinary effort.

- 34 people obtained voter IDs—and voted
- 35 people obtained Aadhaar

People had lived for years without identity.
Not metaphorically. Administratively.
Documentation was not a service.
It was the difference between existence and non-existence.
34 people voted—after years of being invisible to the state.

And then there is the question of resources:

- Food allocation increased from ₹20 to ₹78.20 per person per day

Dignity has a cost.
The system was choosing not to pay it.

This is not a story of "outcomes."
It is a record of what changed, what resisted change, and what failed.

The question is not how many people were reintegrated.

It is why so many, despite
being ready, still remain.

Key learning

One of the most critical learnings from this eight-year process is that **institutional transformation, while necessary, is not sufficient to enable sustainable reintegration**.

As the work within the institution began to show visible shifts — in participation, agency, and readiness among residents — it became increasingly clear that movement out of the institution was not determined by institutional readiness alone.

Many residents who were clinically stable and psychosocially prepared continued to remain within the institution. The barriers they faced were located not inside the hospital, but outside it.
These barriers were layered and often interconnected.
At the level of the family, reintegration was shaped by:

- **Fear** — particularly of violence, relapse, or unpredictable behaviour
- **Uncertainty** about how to support the individual in everyday life
- **Emotional distance** resulting from years of separation
- **Care burden**, especially in contexts of economic precarity

At the level of the community, stigma played a significant role:
- Individuals were often perceived as “permanently ill” or “dangerous”
- Families feared social exclusion if they accepted them back
- There was limited understanding of recovery as a process

At the level of local systems, there were additional gaps:
- Limited access to community-based mental health support
- Weak linkages between institutions and local governance structures
- Absence of follow-up mechanisms once a person left the institution

These factors meant that even when individuals were ready to leave, the conditions necessary for their return and continued recovery were often not in place.

This led to a critical shift in understanding:
Reintegration is not an event of discharge — it is a process that must be supported across contexts.

In response to this, Anjali initiated **Janamanas, our community mental health programme, in Purulia, in 2021.**

Janamanas was designed not as an extension of institutional work, but as a complementary ecosystem that addresses the external barriers to reintegration.

The programme works at multiple levels:

- **With communities**, to build awareness and challenge deeply held beliefs about mental illness and recovery
- **With families**, to address fear, rebuild relationships, and support preparedness for reintegration
- **With individuals** in the community, to enable early identification of distress and prevent long-term institutionalisation
- **With local systems**, to strengthen access to entitlements, services, and ongoing support

Importantly, Janamanas also provides **follow-up support to reintegrated individuals**, ensuring that the transition from institution to community is not abrupt, but supported and sustained over time.

Through this integrated approach, the work began to bridge a critical gap.

Institutional processes enabled individuals to move toward recovery and readiness.

Community processes enabled environments to become more receptive and supportive.

Together, they form a **continuum of care** — one that connects institutional transformation with community inclusion, and makes reintegration both possible and sustainable.

Context and entry point

Anjali's engagement with the Institute for Mental Care (IMC), Purulia began at a time when mental health institutions in India were increasingly being examined through a rights-based lens, particularly following the enactment of the Mental Healthcare Act, 2017. The Act articulated principles of dignity, autonomy, and community living, and created a policy environment that recognised the rights of persons with psychosocial disabilities.

However, the translation of these principles into practice within large, state-run institutions remained uneven.

This unevenness was particularly pronounced for women. The Mental Healthcare Act, 2017 articulates rights that are, on paper, equally applicable to all persons with psychosocial disabilities. In practice, however, the experience of women within institutional settings differs substantially. Gender-blind policies and gender-blind implementation mean that the specific circumstances of women — their histories of gendered violence, their familial and caregiving roles, their distinct vulnerabilities within closed settings — go unaddressed. Entering a system to work for change required Anjali to hold this gendered reality in view from the outset.

IMC Purulia reflected this gap between policy and practice. While administrative systems were functional and clinical care was being provided, the overall structure of the institution continued to be shaped by custodial logics. Daily routines prioritised order and risk management. Decision-making was largely top-down. Opportunities for participation were minimal. Long-term institutionalisation was common, and pathways to reintegration were limited.

Entering such a system required careful positioning.

Anjali did not enter with a pre-defined model to be implemented. Nor did it approach the institution as an external actor seeking to "correct" or "reform" it from the outside. Instead, the approach was to work from within the system, recognising both its constraints and its possibilities.

This meant that the initial phase of engagement focused less on visible outcomes and more on building the conditions necessary for change.

Building relationships **as the first intervention**

The first entry point was relational.

Anjali's team spent time within the wards, interacting with residents in informal ways, observing routines, and understanding the rhythms of institutional life. These interactions were not immediately structured as interventions. They were spaces to build familiarity and reduce distance.

At the same time, engagement with staff was approached with sensitivity. Rather than positioning staff as barriers to change, the effort was to understand their roles, pressures, and perspectives. This helped avoid resistance and created openings for collaboration over time.

Trust-building was slow, but essential. Without it, deeper shifts would not have been possible.

Identifying entry points **within the system**

Rather than attempting large-scale changes, Anjali identified small but strategic entry points within existing structures.
These included:

- Creating regular engagement spaces within wards
- Reactivating or meaningfully using existing platforms such as the Rogi Kalyan Samiti (RKS)
- Introducing conversations around everyday practices such as food, routines, and interaction

These entry points were deliberately chosen because they were:

- Non-threatening to existing hierarchies
- Closely connected to residents' lived experiences
- Capable of demonstrating visible change over time

Introducing **gradual shifts**

Change was introduced incrementally.
Instead of immediate structural overhaul, the approach focused on:

- Repetition and consistency in engagement
- Demonstrating small, tangible improvements
- Allowing staff and residents to experience change rather than being instructed about it

For example, early group sessions were not framed as 'rights-based interventions', but as spaces for interaction. Over time, these spaces evolved into platforms for expression, reflection, and eventually assertion.

Similarly, participation in institutional platforms such as RKS did not begin with direct advocacy. It began with encouraging presence, then participation, and eventually voice.

Cultivating **change over time**

The early phase of this work did not produce immediate or visible outcomes.

There were periods of hesitation, limited participation, and slow progress. At times, shifts seemed minimal. However, these processes were laying the groundwork for deeper transformation.Change within such a system could not be imposed. It had to be cultivated.

Over time, as trust developed, participation increased, and small shifts accumulated, the conditions for more visible transformation began to emerge. This approach — grounded in relationships, embedded within the system, and paced over time — shaped the trajectory of all subsequent interventions and outcomes.

Transforming **everyday life**

The first visible shifts within the institution did not emerge through large structural changes. They began within the texture of everyday life — in how time was spent, how people interacted, and what was possible within the wards.

When Anjali began working in IMC, daily life for residents was largely defined by routine and inactivity. There were long stretches of time with little to do, and limited opportunities for interaction beyond functional exchanges with staff. Engagement, where it existed, was often task-oriented rather than relational.

It is within this context that the **Voices programme** was introduced.

Rather than positioning it as a formal therapeutic intervention, Voices was designed as a set of **structured yet flexible engagement spaces** within the wards. These spaces brought together dialogue, creative expression, and group interaction in ways that were intentionally different from the existing institutional environment.

In practice, this meant creating regular sessions where residents could gather without the pressure of clinical evaluation or behavioural compliance. Activities ranged from conversations and storytelling to art, music, movement, and collective reflection. The form of the activity was less important than the nature of the space it created.

In the early stages, these spaces were met with hesitation.
Residents often attended sessions but did not participate actively. Some remained silent. Others observed from a distance. This was not resistance in a conventional sense, but a reflection of years spent in an environment where expression had neither been expected nor responded to.

Recognising this, the process did not push for immediate participation.

Facilitators focused instead on consistency and predictability. Sessions were held regularly, at the same time and place, allowing residents to become familiar with the space. Participation was not enforced. Residents could choose how and whether to engage — by speaking, by observing, or simply by being present.

This non-coercive approach was critical.
Over time, as residents returned to these spaces repeatedly, a sense of safety began to develop. The absence of judgement, correction, or instruction created a different kind of environment — one where expression became possible without fear of consequence.

Gradually, small shifts began to appear.
A resident who had only been observing began to respond to a question. Someone else joined an activity. Conversations, initially led by facilitators, began to include responses from residents. Laughter, disagreement, and shared moments of attention started to emerge.

These changes were incremental, but they altered the social fabric of the ward.
The Voices spaces enabled forms of engagement that had previously been absent:

- Residents could express thoughts and emotions without fear of reprimand
- Participation was voluntary, allowing individuals to engage at their own pace
- Interaction extended beyond clinical roles, creating more horizontal relationships between residents and facilitators

Over time, these spaces began to influence life beyond the sessions themselves.

Residents who engaged within these spaces started interacting more with others outside them. They began initiating conversations, responding to situations, and participating more actively in everyday routines.

The shift, therefore, was not confined to the programme.
It began to reshape how residents experienced themselves and their environment — from passive occupants of a system to participants within it.

This transformation of everyday life became the foundation upon which deeper changes — such as voice, agency, and reintegration — were built.

Process of change

The shifts that emerged within the Voices programme were not the result of a single intervention or a predefined model. They were built through a set of interlinked practices that unfolded gradually over time, each reinforcing the other.

A critical starting point was consistency.
Sessions were held regularly, often in the same physical spaces within the wards and at predictable times. In an environment where most interactions were functional and task-oriented, this regularity created a different kind of rhythm. Residents began to anticipate these sessions, even if they did not actively participate at first. The repetition of the space — returning to it again and again — allowed familiarity to develop. Over time, this familiarity became the basis for trust.

Trust did not emerge immediately. In the initial phases, residents often remained silent, disengaged, or observant. However, the fact that the space continued to exist without pressure or expectation signalled something important — that participation was not conditional.

This brings us to the second element of the process: voluntary participation.

Residents were not required to speak, perform, or engage in any prescribed way. They could choose to sit through sessions without responding, join an activity partially, or participate fully. This absence of coercion was critical in a setting where much of life was structured through compliance. Over time, the ability to choose — even in small ways — began to restore a sense of control.

As residents experienced this autonomy repeatedly, participation began to shift. What initially appeared as hesitation gradually transformed into engagement. Residents who had only observed began to contribute, first tentatively and then with increasing confidence.

Another central aspect of this process was the role of facilitators, particularly their emphasis on listening over directing.

Facilitators did not position themselves as instructors or authorities within these spaces. Instead, they focused on creating room for residents' voices to emerge. When residents spoke, their words were acknowledged, sometimes repeated, and often built upon in the group. This act of listening — sustained and visible — played a crucial role in validating residents' experiences.

For many, this may have been the first time in years that their thoughts were not only expressed but taken seriously.

Over time, this shifted the nature of interaction within the space. Conversations began to move away from facilitator-led exchanges toward more resident-driven engagement. Residents responded to each other, agreed, disagreed, and built on shared experiences.
Equally important was the fact that these spaces were non-clinical in nature.

They were not framed around diagnosis, symptoms, or treatment plans. This distinction reduced the sense of being evaluated or corrected. Residents were not engaging as "patients," but as individuals participating in a shared space.

This reduced resistance significantly. Participation no longer carried the weight of expectation or judgement. Instead, it became an opportunity for interaction, expression, and presence.
Over time, these elements — consistency, autonomy, listening, and non-clinical engagement — began to work together.

They created an environment where:

- trust could develop gradually
- participation could emerge organically
- voice could take shape without fear
- relationships could become more horizontal

The impact of this process extended beyond the sessions themselves.
As residents experienced these shifts repeatedly, they began to carry them into other aspects of institutional life — interacting more with others, expressing preferences, and responding to situations with greater confidence.

In this way, the process of change was not confined to a programme.
It became embedded in everyday life.

Impact

Over time, the shifts within the Voices spaces began to translate into visible changes in how residents engaged with themselves, with others, and with the institutional environment.

One of the earliest changes was in the way residents began to **express their needs and preferences**.

In the initial stages, many residents did not articulate what they wanted or needed. Decisions about food, routines, and daily activities were largely external to them. As engagement deepened, residents began to voice specific concerns — about the quality and quantity of food, access to clothing, cleanliness of spaces, and how they were spoken to by staff. These were not abstract expressions, but grounded in everyday experience. The act of naming these needs marked an important shift from passive acceptance to active articulation.

Alongside this, there was a noticeable change in the nature of **participation**.

Participation within the institution had earlier been largely compliance-driven — residents followed routines because they were expected to. Through repeated exposure to non-coercive spaces, participation began to take on a different meaning. Residents started choosing to attend sessions, engage in activities, and remain present in shared spaces. This shift from compliance to voluntary engagement indicates the emergence of autonomy, even within a constrained environment.

Changes were also visible in the quality of **interaction**.

Earlier, interactions were limited and often functional — centred around instructions, responses, or conflict. As residents engaged in group spaces, new forms of interaction began to emerge. They responded to each other's statements, shared experiences, and at times supported one another. Conversations extended beyond immediate needs to include

opinions, disagreements, and moments of collective reflection. This indicated not just increased communication, but the development of social connection.

Perhaps most significantly, residents began to **take initiative in everyday life.**

This included small but meaningful actions — organising seating arrangements, ensuring fair distribution of food, switching lights and fans, supporting others during activities, or reminding staff of agreed processes. These actions were not assigned as responsibilities, but were taken up by residents themselves.

Such instances reflect a deeper shift in how residents related to their environment. They were no longer only responding to the system; they were beginning to act within it.

Taken together, these changes indicate the emergence of **agency**.

Agency here is not understood as complete independence, but as the ability to:

- recognise one's needs
- express them
- make choices, however small
- participate in shaping one's immediate environment

In the context of a long-term custodial institution, these are significant markers of transformation.

They signal a movement away from passivity and toward participation — a shift that underpins all subsequent processes of recovery and reintegration.

Aditya
from waiting to participating

When Aditya first began engaging with Anjali's sessions inside the institution, his interaction with the world was marked by repetition and waiting.

He would say only one thing, over and over again:
"*Ami kokhon bari jabo?*" — When will I go home?

This question was not simply about discharge. It reflected a state of suspension — where his sense of self and future was entirely located outside the present. His engagement with the institution, and with others within it, remained minimal. He did not participate in activities, nor did he respond to prompts in any sustained way. Like many others, he occupied the space, but was not actively part of it.

In the initial phases of the Voices sessions, Aditya would be present but largely disengaged. He listened, observed, and occasionally repeated his question. There was little indication of participation in the conventional sense.

However, the consistency of the sessions, combined with the absence of pressure to respond, created conditions where engagement could emerge gradually.

Over time, small shifts began to appear.
Aditya started staying through entire sessions. He began responding to simple prompts, sometimes non-verbally, sometimes with short verbal responses. His attention, which had earlier been fixed on the idea of leaving, began to extend to what was happening around him.

This shift became more visible during a picnic organised as part of the programme.

In this setting — outside the routine of the ward, and within a shared, less structured environment — Aditya began to take initiative in ways that had not been seen before.

He closely observed the process of food distribution. When he noticed that some residents were not being served properly, he intervened, saying:

“Please give proper food to everyone.”
He did not stop at observation. He took on an active role — ensuring that food reached everyone, monitoring distribution, and guiding others in the process.

Alongside this, he began to take responsibility for small but important aspects of the environment. He arranged seating, switched lights and fans on and off as needed, and supported the flow of the activity.

These actions were not assigned to him.
They emerged from his own initiative.

Aditya’s shift is significant not because it reflects a dramatic transformation, but because it captures a fundamental change in orientation.
He moved from:

- waiting for something to happen to him
- to acting within the present moment

From:

- repeating a single question about leaving
- to engaging with the needs of others around him

From:

- being present in the space
- to participating in shaping it

His journey illustrates how sustained, non-coercive engagement can gradually reorient an individual’s relationship with their environment — enabling movement from passivity to participation, and from isolation to relational awareness.

Voice, agency
and collective identity

The emergence of voice within the institution marked a critical turning point in the overall process of transformation. While earlier shifts in participation and engagement altered how residents interacted within everyday spaces, the ability to articulate concerns within formal institutional platforms fundamentally changed how residents positioned themselves in relation to the system.

One of the key sites where this shift became visible was the **Rogi Kalyan Samiti (RKS)** — a formal body intended to enable participation and accountability within the institution.

Process: From Individual Voice to Collective Voice
In the initial stages, residents' presence within RKS [Rogi Kalyan Samiti/ Patient welfare committee] meetings did not translate into participation.

They attended, but did not speak.

This silence was not incidental. It reflected years of being located within a system where decision-making was external, and where speaking up had neither been expected nor responded to meaningfully. The structure of the meeting existed, but the practice of participation had not taken root.

Recognising this, the early phase of engagement required **active facilitation**.

Anjali's role in these meetings was not to speak on behalf of residents, but to create conditions where speaking became possible.
This involved:

- Encouraging residents to articulate concerns, even in fragmented or tentative ways
- Repeating or clarifying what was said, so that it entered the formal discussion
- Ensuring that these concerns were acknowledged within the meeting space

This stage was critical because it established a link between **expression and recognition**.

For many residents, this may have been the first time that something they said within an institutional setting was not dismissed, ignored, or redirected.

The first moments **of speech**

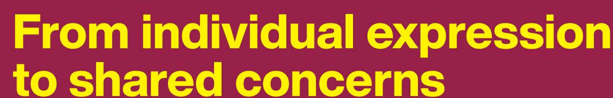
The shift did not occur collectively at once.
It began with isolated instances.

In one of the early meetings, a resident spoke — hesitantly, and with uncertainty. The statement was brief, and not fully formed. What followed, however, was significant.

Instead of being overlooked, the concern was repeated, acknowledged, and responded to within the meeting.

This moment altered the dynamics of the space.

Another resident spoke in a subsequent meeting. Then another. These were not coordinated acts. They were individual responses to a changing environment — one where speaking was becoming possible.



From individual expression to shared concerns

As more residents began to speak, a pattern started to emerge. Concerns that were initially expressed as individual issues began to repeat across residents. Questions around food, daily routines, treatment by staff, and access to basic needs surfaced multiple times.

Through this repetition, something shifted.

Individual experiences began to be recognised as shared conditions.

Residents were no longer speaking only for themselves. They were articulating issues that affected many.

At this point, voice began to take on a collective dimension.

Hearing themselves being heard

A pivotal moment in this process was not simply when residents spoke, but when they began to hear themselves being heard. This distinction is important.

It refers to the experience of:

- speaking within a formal space
- having that speech acknowledged and taken up
- recognising that one's words have weight within the system

This moment had a transformative effect.

It shifted residents' understanding of their own position within the institution. They were no longer only recipients of decisions — they were participants within a process where their perspectives could shape outcomes.

From participation to assertion

Over time, the need for facilitation reduced.

Residents began:

- raising concerns without prompting
- responding to each other's statements
- insisting on issues being addressed

This shift became particularly visible in discussions around food and daily living conditions, where residents collectively questioned responses and pushed for accountability.

What began as encouraged participation evolved into **assertion**.

Formation of collective identity

Through this process, residents began to see themselves not only as individuals within the institution, but as part of a group with shared experiences and concerns.

This collective identity was not formally constructed.

It emerged through:

- repeated articulation of shared issues
- recognition of common conditions
- participation in shared spaces of discussion

Voice, therefore, did not remain an individual capacity.
It became a **collective resource**.

Link to agency

The emergence of voice was closely tied to the development of agency. As residents began to:

- articulate needs
- question existing practices
- participate in decision-making spaces

they also began to exercise greater control over aspects of their everyday lives.

Agency, in this context, was not absolute autonomy, but the ability to:

- express one's position
- influence immediate conditions
- participate in shaping one's environment

This shift — from silence to voice, from individual expression to collective articulation — represents one of the most significant transformations within the institution.

It reconfigured not only how residents engaged with the system, but how the system responded to them.

What residents **began articulating**

As residents began to find their voice within both informal spaces like the Voices sessions and formal platforms such as the RKS meetings, the content of what they expressed became increasingly layered and specific.

In the initial stages, articulation was often fragmented. Residents spoke in short phrases, sometimes repeating concerns, sometimes expressing discomfort without fully naming it. Over time, as confidence grew and the experience of being heard became more consistent, these expressions became clearer, more detailed, and more assertive.

What residents began articulating can be understood across multiple, overlapping dimensions — each rooted in lived experience within the institution.

Articulation of basic needs

One of the earliest and most consistent areas of articulation related to everyday living conditions.

Residents began speaking about:

- the quality, quantity, and timing of food
- the manner in which food was served
- access to clean clothing and personal belongings
- hygiene within the wards

These concerns were grounded in daily experience and often repeated across individuals. What is significant here is not only the content, but the shift in stance. Practices that had long been normalised — such as eating in undignified conditions or receiving inadequate portions — began to be questioned. Residents moved from adapting to these conditions to identifying them as issues that could be addressed.

Articulation of relational needs

As spaces for interaction expanded, residents also began to express concerns about how they were treated within the institution. This included:

- the tone and manner of communication from staff
- the ability to interact with others within and across wards
- restrictions on movement within the campus

These articulations reflect a shift from focusing only on material conditions to engaging with the **quality of relationships**.

Residents began expressing a desire not just for care, but for **respectful engagement**. They questioned dismissive behaviour, responded to how they were addressed, and expressed preferences around interaction. This marks an important movement toward recognising oneself as a person in relation to others, rather than as an object of care.

Articulation of basic needs

As trust deepened, residents began expressing needs that were less visible but equally significant. These included:

- the need to be heard and taken seriously
- feelings of isolation or neglect
- the desire for meaningful engagement and activity
- the importance of dignity in everyday interactions

These articulations did not always emerge in structured language. They were often expressed through narratives, fragments of conversation, or repeated concerns.

What is significant is that residents began to move beyond describing external conditions to expressing **internal experiences**.

This reflects a deepening of engagement — where individuals are not only responding to their environment, but reflecting on their own emotional and psychological states.

Articulation of rights-based needs

Over time, as discussions around rights and citizenship were introduced and experienced in practice, residents began to articulate needs that extended beyond the institution. These included:

- participation in decision-making spaces such as the RKS
- access to identity documentation, including Aadhaar and voter ID
- the right to vote and engage as citizens
- the desire to return to family and community life

This shift is particularly significant because it reflects a movement from needs to rights. Residents were no longer only asking for improvements within the institution. They were asserting their position within broader social and civic structures.

From fragmented expression to structured voice

Across these dimensions, a clear progression can be observed. Residents moved from:

- fragmented, individual expressions
- to clearer articulation of specific concerns
- to recognition of shared issues
- to collective assertion within institutional spaces

This process transformed articulation into voice.

Why this matters

In a long-term custodial setting, where routines are normalised and agency is limited, the ability to articulate needs — especially in ways that influence systems — is a significant shift. It reflects:

- increased awareness of one's conditions
- the confidence to question them
- the expectation that they can be changed

These articulations, across basic, relational, emotional, and rights-based dimensions, form the foundation upon which agency, participation, and reintegration become possible.

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Diet meetings
from complaint to collective assertion

Food was one of the first and most immediate sites where residents began to articulate their concerns.

In the early stages, these concerns emerged in fragments — comments about insufficient portions, dissatisfaction with quality, or discomfort with how food was served. Individually, these expressions were often dismissed as routine complaints, folded back into the everyday functioning of the institution.

The diet meetings became a space where these fragmented concerns began to take form.

Initially, residents attended these meetings but spoke hesitantly, if at all. When concerns were raised, they were often met with procedural responses or deflection. The contractor or staff would explain constraints, justify existing systems, or move the discussion forward without substantive engagement.

In earlier conditions, this would have marked the end of the interaction.

But something had begun to shift.

Residents did not withdraw.

When their concerns were not acknowledged, they raised them again.

When responses were vague, they asked follow-up questions.
When explanations did not match their lived experience, they challenged them.

The tone of these interactions began to change.

What started as individual complaints slowly became shared concerns. One resident's statement would be echoed by another. Others would add detail, clarify issues, or reinforce what had been said. The conversation no longer moved in a single direction — from authority to recipient — but became a space of exchange.

Importantly, residents began to hold the discussion in place.
They did not allow it to be redirected or closed prematurely.
They insisted on staying with the issue.
This persistence marked a critical shift.

Voice was no longer tentative or facilitated — it had begun to assert itself.
Over time, the nature of participation in these meetings transformed. Residents were not only raising issues, but collectively negotiating them. They questioned inconsistencies, compared experiences across wards, and sought accountability in ways that had not been possible earlier.

The diet meeting, in this sense, became more than a discussion on food.
It became a site where:

- everyday experience translated into articulated concern
- individual expression became collective voice
- participation moved toward assertion

This shift did not emerge through confrontation alone, but through repetition, recognition, and the gradual confidence that their voices would not be ignored.
Food, as an entry point, grounded this process in lived reality.
But the implications extended far beyond it.

In holding their ground around something as fundamental as food, residents were also redefining their position within the institution — not as passive recipients of care, but as participants capable of questioning, negotiating, and shaping the conditions of their everyday lives.

Peer leadership **and redistribution of power**

The emergence of peer leadership within the institution became most visible during the COVID-19 pandemic — a period that disrupted not only routine functioning, but also the continuity of the processes that had been built over time.
Until this point, the Voices programme had relied on regular, in-person engagement by Anjali's team. These sessions had become a consistent feature of life within the wards, creating spaces for interaction, expression, and participation.

With the onset of COVID-19 and the subsequent restrictions on external entry into institutions, this continuity was abruptly interrupted.

Facilitators were no longer able to enter the wards.
This disruption created a moment of uncertainty.

There was a real risk that the spaces which had enabled participation, voice, and interaction would collapse in the absence of external facilitation. Given the history of institutional life — where activity often depended on external inputs — it would not have been unexpected for engagement to cease.

However, what unfolded during this period was markedly different.

Residents began to take initiative in sustaining these spaces themselves.

In the absence of facilitators, they started gathering in groups, recreating the structure of earlier sessions in ways that were accessible to them. Activities continued — not in the same format, but in spirit. Conversations were held, exercises were conducted, and time was organised collectively.

This was not a formally assigned responsibility.
There was no directive for residents to continue the programme.

The continuation of these spaces emerged from within the group. Residents who had earlier been participants began to assume facilitative roles. They encouraged others to join, helped organise activities, and supported those who were less engaged. In doing so, they were not only maintaining continuity, but also reshaping the nature of the space.

Care began to circulate horizontally.

From participation to leadership

This shift marks an important transition.

Earlier, participation had meant engaging within a space created by others. During this period, residents moved beyond participation to **holding the space themselves**.

They were:

- organising sessions
- guiding group activities
- supporting peers in moments of distress or disengagement
- ensuring that interaction continued despite constraints

This reflects the emergence of leadership — not as a formal role, but as a function of responsibility and initiative.

Gouri
holding continuity in a moment of disruption

One of the clearest instances of this shift can be seen in Gouri's role during the lockdown.

Gouri began organising and leading yoga sessions for other residents.

These sessions provided more than physical activity. They created a structure within a disrupted environment — a space where residents could gather, engage, and experience continuity.

For Gouri, this role marked a shift in how she positioned herself within the institution. She was no longer only participating in activities, but creating them for others.

Gouri's story is significant beyond its immediate context. Women in custodial psychiatric settings are rarely accorded leadership. Their agency is frequently understood as symptom rather than strength — interpreted through a clinical lens that pathologises assertion and independence. The gendered script of custodial care expects women to be compliant, quiet, and managed. Gouri's emergence as a leader — organising, instructing, sustaining community — is a direct challenge to that script. It demonstrates that when women with mental health conditions and/or psychosocial disabilities are given space, consistency, and trust, their capacity for leadership, care, and collective responsibility emerges powerfully. This is not an exception. It is what becomes possible when institutional structures stop treating women's personhood as a problem.

For the group, her leadership created a sense of stability at a time when familiar structures had broken down.

Redistribution of power

This moment is significant not only because activities continued, but because it altered where control and responsibility were located.

Prior to this, spaces of engagement were largely facilitated by external actors. During the pandemic, residents demonstrated that these spaces could be sustained from within.

This represents a **redistribution of power**.

- Authority over the space became less centralised
- Responsibility became shared
- Care shifted from being delivered to being collectively generated

This shift also challenges a core assumption within custodial systems — that individuals within such institutions are dependent on external actors for structure and engagement.

Instead, it demonstrates that, given the opportunity and experience, residents are capable of:

- organising collective activity
- supporting one another
- sustaining processes over time

Beyond the moment

While the conditions of the pandemic were temporary, the implications of this shift are long-term.

The experience of holding spaces collectively contributes to:

- increased confidence
- strengthened peer relationships
- a deeper sense of ownership over shared environments

It also reinforces earlier processes — voice, participation, and agency — by extending them into practice.

This phase illustrates that transformation is not only about introducing new practices, but about enabling those practices to be sustained, adapted, and owned by the community itself.

In this sense, peer leadership is not an additional outcome.

It is a critical indicator that the process of change has begun to internalise.

Rights and citizenship

As residents began to engage more actively within the institution — expressing needs, participating in discussions, and taking initiative — another shift began to take shape: the reconfiguration of identity.

For long periods, many residents had been positioned primarily as "patients" within a closed system. Their interactions with the outside world were limited, and their identities were often reduced to diagnosis and institutional status.

The work within the institution gradually began to expand this frame.

Through ongoing engagement, discussions, and practical processes, residents were introduced to the idea that they were not only recipients of care, but individuals with rights — extending beyond the institution into the broader social and civic domain.

This shift did not happen through **abstract instruction** alone. It was grounded in practice.

A key part of this process involved enabling residents to access identity documentation, such as Aadhaar cards and voter identity cards. For many, this was the first time they were formally recognised within state systems as individuals with a civic identity.

Obtaining these documents was not a simple administrative step. It required:

- navigating bureaucratic processes
- establishing identity in the absence of documentation
- coordinating with institutional and external systems

The process itself became a site of engagement — where residents began to understand what it means to be recognised as a citizen.

For women residents, this process of civic recognition carried a distinct significance. Many women in long-term psychiatric institutions have been socially and legally invisible for years — without identity documents, without property rights, and without any formal acknowledgement of their existence as rights-bearing persons. The absence of documentation is not neutral: it renders women entirely dependent on the institution for their existence within the state's systems, and makes departure from the institution practically impossible. Obtaining an Aadhaar card or a voter ID is, for a woman who has spent a decade

inside, a reclamation of personhood. It is an assertion that she exists, that she has rights, and that she belongs to a world beyond the ward. This is not merely administrative — it is the beginning of being legible to the world as a person, not a patient.

From documentation to participation

The significance of documentation became most visible during elections. Residents who had spent years — sometimes decades — within institutional spaces were now stepping outside to participate in voting.

This act, while routine for many, marked a significant transition.
It represented movement:

- from institutional confinement to public participation
- from being managed within a system to engaging with it
- from invisibility to recognition

Voting became not just a procedural activity, but a moment of claiming presence within the public sphere.

Voting and the assertion of autonomy

During one such voting process, a resident was asked whom he had voted for. He responded: “This is confidential. I cannot share it.” At one level, this is a simple statement. However, within the context of long-term institutionalisation, it reflects a profound shift.

This response indicates:

- an understanding of the principle of secret ballot
- awareness of one’s right to privacy
- the confidence to assert that right

Importantly, it also reflects a change in relational dynamics. The resident did not feel compelled to respond. He recognised that he had the authority to withhold information. This marks a movement away from compliance toward autonomy.

Reframing identity

Through these processes, residents began to reimagine themselves in relation to the world beyond the institution.
They were no longer only:

- individuals receiving care
- occupants of a ward
- subjects of institutional routines

They were also:

- citizens with rights
- participants in public processes
- individuals with identities recognised beyond the institution

Why This matters

In custodial settings, where autonomy is often limited and decision-making is externalised, the restoration of civic identity is a significant shift.

It signals:

- recognition by systems beyond the institution
- access to rights that extend into community life
- the possibility of belonging within a broader social framework

This shift also plays a critical role in reintegration.

The ability to access documentation, exercise rights, and engage with systems creates pathways for individuals to move beyond institutional boundaries — not only physically, but socially and politically.

The movement from “patient” to “citizen” is not a singular event.
It is a process — built through recognition, participation, and assertion.
In this process, rights are not only granted.
They are understood, experienced, and exercised.

Strengthening **reintegration pathways**

A central strand of the Voices programme has been the effort to enable movement out of long-term institutional care and into community life.

This was not approached as a single moment of discharge, but as a process that had to be built over time — across psychological, social, and administrative dimensions.

Within the institution, this meant working with what it takes for a person to be able to leave.

This included:

- building confidence and familiarity with life beyond the institution
- engaging with uncertainty, hesitation, andambivalence around return
- facilitating access to identity documentation and formal recognition
- tracing and reconnecting with families
- coordinating with institutional systems to enable discharge

These processes were often slow and non-linear.

Readiness did not emerge uniformly.
For some, it required sustained engagement over long periods.

For others, it involved navigating complex emotional terrain — including fear of return, loss of connection, or uncertainty about belonging.

At the same time, discharge itself required working through institutional systems — aligning clinical assessments, administrative procedures, and logistical arrangements.

Where reintegration became possible, transitional support played a critical role.

This included accompanying individuals through the process of

return, supporting early adjustment within family and community settings, and maintaining contact in the period immediately following discharge.

Through these efforts, shifts became visible.

Residents who had spent years within the institution began to express a desire to leave, engage with the idea of life beyond the hospital, and demonstrate increasing confidence in navigating everyday situations.

At an institutional level, reintegration also began to take shape as a more visible pathway.

However, as these processes unfolded, a significant limitation became increasingly clear.

Individuals who were prepared to leave were not always able to do so.

And those who did leave were not always able to sustain their return.

This pointed to a gap that could not be addressed within the institution alone.

After the hospital gate
living reintegration

The movement out of the institution marks a transition — but not a resolution.

If discharge enables exit, what follows is the work of living.
It is here, beyond the hospital gate, that reintegration is tested.

For many individuals, returning home is also a return to relationships shaped by time, distance, and uncertainty.

These relationships do not resume where they left off.
They have to be renegotiated.

Family members may carry fear — of relapse, of unpredictability, of the responsibilities that lie ahead. Individuals returning may encounter distance, overprotection, or conditional acceptance.

Living together again becomes a process, not an immediate restoration.

Reintegration also unfolds within the ordinary.

Sharing space, participating in daily routines, making decisions, navigating social interactions — these form the fabric of everyday life outside the institution.

For individuals who have spent years within structured environments, these shifts can be unfamiliar.

For families, enabling autonomy while ensuring care creates its own tensions.

Beyond the household, the community becomes another site of negotiation. Here, stigma often operates in subtle but persistent ways.

Individuals may be included physically, but remain socially distant — spoken about rather than spoken to, present but not fully participating.

For women, this partial inclusion takes a particularly severe form. Social belonging for women is often contingent on adherence to roles — as wife, mother, daughter-in-law — that institutional life has interrupted or foreclosed. Women who return without a husband, without children in their care, or whose families have reorganised around their absence may find that there is, quite literally, no recognised place for them. Community belonging, for women with psychiatric histories, may require not simply the reduction of stigma but the active creation of new relational possibilities — something that existing community structures rarely provide without deliberate intervention. Reintegration for women is thus not only a question of whether communities will accept them, but whether communities have any framework at all within which to receive and include women whose lives have deviated, through no fault of their own, from expected social trajectories.

Opportunities for engagement — social, economic, and relational — remain limited.

In this context, reintegration does not automatically translate into belonging.

Sustaining life outside the institution is also closely tied to livelihood.

Work provides not only income, but structure, identity, and social presence.

Yet access to livelihood remains uneven — shaped by disrupted pathways, limited opportunities, and hesitation from employers and communities.

Without this, independence remains fragile.
At the same time, continuity of care becomes uncertain.

Within the institution, support is structured and available.

Outside it, access to services, medication, and follow-up depends on systems that are often fragmented or inconsistent.
Families are left to navigate these systems with limited support.
Care becomes episodic — present in moments of crisis, but not sustained in everyday life.

Taken together, these conditions create a state of ongoing negotiation.

Reintegration is not a stable outcome.

It is an evolving process — marked by progress, setbacks, adaptation, and uncertainty.

This leads to a critical shift in understanding:
Reintegration cannot be sustained by individual readiness alone.
It depends on whether the environments to which individuals return are able — and willing — to receive them.

Challenges in **sustaining reintegration**

The experiences that followed discharge revealed a set of recurring challenges.

These were not isolated barriers, but interconnected conditions shaping the possibility of sustained reintegration.

At the level of the family, reintegration was shaped by:

- fear of violence, relapse, or unpredictability
- emotional distance following prolonged separation
- uncertainty about how to provide care and support
- the burden of caregiving within conditions of economic strain

At the level of the community:
For women, these challenges were compounded by gender-specific dynamics. Families were often more reluctant to receive women back than men — particularly if the woman had been widowed, separated, or had children in her absence. The stigma of psychiatric history attached differently and more severely to women, foreclosing marriage prospects and narrowing social acceptability in ways that had no equivalent for men. Women returning from institutional care frequently faced a double bind: their mental health history marked them as unfit for domestic roles, while the absence of alternative economic or social pathways left them with few options outside the household. Women with mental health conditions and/or psychosocial disabilities thus faced not only the barriers that all reintegrating residents encountered, but additional, gendered layers of exclusion that required deliberate and specific engagement.

- stigma and labelling continued to influence perception
- individuals were often seen as permanently unwell or risky
- families feared social exclusion
- understanding of recovery remained limited

At the level of systems:

- access to community-based mental health care was limited
- follow-up mechanisms after discharge were weak or absent
- linkages between institutions and local governance structures were fragmented
- administrative barriers affected access to entitlements and services

At the level of the individual:

- confidence in navigating unstructured environments was often fragile
- decision-making in everyday contexts required adjustment
- social and livelihood pathways had been interrupted

These challenges pointed to a structural gap.
While institutional processes enabled movement toward recovery and readiness, there was no corresponding ecosystem to support life beyond the institution.

In this absence, the responsibility of reintegration was often absorbed by individuals and families — without adequate support.

Extending the process
community ecosystems

It is within this gap — between leaving the institution and being included in the community — that the Janamanas programme was initiated.

Not as an extension of institutional work, but as a necessary response to what lies beyond it. If institutional processes enabled individuals to move toward recovery, community processes needed to create conditions where that recovery could be sustained.

Janamanas works across multiple levels:

- with communities, to build understanding and challenge deeply held beliefs about mental illness
- with families, to address fear, rebuild relationships, and support preparedness
- with individuals, to enable early identification of distress and prevent long-term institutionalisation
- with local systems, to strengthen access to entitlements, services, and ongoing support

It also ensures continuity of engagement with reintegrated individuals, so that the transition from institution to community is not abrupt, but supported over time.

Through this, the work begins to bridge a critical divide.
Institutional transformation alone cannot enable reintegration.
Community readiness alone cannot sustain it.

It is the connection between the two that makes movement possible.

Reintegration, in this sense, is not a point of exit — it is a process of building conditions for belonging.

Koruna
from rejection to relational acceptance

Koruna's reintegration was not a straightforward transition from institution to home. It was a prolonged process shaped by resistance, doubt, and gradual shifts in perception — both within the family and the wider community.

When initial attempts were made to reconnect Koruna with his family, the response was not welcoming. His uncle, who was one of the primary points of contact, expressed deep scepticism:
"Do people with mental illness ever get better?"

This question reflected more than a lack of information — it reflected a deeply internalised belief that recovery was either temporary or impossible. Underlying this were multiple fears: that Koruna might become violent, that he would not be able to sustain himself, and that his return would bring stigma upon the household.

Early visits were marked by hesitation. Conversations were guarded. There was no outright refusal, but there was no acceptance either.

At this stage, the process required sustained engagement rather than persuasion.

Anjali's approach focused on:

- Repeated visits to the family to build familiarity and trust
- Open conversations around recovery, framed through Koruna's current functioning rather than diagnosis
- Addressing fears directly — particularly around violence and unpredictability
- Creating opportunities for the family to see Koruna in a different light

Parallel to this, engagement extended to the community. Informal conversations were held with neighbours and local stakeholders, not as formal awareness sessions, but as relational interactions that slowly challenged assumptions about mental illness.

Over time, these engagements began to shift perception.

The family's stance moved from rejection to cautious openness. This shift was not marked by a single turning point, but by a gradual reduction in fear and an increasing willingness to consider reintegration.

Koruna's own readiness played a crucial role. His ability to engage in conversation, respond calmly, and demonstrate consistency in behaviour became an important form of evidence for the family.

Eventually, reintegration became possible.

However, the process did not end with his return. Follow-up engagement remained critical in ensuring continuity — supporting both Koruna and his family in navigating everyday challenges and reinforcing confidence in the decision.

Today, Koruna lives within his community, and the same environment that once questioned his recovery now interacts with him as part of everyday social life.

His journey reflects that reintegration is not only about returning home — it is about transforming the conditions that make return possible.

Crisis, Abandonment **and continuity**

The COVID-19 pandemic exposed the fragility of the systems that had been built.

Within the institution, sessions were disrupted. Residents expressed a deep fear of abandonment.

This fear was not simply emotional. It was rooted in lived experience.

For many residents, institutionalisation had already involved separation from families and loss of relationships. The presence of facilitators and structured engagement had created new forms of connection.

When these were suddenly withdrawn, residents feared:

- Being left without support
- Losing meaningful relationships
- Returning to isolation

This was not dependency in a simplistic sense. It reflected the importance of consistent relational engagement in sustaining recovery.

Krishna
sustaining recovery through crisis

Krishna’s story highlights a different dimension of reintegration — not just the transition out of the institution, but the ability to sustain life in the community in the face of disruption.

Following his reintegration, Krishna began rebuilding his life through a small hardware shop. This was not merely an economic activity, but a critical component of his recovery — providing structure, purpose, and a sense of independence.

The process of establishing this livelihood was gradual. It involved:

- Identifying a viable activity that aligned with his skills and context
- Providing initial support to set up the shop
- Ongoing engagement to ensure continuity and confidence

For a period, this stability held.
However, the COVID-19 pandemic disrupted this trajectory.

With lockdowns in place, Krishna's shop could not function. Income stopped abruptly. The fragile economic base he had built began to collapse.

At this point, the risk was not only financial. Loss of livelihood also meant loss of routine, purpose, and social interaction — all of which are critical to sustaining recovery.

The possibility of regression was real.
Anjali's engagement during this period focused on immediate and stabilising support:

- Providing financial assistance to meet basic needs
- Ensuring access to essentials such as food and medicines
- Maintaining regular communication to reduce isolation

This support was not designed as long-term dependency, but as a bridge through crisis.

As restrictions eased, Krishna gradually resumed his work. The continuity of support during disruption played a critical role in enabling this return.

Reflecting on this period, Krishna shared:
"If Anjali had not supported me, it would have been very difficult."

His experience highlights that reintegration is not a one-time event. It is an ongoing process that requires support systems capable of responding to disruption.

Sustaining recovery, particularly in contexts of economic vulnerability, depends as much on continuity of support as on initial reintegration.

Transformation across levels

Over eight years, change occurred across multiple levels.

At the level of the individual, there was a visible increase in confidence, expression, and agency.

At the institutional level, practices shifted from custodial to participatory, with greater openness to engagement and reform.

At the community level, awareness increased, and stigma began to reduce.

At the systems level, the work demonstrated a model for deinstitutionalisation that is both grounded and replicable.

Jaya
from passive presence to purposeful engagement

Jaya's journey reflects the transformation that occurs within the institution, and how it translates into a sense of purpose and ownership.

When Anjali began working in IMC, Jaya's life, like many others, was largely confined to the ward. Her days were structured by routine, with little opportunity for engagement or decision-making. Participation in activities was minimal, and interaction was limited.

Her initial engagement with the Voices programme was tentative. She attended sessions, but participation was cautious. Like many residents, she was still navigating what it meant to be in a space where expression was possible.

Over time, through consistent exposure to group activities and interactions, her participation deepened.

She began:

- Engaging more actively in discussions
- Responding to prompts and sharing thoughts
- Interacting with peers more comfortably

The shift was gradual, but visible.

As her confidence grew, she began taking on small responsibilities within activities. These were not assigned as formal roles, but emerged organically through participation.

This laid the foundation for a more structured form of engagement — her involvement in a vegetable-growing initiative within the institution.

This initiative created a space where residents could engage in productive activity linked to everyday life.

Jaya's role within this process evolved over time. She began:

- Participating in planting and maintenance
- Understanding cycles of growth and harvesting
- Assisting in managing produce

Eventually, her role expanded to include:

- Tracking production
- Participating in decisions around use and distribution
- Engaging in basic record-keeping

This shift from participation to responsibility reflects a deeper transformation.

Jaya was no longer only engaging in activities.

She was managing processes.
This created:

- A sense of ownership
- A sense of contribution
- A sense of purpose

Her journey reflects how structured, sustained engagement within the institution can move individuals from passive presence to active participation, and eventually to meaningful responsibility.

Closing insight

Over eight years, Anjali's work at IMCP has shown that transforming mental health systems requires more than reforming institutions—it requires restoring voice, rebuilding relationships, and reimagining communities as spaces of care, dignity, and belonging.

Central to this transformation — and inseparable from it — is the recognition that women living with mental health conditions and/or psychosocial disabilities face a specific, compounded, and gendered experience of exclusion. Their incarceration in psychiatric institutions is not only a mental health matter: it is an expression of violence — the violence of abandonment, of social and legal erasure, of institutional confinement, and of the denial of dignity, autonomy, and care. Transforming mental health systems must therefore be a feminist project as much as a psychiatric one. It must name the gendered dimensions of institutionalisation, centre the voices and realities of women, and build systems capable of responding to multiple and intersecting forms of marginalisation. The work at IMC Purulia, with women and men alike, points toward what this can look like — imperfectly, in progress, but with clarity of direction.

And yet, the journey is not complete

Silence lingers in some corners, people are still waiting —waiting to be heard, to be supported, to find their way forward.

Reintegration remains complex; stigma continues to shape community responses; systems, at times, still fall back into older patterns of control and containment.

The work of transforming mental health care is non-linear; it does not move at a constant speed. It requires continuous negotiation, reflection, and renewal. For which constant endeavour is required and we thank PHF for constant support.

And so, the journey continues.

That things have changed is real and significant.

Today, there is movement where there was once stagnation.
There is voice where there was once silence.
There are choices where there were once none.

Most importantly, there is **hope**.

Hope that more people will take this journey on their own terms.
Hope that more families, communities will be ready to include them.
Hope that systems will continue to evolve toward dignity, rights, and inclusion.

This journey is far from over. Our work is far from over!

Strategic approaches

- Treat access as conditional, not guaranteed.
- Institutional partnership often begins as permission. Plan for continuous negotiation.
- Anticipate resistance as part of the process.
- Introducing accountability, especially around violence, will trigger pushback. Build for it.
- Diversify points of engagement. Do not rely on a single authority figure. Work across levels within the institution.
- Combine relational work with formal accountability.
- Dialogue alone is insufficient; escalation alone is unsustainable. Use both.
- Use documentation as a strategic tool.
- Maintain records to anchor discussions, ensure continuity, and enable escalation when required.
- Calibrate response, don't default to reaction.
- Assess when to confront and when to sustain engagement. Timing is part of strategy.
- Plan for leadership volatility.
- Changes in institutional leadership can disrupt access and direction. Build resilience into the approach.
- Prioritise continuity of presence.
- Sustained engagement builds legitimacy. Withdrawal often resets power back to the institution.

Derived from field experience within a state-run mental health institution.

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