REBUILDING LIVES
A MENTAL HEALTH INITIATIVE IN RURAL JHARKHAND

DECEMBER 2022
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Community-Based Rehabilitation

Community-Based Rehabilitation (CBR) is an approach to enhance the quality of lives of persons with disabilities (PWDs) within their community. Within the goal of Health for all, it is important to ensure the inclusion and participation of people with disabilities and their families.

The aim of our CBR programme is to promote and protect the rights of people with mental health problems, supporting access of care, recovery, facilitating their participation and inclusion in their families and communities.
1. Story of Community-Based Rehabilitation of a person with severe mental illness

Nisha’ Story (Name Changed)
Age: 21 years
Block: Khuntpani, District: West Singhbhum, Jharkhand

Nisha had been suffering from severe mental illness for four years. She used to talk to herself and was not emotionally stable. People accused her of “practicing witchcraft (Dayin\Dahani)” and excluded her from attending village festivals and family rituals. She was unable to do her routine household chores.

After knowing about her condition Suresh Purty, our village-based peer facilitator (Sukhu-Dukhu-sathi-सुखु-दुखू साथी) brought her to the Tele-psychiatric clinic at Ichinda in Chakradharpur block (Address https://goo.gl/maps/Yst6EskQPPb7hnq28 ) that is being run collaboratively by Ekjut and Central Institute of Psychiatry, Ranchi. She was diagnosed and started on regular treatment with free medicines. She was regularly visited by Suresh at home for counselling and was invited to the Sukhu-Dukhu meeting (Monthly support group meeting-सुखु-दुखू बैठकी) facilitated by the Sukhu-Dukhu Sathi. With this comprehensive care, she slowly began to recover from the illness.

The Social Contact programme being held in her village, where people with mental illness share their lived-in experiences with their community; is reducing stigma and making it easy for people like Nisha to recover in a discrimination-free environment.
2. Context

The programme areas are rural, largely inhabited by the ‘Ho’ (हो) Adivasi communities, and covers a population of 100,000 (approx.) in West Singhbhum, an aspirational district of Jharkhand. A third of the 67.3% of tribal population of West Singhbhum (population 1502338, Census 2011), lives below the state-specific poverty line. Ho is the predominant tribe community who are not monolithic and has its self customary governance system. They have a communitarian way of life and are close to nature.

Subsistence agriculture which is primarily rain-fed, and some dependence on forest produce are the main sources of livelihood, but these are being increasingly supplemented by wage labour, with intra-district and inter-state migration. All other socio-economic and health indicators are poor in the district. Some of the predictors of maternal distress are early marriages, lack of dietary diversity and adequacy, high mortality and morbidity among children, unmet need for family planning, and domestic and gender-based violence¹, and it is not uncommon to find that vulnerable

¹ https://doi.org/10.1016/j.jad.2012.01.029
people from the community are falsely being accused of practicing witchcraft. Fewer and unequal access to services, discrimination and stigma further affects the mental health of the community.

3. The Problem

One in every eight people (970 million) around the world were living with mental disorders in 2019 (WHO) and 13.7% of India’s population and nearly 150 million Indians are in need of care and support, of which 80% of them lack access (National Mental Health Survey, 2016). Mental illness is a predictor of suicide and premature deaths. Mental illness and poverty are closely linked, leading to the intergenerational transmission of poverty.

In Jharkhand, an estimated 11.1% (National Mental Health Survey, 2016) of the population is living with mental illness, and persons with mental illness are often subjected to discrimination, stigma, and abuse of their social, cultural, political, and economic rights as well as restricted participation, social ostracization, and witch-branding.
4. Our Intervention

The initiative includes

1. Collaborative Tele-psychiatry + treatment
2. Door-step counselling
3. Support group meetings for service users and care givers
4. Participatory meetings for community awareness on mental health
5. Social contact program (Stories from persons with lived-in experiences)

The intervention is delivered by Ekjut’s multi-disciplinary team with the core objective of supporting treatment, rehabilitation and social support with the participation of family members and community to enable persons with mental illness to help them engage in a process of recovery.

Activities:

<table>
<thead>
<tr>
<th>Sr. no.</th>
<th>Activities</th>
<th>Frequency</th>
<th>Objective</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Collaborative Tele-Psychiatry</td>
<td>Monthly</td>
<td>To provide quality care and treatment through expert psychiatrists</td>
<td>The collaborative tele-psychiatry center at the Ekjut office in Chakradharpur with support from the Central Institute of Psychiatry, Ranchi, a premier psychiatry institute of India to provide tele-medicine support for diagnosis and treatment. Till now a total number of 190 consultations of service users with severe mental illnesses (schizophrenia, epilepsy, bipolar</td>
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</table>
Peer facilitators (Sukhu-Dukhu Sathis from the tribal areas) provide counselling and support to service users with severe mental illnesses, weekly/monthly regular visits as per protocol. 1235 visits conducted by peer facilitators in far-flung villages. Electronic medical record system is being developed in discussion with the ANT, an organization working in mental health in Assam (MITA app).

|   | Doorstep Counselling services | Regular ongoing support | To help them in process of recovery.  
➢ Support to reduce distress  
➢ Facilitate for rehabilitation |
|---|---|---|---|
| 2 | Support Group Meetings | Monthly | Support group meetings with service users and caregivers for  
➢ sharing, peer learning, problem-solving,  
➢ treatment adherence,  
➢ reducing participation restrictions |
| 3 | Community participatory meetings for mental health awareness. | Monthly | To detect persons with mental illness  
➢ To reduce stigma and discrimination  
➢ To promote positive mental health. |
<p>| 4 | Community-based rehabilitation | As per the requirements of the service | To support rehabilitation of service users for |
| 5 | Support Group Meetings | Monthly | Support group meetings are formed at nine villages of four blocks of the district. In total 75 meetings have been conducted. |</p>
<table>
<thead>
<tr>
<th></th>
<th>Blocks</th>
<th>Villages</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Khuntpani</td>
<td>Porlong, Dopa i, Baihatu, Kum larota</td>
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<tr>
<td></td>
<td>Chakradharpur</td>
<td>Ulidih, Banjikum, Toira</td>
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<td></td>
<td>Sonua</td>
<td>Nishchintpur</td>
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<td></td>
<td>Chaibasa</td>
<td>Sankosai</td>
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<tr>
<td></td>
<td>Community-based rehabilitation</td>
<td>To develop nutrient gardens, vegetable seeds and fencing material have been provided.</td>
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<tr>
<td>#</td>
<td>Programme</td>
<td>Frequency</td>
</tr>
<tr>
<td>---</td>
<td>-----------</td>
<td>-----------</td>
</tr>
<tr>
<td>6</td>
<td>Social Contact Programme</td>
<td>Six monthly</td>
</tr>
</tbody>
</table>
| 7 | Review Meeting with Peer Facilitators (Sukhu-Dukhu Sathis) | Monthly | ➢ To get the ongoing updates and progress,  
➢ provide capacity building support with online sessions by psychiatrist  
➢ to design strategies for recovery | Eight such meetings have been conducted with facilitators (Sukhu-Dukhu Sathis) and Counsellors to understand the progress, learning experiences, and challenges during the process of implementation |
The Community Mental health Team consists of mental health peer facilitators (Suku Duku Sathi), field counsellors, a program associate, an in-house doctor, and a consultant tele-psychiatrist.

People who directly benefited: Service users and their family members (950)

People who indirectly benefited: Participants attending participatory meetings – 1155 (On an average 15 participants per meeting)

Medicine Cost per service user- Rs. 45/- on an average per month per patient

The adherence rate to treatment (Minimum six months completed) – 87%.

5. Social Contact programme

Social contact is a direct, personal contact between members of the general public and members of a stigmatized group and is one of the most promising strategies for reducing stigma and discrimination. This is to create a space and opportunities for people with lived-in experiences to share their experiences.

a) Central Institute of Psychiatry, Indian Psychiatry Society Jharkhand branch and Ekjut jointly organized a live webinar where academicians, psychiatrists, civil society organisations, community members, caregivers and persons with mental illness discussed and shared their understanding of mental health.

Singhbui (name changed), a brave young service user shared her experience of how she was discriminated and locked in her home and with support and care now she is recovering and reenrolled in college to study science. Sukhu-duku sathis Bahalin and Shantibala spoke about their work with youths from villages and how they were
reaching out to persons with mental illness. In this live session, more than 300 people participated.

b) With the reopening of restrictions following COVID-19 Lockdown, the Social Contact programme was conducted in 31 July 2022 in Baihatu village. Service user and caregiver shared their stories of recovery and urged people not to discriminate against them and also appealed to people to not hide mental illness in the family and seek help and care from Nainika and Sikandar, the mental health facilitators from the same village. More than 250 community members participated, and the village head and PRI member addressed the meeting recognizing destigmatized mental illness in the village.

6. Persons wandering on the streets who were reunited with their families

Weak, wobbly and disoriented, Aduri (name changed) was found wandering on Chainpur - Ulidih road. During the next five days of her stay in Chakradharpur, Jharkhand, she was looked after well, was provided shelter, food and company by Pratima, Sumitra, Lakshmi and Kooily (our colleagues and neighbours), guided by Ekjut's Mental health team. During her stay, an attempt was made to understand fragments of the words she was muttering to try to associate them with places and people who might have been linked to her in some way. Since she was speaking in Bengali, we assumed that she was from West Bengal or someplace near it. She was confused about her home address, so it took many rounds of conversation in her own language to shortlist the possible location for her home which we
assumed was in Purulia district of West Bengal. We were even then not completely sure about her name. We arranged for a vehicle and set off for the district, which is a 6-hour’s car-ride away. After reaching the village, we started inquiring at places that fit her various descriptions of home, and after a few minutes of inquiry found a fitting match which was in a different Tola (Hamlet). The villagers also sent a child in the car with us to guide the way. On reaching the house, we inquired about Aduri and the woman who opened the door told us that she herself was Aduri. On further inquiry we found out that she was Aduri's sister-in-law and it was, in fact, her home.

Her sister in law said that she had a dream that she was alive and would be brought back soon! It was an overwhelming moment for both the family members and the team.

Gondo Sumbrui (Name Changed)

Age- 17 years

Block - Chakradharpur, District - West Singhbhum

Gondo was brought for some Desi (traditional healers) treatment to his uncle’s place at Chainpur Panchayat after the condition of his mental illness deteriorated following irregular treatment at medical clinics. This desi treatment included visits to a “shaman” who was believed to have the power to ward off evil spirits, sacrifice chickens and could propitiate God through his chants and rituals).

One morning, he wandered off and was seen roaming about at a colleague’s compound. He was rescued, and his uncle’s family was counselled about the need for a visit to our telepsychiatry clinic for diagnosis and treatment and regular provision of free medicines. He has now shifted back to his parent’s place at Asantalia village. Ekjut’s counsellor, Shantibala makes sure that he keeps his
regular appointment with the clinic. As he begins to feel better, he has started attending Suku Duku meetings with his father near his village, in Asantalia Panchayat. He has begun to accompany his father in agricultural activities.

The 2017 Mental Health Care Act reminds us about the rights of persons with mental health issues and the responsibilities of duty bearers. Every person with mental illness shall have a right to live with dignity and the right to community living; Right to protection from cruel, inhuman and degrading treatment and to be protected from all forms of physical, verbal, emotional and sexual abuse as the responsibility of duty bearers. There is a need of SOPs for a respectful and dignified support for persons with mental health issues who end up wandering with dementia or other severe mental health conditions in the streets.

As an organisation that is mandated to provide treatment and care for Persons with Psychosocial disabilities, we are bound by these provisions.

Besides Aduri and Gondo, there were others who were reunited with their families by the Ekjut mental health team in West Singhbhum district, the neighbouring districts Saraikela and Kharswan, and the states West Bengal and Odisha.

7. Tracking Recovery

The recovery model argues against just treating or managing symptoms but focuses on building the resilience of people with mental illness and supporting those in emotional distress. ² With this understanding we piloted an adaptation of the CHIME model of recovery for its suitability in our work.

² Ballesteros-Urpi A, Slade M, Manley D, et al
Piloting CHIME model

We tried to pilot the suitability of the CHIME framework keeping in mind the context, visual literacy, and language with few consenting service users including Sukumati (Name Changed) to the Ekjut office in Ichinda village, Chakradharpur, and obtained consent for about an hour’s session to co-learn about their recovery process and plotted the recovery in a cobweb diagram adapting the CHIME framework. We wanted to see the journey can be plotted as a visual representation of their recovery.

SUKMATI’S STORY (name change)

After hearing that a young woman named Sukhmati (name changed) with mental illness was kept locked in her house. Ekjut’s Sukku dukku saathi Savitri persuaded her family members to allow her to meet with her in her home. This was in January of 2019. Sukhmati was kept in a corner of the house in a place where the household cattle like goats and chicken are kept. Her mother said that they had done this to protect her from others and said it was needed to be done because of her unruly behaviour and that they had tried all kinds of remedies including visits to the shamans (Ojhas) but in vain. Her mother asked Dr Sachin and Sumitra to take her away when they visited them the second time to persuade the family for regular treatment and follow-up through our medical team. Sukhmati kept her face hidden in a saree and sat in a corner of the room where she was kept. She was started with regular treatment, home visits by Savitri who accompanied her to the monthly support group meetings. She was like a pal, even accompanying her to the nearby river for a dip in the water as she gradually began to feel better. It was ironic that in absence of proper

Conceptual framework for personal recovery in mental health among children and adolescents: a systematic review and narrative synthesis protocol

advice and care, Sukhmati had to face isolation and confinement for such a long time in her own home, which she herself had helped build.

Brief summary below the cobweb.

(S- connectedness, H-hope, I-identity, M-meaning in life, E-empowerment). Font size

Savitri (Peer Facilitator) invited Sukhmati to join us in a circle with a chart paper placed in the middle on which Savitri drew five straight lines extending outwards from the middle in all directions like spokes in a wheel, representing:

C: connectedness (जुड़ाव)
H: Hope (आशा)
I: Identity (पहचान)
M: Meaning in Life (जीवन का अर्थ)
E: Empowerment (सशक्तिकरण)
The five Hindi words were the result of discussion and deliberation earlier with the Suku duku saathis and service users. The meanings of which were now explained to Sukhmati. Using movement of tamarind seeds from the centre outwards on each line, she was able to reflect and show how far her journey of recovery had been against each of the above parameters.

The following sequence, as agreed with the team, was followed:

पहचान (identity)

जुड़ाव (Connectedness)

जीवन का अर्थ (Meaning in Life)

आशा (Hope)

Sashaktikaran (Empowerment)

**Sukhmati's Recovery**

We tried to co-learn about Sukhmati’s recovery by using the CHIME framework.

**Identity:**

Q: How did you come today to the clinic?

A: I came with Savitri Didi (who is counsellor and resides in Sukhmati’s village) to take my medicines as my medicines are about to deplete

Q: How does she address you?

A: She too calls me didi (sister)

Q: And what about others in your Village?

A: People address me as Didi (sister) and masi (Aunty) or they recognise me by my name. I am happy that people address me that way. Earlier people used to call me Paagli (meaning mad). (odiya)

She moved the tamarind seed along the line to show the progress she had made. *The point she chose was marked by Savitri.*
Connectedness: Earlier when I was not well I used to mix with people occasionally, but now sometimes I go to marriage functions, chatihari/narta (naming ceremony), mela (fair), Saraswati puja (a ritual followed by Hindus) and to watch mage porab (a festival celebrated by Ho Tribal community in Kolhan region of Jharkhand) and the weekly haat (weekly market). However, I do not like much to actively participate in these events very often.

Earlier I used to be fearful, shy and angry with people and would prefer to sit at home, however now I like to talk to people. I also like to come to the Ekjut clinic as I like to talk to people here.

*The point she chose along the line was marked by Savitri.*

This exercise (conversation and plotting) was continued till all the parameters were covered and the outer lines were now joined as a record of her recovery as per the CHIME framework as on 18/08/2022.

At the end, we asked Sukhmati where she would like place herself in the journey of recovery from very less/less/more/even more/complete, to which she smiled and replied, "I think that I have recovered completely" (Hindi)

We documented in detail about our experiences and challenges in conducting this exercise as we decided to go ahead with our review and reflection on the 31th of August with ten other service users.

8. Adaptation of the CHIME model in Ekjut’s evaluation work

On 31st August, ten service users who had made significant improvement were purposively selected by our Sukhu-Dukhu saathis who invited them for the next phase of rolling out of the CHIME model. Idea was to see how it is working before we invite the rest of our service users. The purpose of this exercise was to assist our service users to reflect if and how they're gradually gaining control of their lives, rather than
inquiring about the "return to the elusive state of premorbid level of functioning”, but to use the reflection process in the spirit of co-learning.

Snippets from the workshop on 31st Aug.

IDENTITY

My name is Sukurumi (Name changed) and I live with my mother. I have only one name and people call me Sukurumi in the village. "She does Majduri (casual labourer) identified like this and relatives by my relations."

When my condition wasn't good, I didn't even recognise myself and the people of my village also said I was going mad. As I got better I started talking to my sisters and other people also started talking to me properly. They call me “sandhya’s mother” or “chandu dai” at my own home and my in-laws call me by my village’s name.

"Savitri is becoming mad-mad type, looks like she will not recover. She’ll always remain like this.” She recalls how people talked about her. Now I’m better with daily medicine and now people address me as “kaki(Aunt)”, “mami”(Aunt), “marang mai”(big Sister).

Pahle nam se pukare the, jaise gaaw ma hetoom, daai (didi/sister) aur sarita mai bolek bule the. Jab manasik tnah hone lagto apne ap se baat karte aur heste the. Gaaw vaste aur padoosi log pagalo aur "daain" bulate the. Jab ekijute ki tarfa se jalaj chaal hua to kaafi shiree mein suyhar hua. Gaaw vaste aur padoos vaste bh approx baat karte the.
Before my illness they used to call me “hatum dai” and “sarita mai”. When my illness worsened I started talking to myself and laughing without reason, the villagers and my neighbours started calling me “pagali” or “dayin” (witch/accused of practicing sorcery). Ever since I came in contact with Ekjut, I’m feeling better and now the villagers and my neighbours talk to me (well).

Earlier I was labelled a “vagabond” but now they call me “chacha”, “mama” or by their relation to me.

Earlier I used to forget everything so they called me scatterbrained (bhulakkad). Now that I am better with regular medicine, they don’t say it anymore.

**CONNECTEDNESS**

ReConnected with my garden, connect with the family. Now I am cooking for everyone(family), started wage labour, rejoining with friends again, participating in festivities as well as ‘jagen’ (burial rituals in his community (HO people)) and visiting the homes of sambandhis (relatives), caring for my domestic cattle, giving them water and fodder.

When I was unwell, I was not even in communication with my neighbours. I am under treatment from last 6 months, attending support group meetings and have been visited (by sukhuduku sathi). As my condition improved, I started visiting my uncle’s home, participated in jagen, (burial rituals in his community (HO people), bajar and market and working in the agriculture fields).
When I was unwell, I avoided my relatives and neighbours. Nowadays I am conversing with everybody. When I am walking on the street, people greet me even from a distance (where are you going?). When I am working in the field, I too greet people walking on the streets.

Earlier I never used to go anywhere. I had wandered off and was missing for a few days. Now I’m cured and joining in the festivities. I also visit my relatives and also talk to my friends in the village.

**MEANING IN LIFE**

I will take care of my health and would like to help my neighbours with their work.

Once I get to recover, I will stay with my family together and I will provide education to my children when they grow up

For me meaning in life is Everyone in my village stays well. I hope that others in the village don’t suffer the same pain I went through

I like the early morning dip in the cold water of (sanjay) river flowing by my home. Having a conversation with people who are friendly.

**HOPE**

I hope a few things can change. I want others to think about my pain.
Earlier I was unable to think anything, used to forget quickly. Now I am hopeful (as I’m feeling better) that I will be able to perform all the processes for paddy cultivation during this monsoon. I will work hard so that the yield will be better and will last longer.

I’m hopeful I’ll also be able to work in the garden but since my family members tell me not to work so much, I lose heart and think I’ll not be able to do much.

I will ask my parents to buy me a sewing machine and become a tailor in my village. That will earn me some money and I will buy clothes for myself too.

I hope that my children study well. I have a daughter, if she studies well then, she can get a job as an aanganwadi worker.

Now I’m thinking that of starting a big garden from which I’ll sell vegetables in the market. I will use the money for my household and keep some for myself.

I work in the field, remove weeds. I hope that when the weeds are gone, the yield will be good.

EMPOWERMENT

कुछ काम अपने से करते हैं जैसे अपने से खाना बनाते है, रोटी बनाते है, लकड़ी भी फाड़ते है, बच्चा लोग स्कूल जाता है ना इसी लिए. और कुछ दुकान का सामान भी जाकर लाते हैं। मेरे पास तो पैसा नहीं है इसीलिए घर वाली को मांगते है; पैसा रहने से अपने लिए भी लाते है। गाँव मे किसी का घर मे मेहमान आते है तो हम लोग धुमने जाते हैं; बीमार होने से अपने से अस्पताल जाते है।
I do some work on my own like making food, and cutting wood. Since my children go to school, I also get any supplies that are needed for my shop. I don't have money, I ask for money from my wife and if I get the money I shop for myself too. I also go to houses in my village when guests come to visit.

Due to empowerment the service user not only does his household chores but also works on the farm and takes responsibility for his older brother's house since he has passed away.

Earlier I used to follow my daily chores, self-care and grooming only when insisted upon by my family. Now I can take care of myself and do household chores.

Now I am doing good and able to do all the work. If there are no soaps and oil in the home, I buy on my own. Sometimes I seek my mother's permission and sometimes I go off on my own.

**Annual Review and Reflection**

Earlier on the 30th of August during a daylong session as part of an annual review and reflection process facilitated by Dr. Nilesh Mohite, Community Psychiatrist, with a team of (22) Sukhudukhu sathis who come from the same villages as the service users), we tried to understand the following parameters as shortlisted by the team members from the perspective of service providers (Sukhdukdu sathis). These were adequately discussed and the team came up with a review of before and after analysis.
<table>
<thead>
<tr>
<th>Indicators</th>
<th>People affected Before the intervention (n= 104)</th>
<th>Improved ( n=104)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily Activities</td>
<td>104</td>
<td>101</td>
</tr>
<tr>
<td>Adherence To Treatment</td>
<td>104</td>
<td>90</td>
</tr>
<tr>
<td>Discrimination/Stigma</td>
<td>88</td>
<td>86</td>
</tr>
<tr>
<td>Violence</td>
<td>20</td>
<td>All</td>
</tr>
<tr>
<td>Accusation of practicing Witchcraft</td>
<td>14</td>
<td>All</td>
</tr>
<tr>
<td>Participation in social events</td>
<td>104</td>
<td>92</td>
</tr>
<tr>
<td>Livelihood</td>
<td>104</td>
<td>89</td>
</tr>
</tbody>
</table>

Improvements were of varying degrees.
9. Factors Leading to Recovery

Learnings of facilitators (Based on field dairies, perception of Service Providers and clinic records). They developed an understanding that people who are living with mental illness can improve their health and wellbeing through regular treatment and care through our collaborative tele-psychiatric clinics, support group meetings in the community by peer facilitators (suku duku saathis), home visits and counselling by trained counsellors and care from family. As they begin to recover, those who are interested, also receive support from Ekjut's livelihood promoters for enhancing their agro-based livelihood activities such as nutri-gardens, and backyard poultry. This process of rehabilitation happens best when there is no discrimination and stigma in the larger community, our participatory meetings are addressing this through monthly Participatory Learning and Action meeting cycle.

1. Tele-psychiatry that is collaborative (Psychiatry+social medicine, premier institute+ center of excellence rural hub)

2. Generic medicines from reputed manufacturer (Locost)

3. Counselling that is at the doorstep, within the community in local language and dialects with empathetic and reflective listening

4. Monthly Support groups meetings facilitated through peer facilitators coming from the same community, the meetings encourage participation, peer learning and problem solving. The information about the support group meeting is spreading to other blocks and there is a potential for replication.

5. Addressing basic needs through linkages with government welfare schemes
6. People who are having regular medicine, and participating in the activities are now recovering and helping their families in agriculture and getting involved in other household chores. They are being supported for a community-based reintegration process that contributes to self-esteem, improve social bond, mobility and physical activity and resilience.

7. Capacity building and engagement of local youth in this mental health programme is yielding results. There is increased visibility and respect for Suku Duku sathis as well as for their work in the community

8. Service users are resuming routine work such as getting daily wage labour, working in nutrition garden and in the agriculture field, and maintaining the self-care practices.

**Upstream Enablers:**

- The local trained youth facilitators as part of the community mental health team are at the forefront, speaking the same language and dialect. These facilitators had been part of leadership training and built capacities on facilitation of participatory meetings on mental health issues in the community.
- Understanding predictors of distress is the key to addressing the mental health of the community.
- Supportive community environment
- Previous evidence-based work with the community on reducing distress (reference ref PLA reducing postnatal depression, it is feasible to address gender based issues
- Inhouse Doctor and collaborative telepsychiatry center
- Timely support through medicine, care, listening, and the rehabilitation support
- Availability of good quality generic medicine at low cost
- Use of WhatsApp Messages to share the observation and learnings from home visits with supervisors respecting confidentiality.
**Downstream Enablers:**

- Acceptance and regularity of participation in support group meetings
- Social Contact programme to reduce stigma
- Agro-based rehabilitation
- Many service users have lands for nurturing garden and backyard poultry
- Safety net social support programme for the most marginalised (Frontline workers helping in leveraging social services)
- Rural location of the clinic accessible to people of neighbouring blocks of West Singbhum and Saraikella district with low-cost medicines
- Supportive families and community

**10. Challenges**

The existing contextual distress factors such as poverty, alcohol use, stigma, practices related to mental health care, and cultural taboos are challenges needing long-term engagement.
Our CBR programme includes

Protecting and Promoting Rights
Access to Care and Treatment
Participation and Inclusion
Rehabilitation

Consent taken for the use in this document
Our Team Led By Sumitra Gagrai

1. Bahalin Leyangi
2. Sunita Honhaga
3. Kunti Devi
4. Shikandar Pareya
5. Budhan Singh Haiburu
6. Madhuri Purty
7. Bagun Purty
8. Nainika Banra
9. Sandhya Tamsoy
10. Rani Macchua
11. Savitri Banra
12. Suresh Purty
13. Shantibala Samad
14. Binit Kumar Mahanta

Our Partnering Community
Report Prepared By: Subhashree and Arohi Taparia