



**RE**

Funding  
Mental Health

**FRAME**

# RE

Funding  
Mental Health

# FRAME

**ISSUE NO. 1**

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THE MARIWALA HEALTH  
INITIATIVE JOURNAL

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## Message from the Founder

I have always wanted to give back to society, in terms of both wealth and personal learnings. This was the impetus for Mariwala Health Initiative (MHI), which came into being in 2015. MHI was envisaged, among other things, as a thought leader in the mental health field in India. Setting up MHI was a journey in itself, and we used my learnings in the for-profit sector to conduct insight-gaining exercises with stakeholders such as psychologists, counsellors, and users of mental health services. We soon came to the conclusion that there was a dire need for attention in this area. Not only did diverse marginalized communities face insurmountable barriers in being able to access mental health, there were notable shortcomings in the quality delivery of services. We decided to engage deeply with felt needs – and to nurture a long-term initiative that would rely on innovation as a driving force. When we began to consider low-cost innovations to bring mental health support to the people most in need, we realized that innovative work in the sector did exist in several places, but was hampered by the lack of financial support as well as a paucity of advisors and mentors. Innovation, preventive health, and scaling up thus became some of MHI's significant conceptual drivers.

We see well-being as a combination of mental health and social factors, and aspire to create a holistic mental health ecosystem that is accessible to everyone, across social landscapes. MHI works, then, as a catalysing and enabling force for organizations that strive towards this goal. Our collaborations over the last three years with organizations engaged in cutting-edge work in the area of mental health have been invaluable learning experiences for us. Our partner organizations work with a mix of urban and rural communities, across linguistic and economic strata. Armed with many lessons from the field, we are poised to take bigger leaps and accelerate our financial and advisory role in order to support a range of exciting mental health projects led by professionals, activists and organizations – all the way to national policy levels.

MHI has built a foundation, and we are now keenly focused on long-term social transformation in the mental health sector. We hope that more stakeholders will share knowledge and work together with us. We invite everyone to join the movement to build a mental health ecosystem in the country that is rights-based and provides universal access to mental health.

Thank you!



**HARSH MARIWALA**

## Note from the Director

Mental health has always been a personal interest area. I've had the privilege of being able to access mental health resources when needed, including its discourse in terms of language and scholarship. It was, then, the first sector I considered when exploring redistribution of wealth options.

From the very outset, mental health was, for me, a feminist issue, given that it is an area riddled with stigma, invisibility, marginalization, discrimination, as well as lack of access to knowledge and treatment. Our initial research revealed glaring lacks, dauntingly urgent and complex needs, and grossly underserved communities. No less striking was the silence surrounding mental health concerns, despite these being part of almost everyone's lived reality. Silence that becomes, in this as in many other contexts, violence.

MHI emerged from an easy meshing together of the values that drove my father and me. For him, it was the concept of innovations in service delivery and capacity-building, so as to reach a vast number of people; for me, it was the idea of accessible mental health, grounded in an approach based on rights and agency. Our shared values also enabled us to work on ensuring that MHI is associated with projects that are transparent, inclusive, accessible, and that consciously steer away from replicating structural power dynamics.

Using these filters to inform our work, we were motivated to aim at creating a 'big picture' of mental health that expands on narrow medical definitions, while signalling a shift towards inclusive, holistic, and empathetic attitudes and practices. One of the most exciting aspects of setting up MHI has been the embedding of these key principles as guides, and touchstones for debate.

The very first step was leveraging various privileges we hold through our social and cultural networks, and our access to resources other than money – using our good offices to visibilize our partners and their work. Another step has been the building of an accessible website, because disability rights are an integral axis of our approach. Additionally, we hope this edition of our mental health journal, *reframe*, is the first of many, that broadens and complicates mental health discourse.

As MHI grows, we hope to centre our own accountability; hire a diverse team; and push ourselves, continually, in meaningful ways, to support marginalized communities and to use every means at our disposal not only to transform existing discussions around mental health, but also to widen the scope for participation in these crucial conversations.



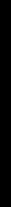
**RAJVI MARIWALA**



JHILMIL

BRECKENRIDGE

Mental Health Activist, Poet, Writer



Who decides what is normal and what an aberration is? And what of the stigma once you are labelled? Everyone who has been through the system, and, even those who have not, know that stigma can often be *more* damaging than the condition itself.

# Funding Me

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# Today's Landscape

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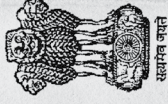
THE RIGHT TO ACCESS  
MENTAL HEALTHCARE AND  
TREATMENT *shall mean mental*  
*health services of AFFORDABLE*  
COST, *of GOOD QUALITY,*  
*available in SUFFICIENT*  
QUANTITY, ACCESSIBLE  
GEOGRAPHICALLY, WITHOUT  
DISCRIMINATION *on the basis*  
*of GENDER, SEX, SEXUAL*  
ORIENTATION, RELIGION,  
CULTURE, CASTE, SOCIAL OR  
POLITICAL BELIEFS, CLASS,  
DISABILITY *or any other basis*  
*and provided in a manner that is*  
ACCEPTABLE TO PERSONS  
WITH MENTAL ILLNESS *and*  
*their families and care-givers.*

MENTAL HEALTHCARE ACT, 2017

Policy  
Discrimination  
Stigma  
Paradigm-shift  
Linkages

रजिस्ट्री सं० डी० एल०—(एन)04/0007/2003—17

REGISTERED NO. DL—(N)04/0007/2003—17



# भारत का राजपत्र

## The Gazette of India

असाधारण

EXTRAORDINARY

भाग II — खण्ड 1

PART II — Section 1

प्राधिकार से प्रकाशित

PUBLISHED BY AUTHORITY

सं० 10] नई दिल्ली, शुक्रवार, अप्रैल 7, 2017/चैत्र 17, 1939 (शक)  
No. 10] NEW DELHI, FRIDAY, APRIL, 7, 2017/CHAITRA 17, 1939 (SAKA)

इस भाग में भिन्न पृष्ठ संख्या दी जाती है जिससे कि यह अलग संकलन के रूप में रखा जा सके।  
Separate paging is given to this Part in order that it may be filed as a separate compilation.

MINISTRY OF LAW AND JUSTICE  
(Legislative Department)

The following Act of Parliament received the assent of the President on the 7th April, 2017, and is hereby published for general information:—

## THE MENTAL HEALTHCARE ACT, 2017

No. 10 OF 2017

[7th April, 2017.]

An Act to provide for mental healthcare and services for persons with mental illness and to protect, promote and fulfil the rights of such persons during delivery of mental healthcare and services and for matters connected therewith or incidental thereto.

WHEREAS the Convention on Rights of Persons with Disabilities and its Optional Protocol was adopted on the 13th December, 2006 at United Nations Headquarters in New York and came into force on the 3rd May, 2008;

AND WHEREAS India has signed and ratified the said Convention on the 1st day of October, 2007;

AND WHEREAS it is necessary to align and harmonise the existing laws with the said Convention.

BE it enacted by Parliament in the Sixty-eighth Year of the Republic of India as follows:—

### CHAPTER I

#### PRELIMINARY

1. (1) This Act may be called the Mental Healthcare Act, 2017.  
(2) It shall extend to the whole of India.

Short title,  
extent and  
commence-  
ment.

# 10%

OF THE INDIAN  
POPULATION IS  
AFFECTED BY  
COMMON MENTAL  
DISORDERS (CMDS)\*

including depression, anxiety disorders and substance abuse, with peer pressure, bullying or being singled out, and exam anxiety as primary reasons.<sup>[1]</sup>



MENTAL HEALTH ISSUES were significantly higher in households with lesser income, poor education and limited employment.

## national mental health survey 2016

A SNAPSHOT OF  
GROUND REALITIES

**150 million** \*  
INDIANS WERE IN  
NEED OF ACTIVE  
INTERVENTIONS FOR  
MENTAL HEALTH ISSUES.  
(one or more)

THIS  
CONSTITUTES  
**15%** \*  
OF ALL INDIAN  
ADULTS.  
(above 18 years of age)

LESS THAN  
**30 million** \*  
SOUGHT CARE.

AFFLICTED



The majority of STATE-LED MENTAL HEALTH PROGRAMS and activities were fragmented, disorganized, and suffered from low priority with regard to implementation.

A significantly neglected area, across states, was the monitoring and evaluation of mental health programs. Only Tamil Nadu and Gujarat had mechanisms to monitor programs regularly.

The number of medical officers at state and district levels trained to deliver mental health services (per lakh population) ranged from 0.1 in Jharkhand, Madhya Pradesh, and Uttar Pradesh to 9.73 in Manipur.

## the treatment gap

is the lack of enough mental health professionals (MHPs).

THIS RANGED FROM

**28 → 83%**

**80%** OF THOSE LIVING WITH PSYCHOSOCIAL STRESSORS OR MENTAL HEALTH ISSUES REMAIN WITHOUT SUPPORT DUE TO LACK OF ACCESS\*

despite being unwell for > 12 months.

\* These values are approximate.

EXCEPT KERALA, ALL STATES FELL SHORT OF THE REQUIREMENT OF AT LEAST **1 PSYCHIATRIST PER LAKH PERSONS.**

The availability of psychiatrists (per lakh population) in states covered by the NMHS varied from 0.05 in Madhya Pradesh to 1.2 in Kerala.

DEMAND

SUPPLY

RESOURCES

**“The standard prevalent biomedical care model is neither an exclusive nor a comprehensive solution as it does not address the link between mental illness, stigma and poverty.”<sup>[2]</sup>**

These findings highlight the sheer magnitude of the problem. However, while the empirical data is bleak, it is also insufficient for designing policies to address issues of access and the provision of better mental health. Such research, with its overreliance on empirical data, tends to ignore structural discrimination – overlooking how the pervasive stigma and silence surrounding mental health concerns affect the awareness, provision and efficacy of, as well as access to, mental health services.

Thus, to tackle the mental health crisis in the country, we need a paradigm shift in how we view mental health – to understand mental health in psychosocial rather than solely biomedical terms. This necessitates an intersectional approach, which takes on board the ways in which systemic and structural barriers all contribute to an individual's mental health.

We also need to put pressure on institutions – dealing with law, policy, education, medicine – to work towards bringing about a continuum of care and well-being that is holistic and survivor-affirmative. Such an undertaking cannot be carried out without supporting ongoing work in mental health as well as advocacy for policy change. Mechanisms of monitoring and evaluation are a necessary part of such a picture.

One way to accomplish these goals is for philanthropic efforts to focus on long-term strategies for radical social transformation. However, the India Philanthropy Reports highlight that while the percentage of private donations towards the development sector has substantially risen over the last decade, the sharing of available wealth for causes beyond education, food and housing is negligible.<sup>[4]</sup> The bulk of philanthropy in India has, traditionally, been for religious or communitarian causes.<sup>[5]</sup> Support for the mental health sector and, more importantly, rights-based work within mental health, is a compelling need.

## A RIGHTS-BASED APPROACH IN INDIA

It is important to foreground here the body of both research studies and mental health services in India that do follow a psychosocial, rights-based, intersectional approach. It is imperative to create links between such work, while making concerted efforts to keep the rights and agency of individuals at its center.

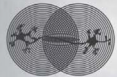


## The Gay-Affirmative Counselling Practice Resource and Training Manual

documents not only gay-affirmative counseling practices but also the experiences of counselors working in NGOs, private practice, and public hospitals, and provides best practices for work with persons of marginalized sexualities.<sup>[3]</sup>

**Aaina** was a national newsletter in 2001-2007, sharing social issues of persons living with psychiatric disabilities, human rights issues in mental health by visibilising the voices of user-survivors, marginalised communities as well as community mental health.

Besides, several organizations have developed locally appropriate, community-based mental health interventions. And there are also disability activists, mental health activists, and feminist activists, working in the area of mental health.



**bapu**  
Trust  
for  
Research  
on  
Mind  
and  
Discourse

# aaina

a mental health advocacy newsletter  
Vol. 5 No. 3, Nov 2005

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### Editorial ✍

Children in Indian schools are now increasingly being brought into the trap of the drug companies by being labeled with a mental illness: attention deficit disorder, behaviour and conduct problems, depression, academic backwardness.... We are hearing about this everywhere, even as the WHO celebrated the last year's MH week with the theme of childhood mental disorders!

Many schools in India now have a counsellor and a referral system to medical professionals to deal with academically backward children. This trend of drugging children is worrying, as international policy makers are cautioning loudly against prescribing antidepressants, especially SSRIs, for children, due to the heightened risk of suicide and violence.

In all this, we are not talking about how children's lives have changed over the years- the pressures of the present education system, the neglect of children's health, the depletion of essential nutrients from our foods, allergies brought on by environmental pollution, replacement of diverse and complex grains and pulses with homogeneous and instant foods, and the fact that wheat, fruit and vegetable has been replaced by magi, pizza, chips, chocolates and Pepsi. Parents around the world are protesting the takeover of their children's lives by the schools, the psychiatrists and the pharmaceutical companies.

Against this background, we also need to consider the therapeutic needs of custodialised, traumatized and victimized children. Their legal and mental health needs are not met within the juvenile justice system.

The state of Maharashtra has been irresponsible about dealing with complaints from families with a psychosocially disabled person. In a recent case in the Mumbai High Court, the Bench headed by Chief Justice AP Shah, admonished the Maharashtra Disability Commission on its poor reading of the law (Section 47).

This issue of *aaina* reports on a recent initiative to draw up a Charter of Rights for persons with a psychosocial disability. Further, news about a study group on the UN Convention on Disabilities is also reported. The 7<sup>th</sup> Ad Hoc Committee Meeting begins on the 15<sup>th</sup> of January and goes on for three weeks. The Chairperson's Draft, which is an assimilation of the discussions in the proceedings so far, will be discussed.

The story of a man diagnosed with bipolar illness, and who bravely used himself as an experimental laboratory, is also described. We are also happy to report news of a recent verdict in the US, where the court granted \$1.6Mn to a woman who suffered from tardive dyskinesia, as compensation.

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1

aain

One of the 20 issues of the Aaina newsletter (2001-2007), the first national voice of users, survivors and mental health activists.

# Communities

An intersectional, rights-based approach to mental health necessitates looking at how structural and systemic discrimination affects people and communities. Below are a few chosen facts that illustrate this. However, this is not a comprehensive listing because it doesn't cover all marginalised communities and requires statistics as well as narratives of lived experiences.

## SUICIDE RATE\*

Scheduled Tribes	10.4
Dalits	9.4

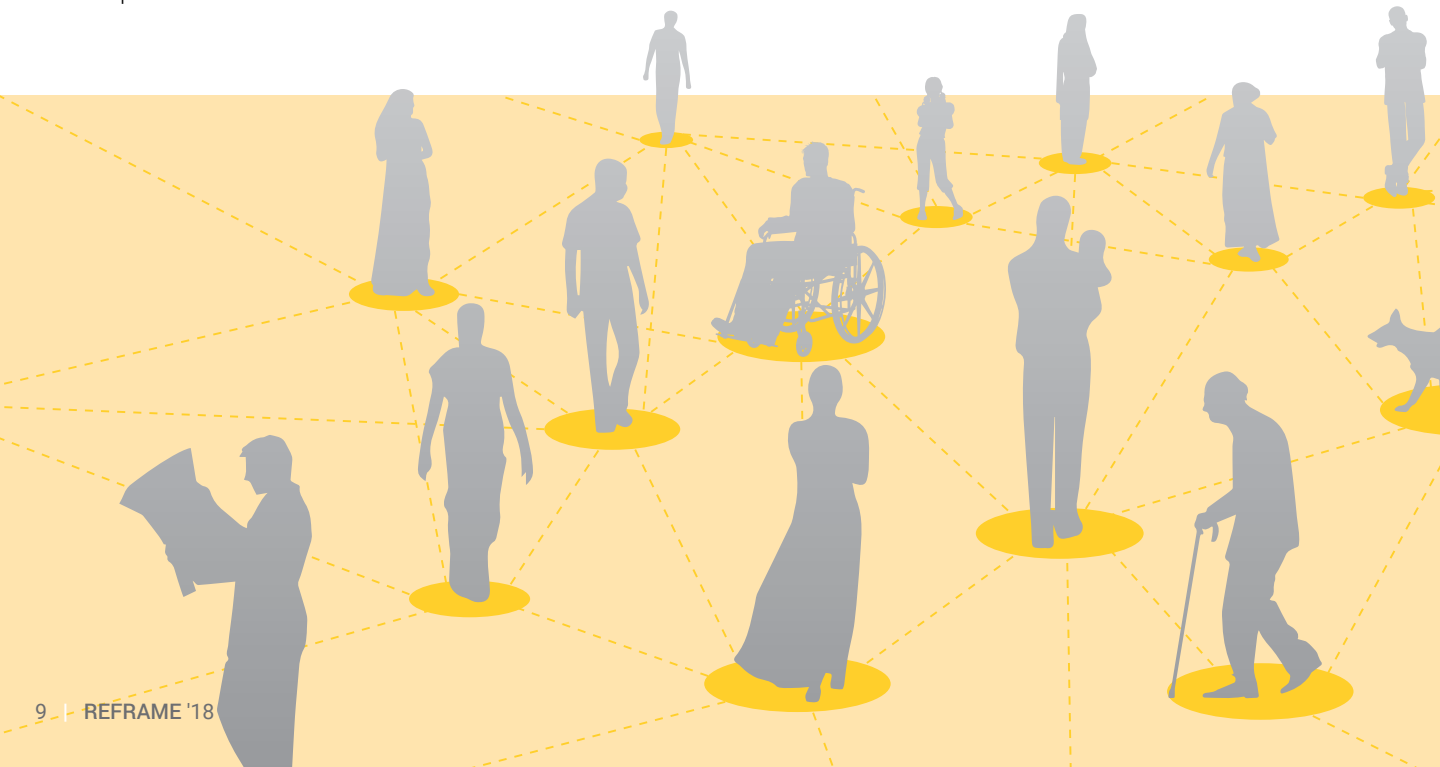
## community & caste

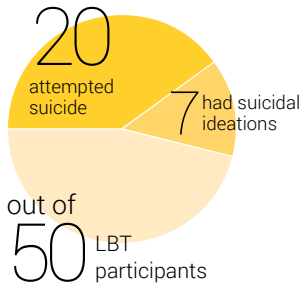
Among caste groups, Scheduled Tribes had the highest suicide rate at **10.4** followed by Dalits at **9.4**. In this context, rate refers to

the number of suicides per population of one lakh. In less than a decade, over 25 Dalit students in India have committed suicide due to caste discrimination and institutional casteism in educational institutions like University of Hyderabad, AIIMS and IIT as well as by discriminatory entrance exams like NEET.

**1 IN 3** homeless persons suffer from mental illness

**economically vulnerable**  
**1 in 3** homeless individuals suffer from a mental illness. Persons from the most marginalised socio-economic background have a risk **8 times higher** than those from higher socio-economic status for schizophrenia. (Banyan India)





**gender and sexuality**

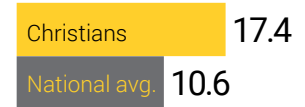
LGBTQIA individuals face unique life stressors such as familial violence, discrimination and violence in public spaces

and institutions as well as struggles with self acceptance. This combination of unique life stressors has a significant mental health impact. In one study, **20 out of 50** LBT participants attempted suicide once or more in their lives. At least **7** others in the study reported suicidal ideations. (LBT consultation and No Outlaws in the Gender Galaxy)

**age** Nearly **9.8 million** of young Indians aged between 13-17 years are in need of active mental health interventions.

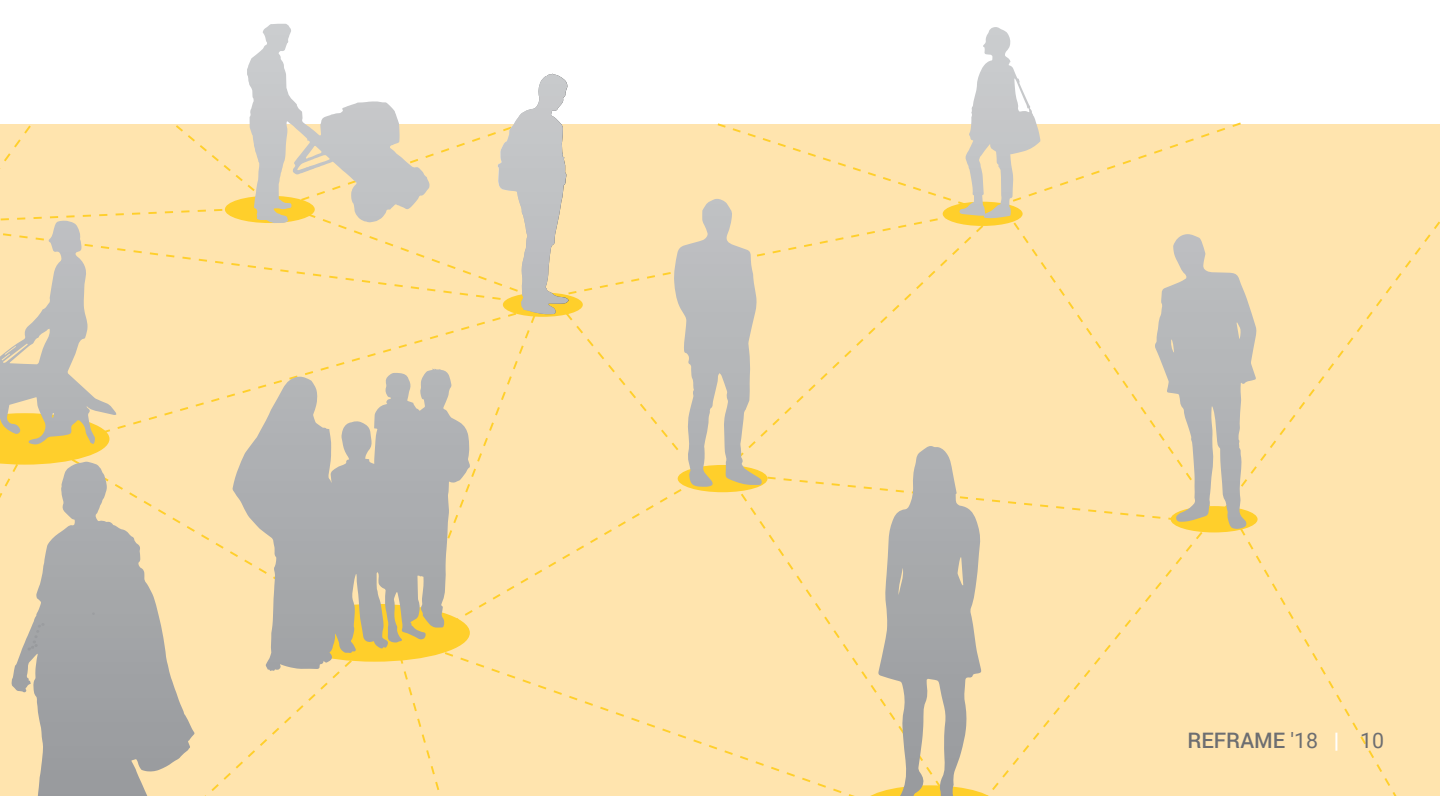
**ability** Persons with Disabilities (PWD) are estimated to be **6-8% of population** in India. Social attitudes and stigma gravely limit the opportunities of PWD for full participation in social, economic and familial life. (WHO study)

**SUICIDE RATE\***



**religious minorities**

Christians have the highest suicide rate at **17.4** – the national average was 10.6. In this context, rate refers to the number of suicides per population of one lakh. (National Crime Records)



# Philosophy

---

THE MARIWALA HEALTH INITIATIVE (MHI) IS A FUNDING AGENCY FOR INNOVATIVE MENTAL HEALTH *projects, with a particular focus on making mental health* ACCESSIBLE TO MARGINALIZED PERSONS AND COMMUNITIES.

*We aspire to the ‘BIG PICTURE’ of mental health, one that expands on narrow BIOMEDICAL APPROACHES TO MENTAL HEALTH, and signals a shift towards an* INCLUSIVE, HOLISTIC, AND EMPATHETIC *mental health ecosystem. We encourage* COMMUNITY-BASED INTERVENTIONS, *promote the* DEINSTITUTIONALIZATION *of mental health systems, and recognize mental health as an* INTERSECTIONAL *issue.*

Psychosocial  
Ecosystem  
Intersectional  
Stakeholders  
Communities

# Mission

To collaborate with a range of stakeholders in the area of mental health, in order to:

**1** Create wider awareness of mental health issues.

**2** Enable and support quality services, and ongoing research.

3

Encourage innovative, culturally sensitive community-based interventions.

4

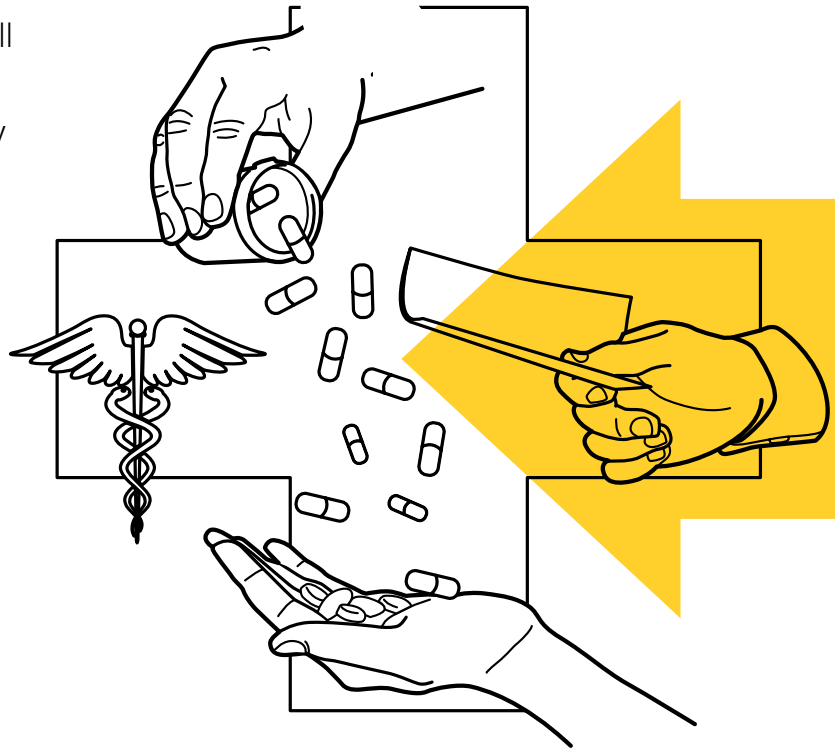
Work towards capacity building for individuals, organizations, communities, and institutions, through training, network building, and knowledge sharing.

5

Stimulate law and policy reforms.

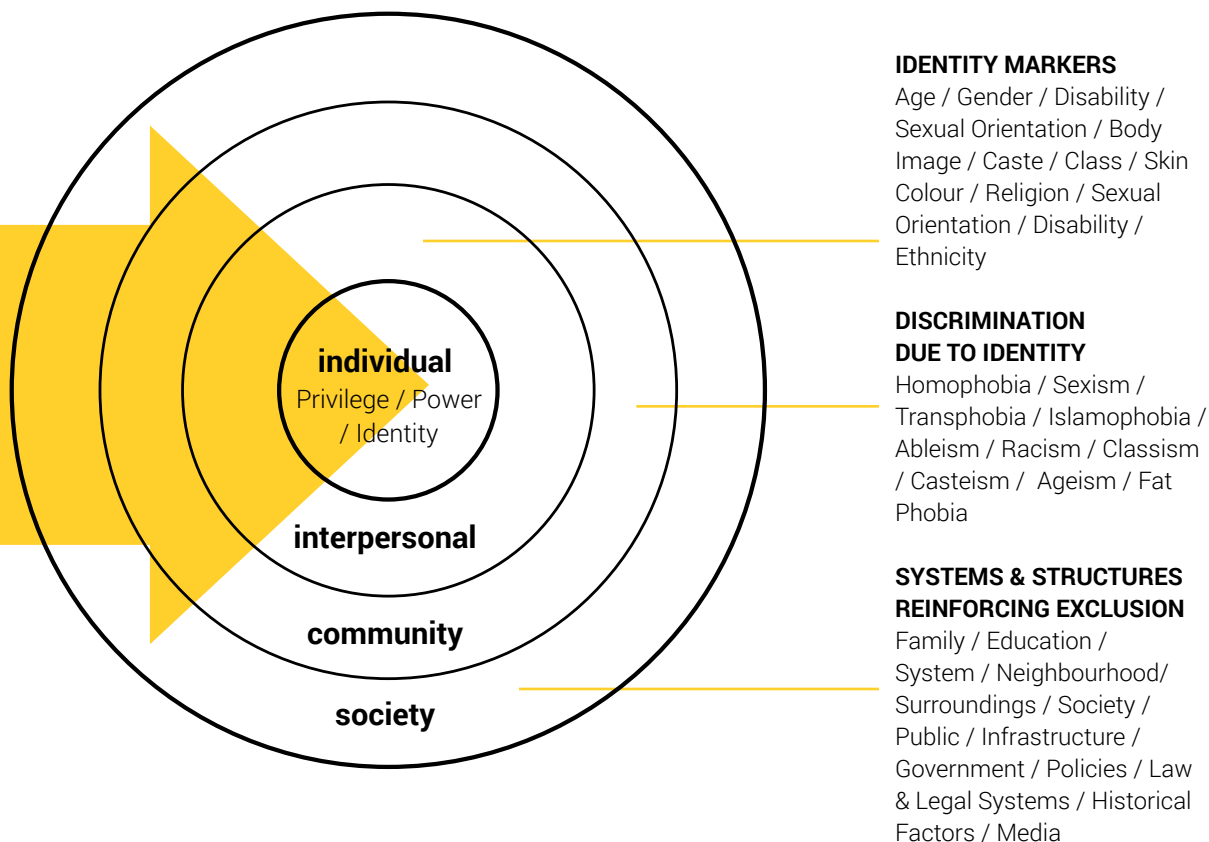
# Approach

The MHI understanding of mental health places the user at the centre, in terms of their social context as well as their active involvement and informed consent in any medication based inputs, which may be a part of their healing process.



**biomedical lens** Mental health is largely viewed, in India, through a biomedical lens, rather than in the context of a multifaceted coming together of individual and social contexts, challenges, marginalizations.





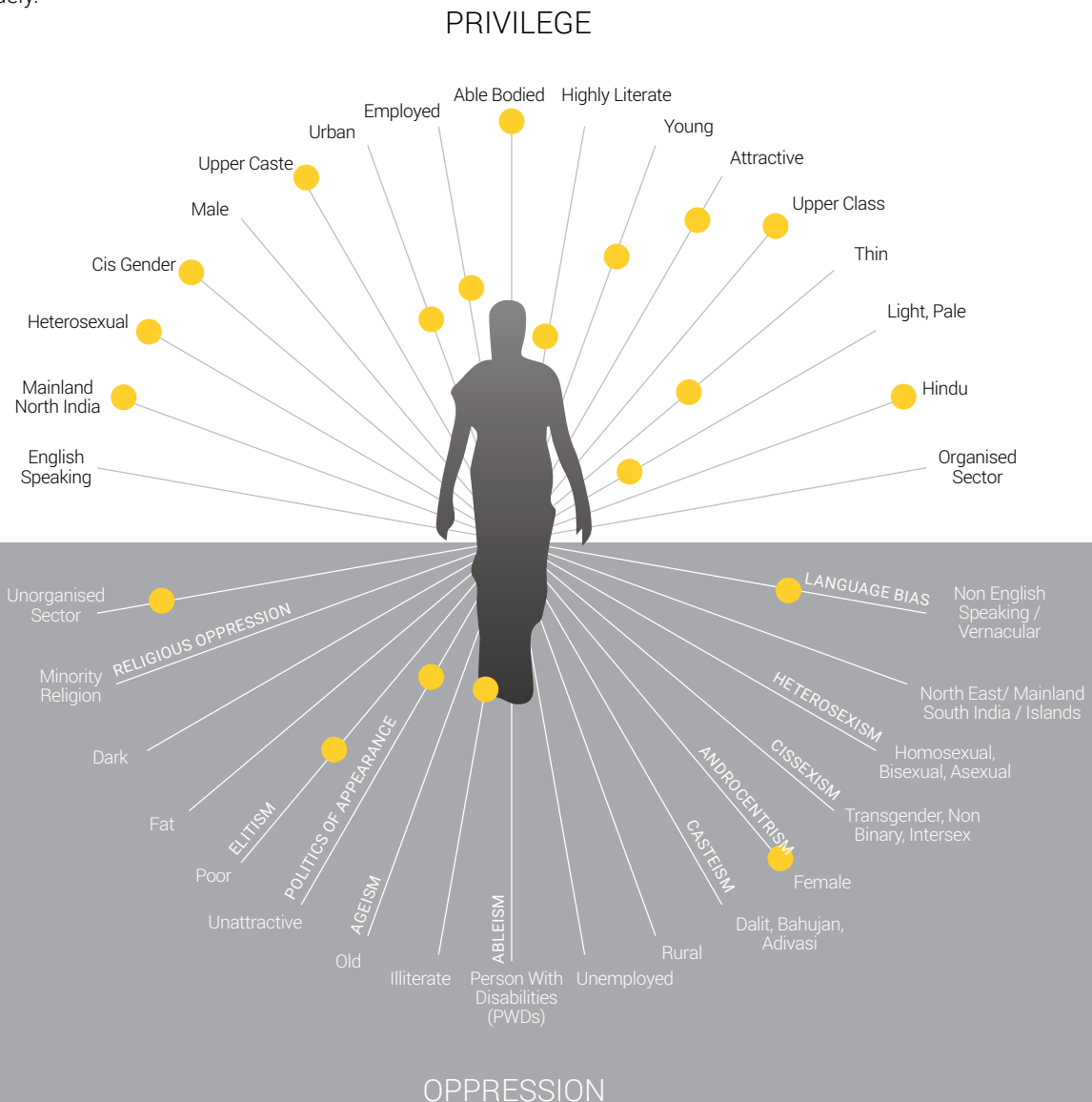
**psychosocial lens** Every person has distinct experiences and dynamic interactions with their social contexts. In this diagram, the individual is at the core, and the outer circles represent markers that shape one's identity and larger structures that affect lived experience.

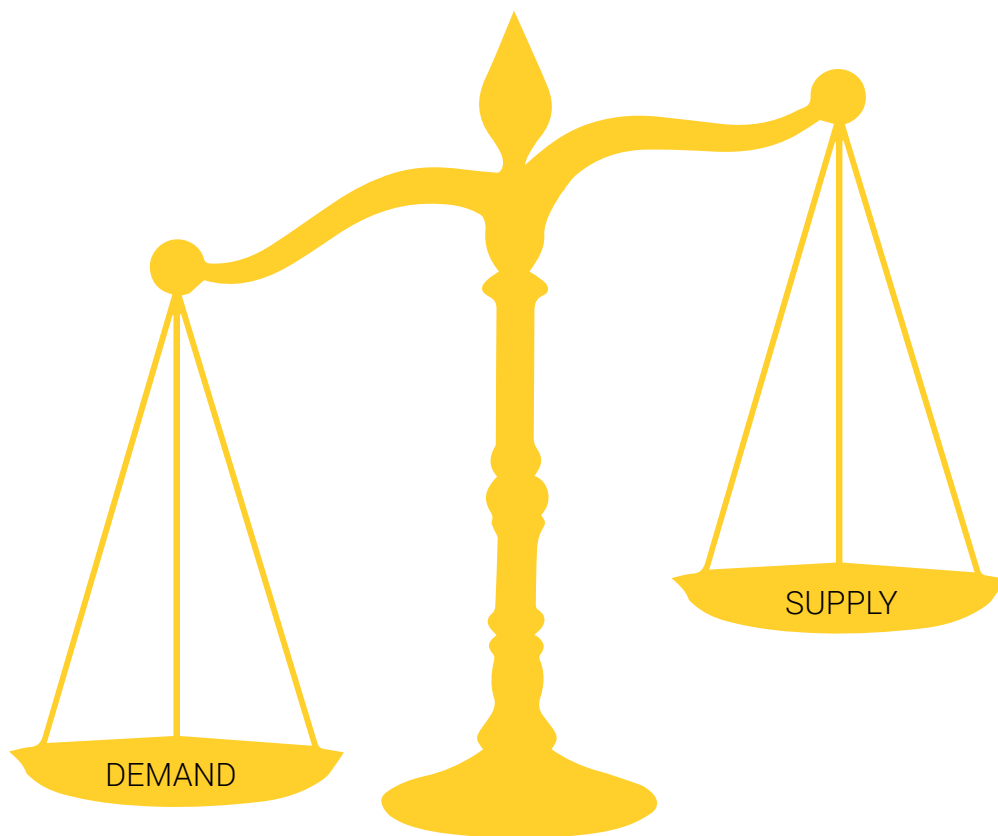
## intersectionality

We mapped a fictional persona to illustrate that oppression and privilege interact in complex ways. A person may have caste privilege and so will experience class or gendered oppression differently and uniquely.

Ragini is a 25-year-old married woman. She stays in Nagpur, Maharashtra. She is Savarna by birth and has a wheatish complexion. She is 10th passed and works as a cook.

This diagram is adapted for the Indian context from the work of North American sociologist and academic, Kathryn Pauly Morgan.





### treatment gap

A significant part of the prevailing mental health discourse is focused on the 'treatment gap' – the discrepancy between the number of persons needing support or interventions, on the one hand, and the number of available mental health professionals, on the other. This 'demand-supply' approach tends to be top-down; it is based on pathologization, and prioritizes diagnosis, minimizing the significance of multiple voices, perspectives, and narratives.



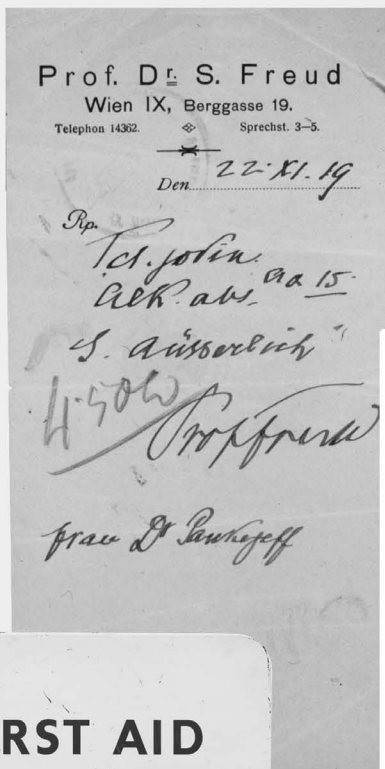
The number of persons treated for mental health issues **versus** the number of people that remain untreated.

Misconceptions about mental illness that cause people to perpetuate stereotypes, prejudice and discrimination against people who live with mental health conditions.

Exclusion of or lack of representation in opportunities, services and policies.

# Rights-based Approach

Persons with mental health challenges are often **invisibilized** within their families, schools, workplaces, as well as **public institutions**. The pervasive **stigma** associated with mental health issues manifests itself in multiple spaces, affecting an individual's willingness as well as ability to **access resources**. Misconceptions, and a lack of awareness, are also impediments to both, the **provision**, and the **efficacy**, of available mental health services. Discrimination that stems from stigma could adversely affect a person's livelihood, education, and family life, as well as their rights within these formal and informal spaces. On a **macro level**, MHI aims to engage in **legal and institutional policy reform**, establishing the **rights and agency** of persons coping with mental health challenges. Through **research**, and governmental and institutional engagement, MHI will be concerned with policy-making in the coming few years.



# Demedicalisation

The medicalized and pathologized perspective on mental illness sees it as a problem of the brain, as something that can and should be fixed and often overlooks the lived experiences of the person experiencing the mental health issue. Medicalization leads to locating the mental health issue at a biological level and ignores the cognitive, emotional, behavioral and social aspects of mental illness. It focuses on analysing symptoms, diagnosing the 'problem' and prescribing medicines to correct the problem. This is a top down, quick fix approach that makes the patient a passive recipient of treatment and sometimes can put them at risk of over-reliance on medication. Instead, we need to advocate to recognise that a person has the right to make informed choices about therapies, medication and a treatment plan.

**FIRST AID  
CASE**



When the patient  
lashes out against "them"—

**THORAZINE®**

brand of chlorpromazine

quickly puts an end to his  
violent outburst

Suicidal.	general Debility.	None.	Jan. 4, 1835.	March 10, 1837.	Recovered.	—
Very destructive.	Dyspepsia.	Mania passed into Melancholia.	Jan. 15, 1835.	Dec. 20, 1841.	Died. Aetat. 41.	Softening of the Brain.
—	Epilepsy.	Became fatuous and paralytic.	Feb. 1, 1835.	April 4, 1842.	Died. Aetat. 42.	Apoplexy; Second Attack.
—	Mammary Abscess.	Melancholia passed into Monomania of Suspicion.	Nov. 10, 1835.	Feb. 14, 1840.	Improved. Delusions remain.	—

to Dr. Hirsch, of the Asylum, German Society of the Association."

# Deinstitutionalisation

**Deinstitutionalisation** is the process of replacing long-stay psychiatric hospitals with less isolated community mental health services.

Persons with mental health issues, particularly those with long term, severe mental illness are often, voluntarily or involuntarily, 'institutionalized' in mental hospitals for treatment. Mental institutions have been historically modelled on prisons and the treatment meted out to patients in psychiatric wards and mental institutions is reminiscent of the surveillance, policing and dehumanization that prisoners are subjected to. Persons with mental illness are rendered voiceless and at the mercy of the hospital. Mental institutions also have no mechanisms for providing long term care and support to recovered residents who may not have homes to return to.



*New Berlin in Moor fields.*



Working of the Ranchi Indian Mental Hospital, Kanke, in Bihar and Orissa, for the year

# Belief System

At MHI we believe in a **psychosocial approach** to mental health – that mental health is a spectrum, and that we must situate **lived experience** at the core of any capacity building work, or intervention. We fund initiatives that are **user-survivor-centered**, shifting mental health dialogue from the old welfare-based model to a (human) rights-based one. In our view, a **paradigm shift** in the conversation is called for: from prescriptive and paternalistic to perspective-oriented and intersectional. To this end, we work with our partners to create and nurture a **mental health ecosystem with multiple stakeholders** – individuals, communities, organizations, and – not least – policy makers and government. We engage with our partners through trainings, knowledge sharing, and networking, to build **organizational capacities**, with an emphasis on **scaling up** existing innovations.

Fundamental change in the frameworks and lenses commonly used in mental health.

Looks at context & combines psychological & social factors.

Focus, support & inform based on individuals & movements that highlight the rights of current and former mental health service users.

First-hand accounts of living as a member of a marginalised community.

Refer to map on page 23.

Accelerating reach, effectiveness or increasing ability.

Strengthen an organisations work by providing a variety of strategic support.

# Stakeholders

Using a rights-based perspective, MHI works with a wide range of stakeholders to build an understanding of indivisible rights, capacity and accountability with both state and non state actors.



**users & survivors** of  
Psychiatric services, Suicide  
Survivors, Users of Mental  
Health Services, Potential Users,  
Caregivers



**activists** Disability  
Activists, Mental Health  
Activists, Livelihood Activists,  
LGBTQIA\* Activists,  
Feminist Activists  
DBA Activists





**law & policymakers**  
Bureaucrats, Municipal Corporations, Anganwadi Workers, Think Tanks, Law & Policy makers, State and Central Govt., Local Representatives



**community** Adolescents, Youth, Elderly, Dalit, Adivasi and OBC communities, Women, LGBTQIA+, Economically Vulnerable, Homeless People, Rural Communities, Urban Informal Settlements, Single Parents, Religious Minorities, Persons with Disabilities



**service providers**  
Psychiatrists, Psychologists, Barefoot Counsellors, Therapists, Non-profits, Psychiatric Social Workers



**researchers**  
Independent Institutions, Individuals, Universities, Colleges

Policies or practices that exclude or are unequal for marginalised communities.

Replacing treatment facilities with community-based support & care.

Emerging from and for the community to create local & national change.

Pushing particular groups of people to the edge of society by not allowing them an active voice or identity.

# Goals

Key to our goals is the **deinstitutionalization** of mental health services. Thus, the initiatives we tend to support are those with a strong focus on **community-based grassroots interventions**, where services and support are provided not just by experts, but also by trained individuals from within the community. In addition to foregrounding community voices and participation, this approach also acknowledges how **systemic barriers** and **marginalizations** specific to their particular context affect an individual's well-being. We believe that the only path to a holistic, **universally accessible** mental health ecosystem is through challenging **structural inequalities**, countering **systems of privilege and power**, and bringing together **diverse standpoints**.

Accessible to all irrespective of caste, class, ability, gender, sexual orientation, religion.

Refer to diagram on page 16.

# The 5 Pillars

MHI uses a 360 degree approach comprising of 5 pillars to support quantum change and encourage innovation, scalability and capacity building.

## **awareness**

Lack of information combined with stigma around mental health inhibits persons with mental health needs from approaching friends, family and mental health professionals for support and care.

## **effective service delivery**

Overall, there is minimal access to mental health services, which are marked by both poor availability as well as poor quality. Accessible, holistic, rights-based services in multiple delivery formats need to be made available to all.

## **capacity-building**

Building the capacity of individuals, organizations, communities and institutions, through training and knowledge sharing, is of critical importance.

## **references & linkages**

Strong linkages need to be forged between mental health service providers, and allied services concerned with livelihood, health, gender, sexuality, education, legal support, as well as government welfare schemes.

## **research**

A thriving and responsive mental health ecosystem must rest on a support base of research that documents and records context and community-specific experiences in the field, along with evaluating the efficacy and impact of a variety of interventions.

# Framework

MHI uses a framework to move toward a transformative, accessible mental health ecosystem. The diagram shows MHI's funding and strategic support to build a broad base of stakeholders. Such collaboration can generate discourse to engage with a variety of institutions and policy.

# 1

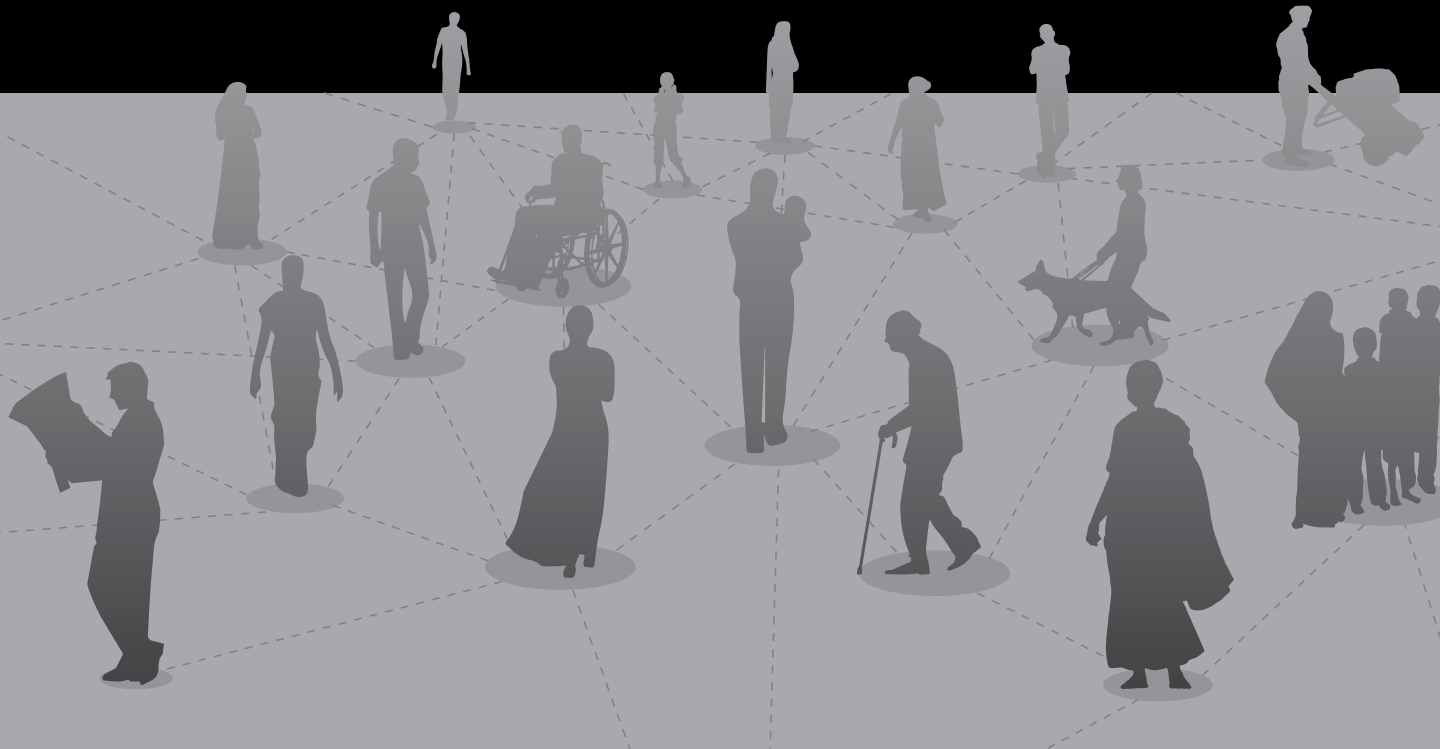
## VIA FUNDING & DIRECT AID

MHI provides funding and strategic support for innovative mental health interventions while connecting stakeholders to encourage exchange of ideas and potential collaborations.



NATIONAL &  
INTERNATIONAL  
FUNDERS

MARIWALA  
HEALTH  
INITIATIVE



# 2

## DIALOGUE

The knowledge and dialogue generated by activists, service providers and researchers enables constructive, context-specific engagement and shaping provision of mental health with communities, public and private institutions, and policy.



ACTIVISTS



SERVICE PROVIDERS



RESEARCHERS

# 3

## STATE & CIVIL SOCIETY

The adoption of a rights-based, user-led, mental health approach by the governmental, non-governmental institutions, enterprises and communities moves us toward collaborations to support and intensify efforts and accountability for a vibrant mental health ecosystem.



GOVERNMENT



INSTITUTION

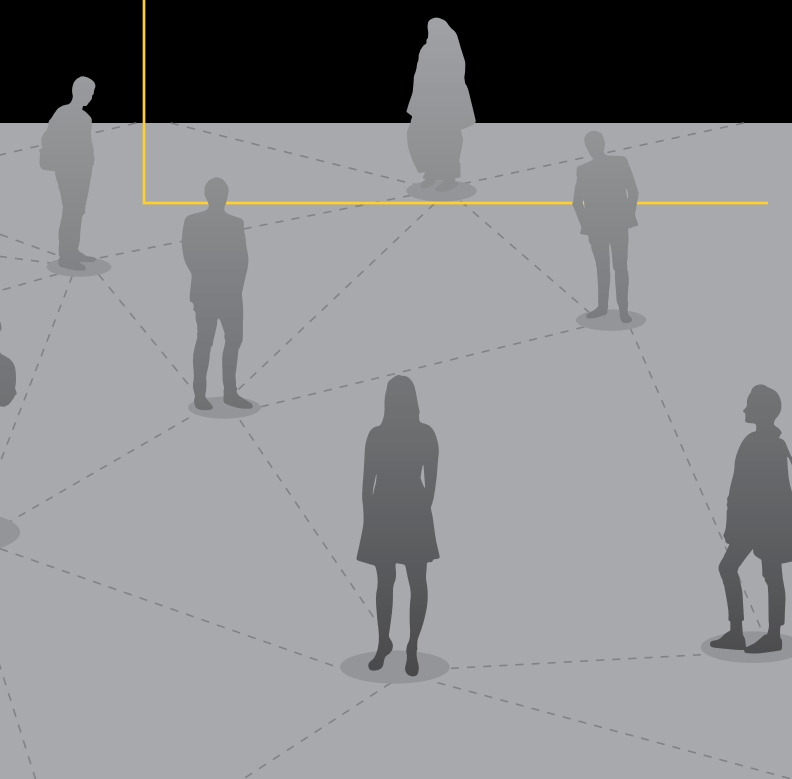


COMMUNITIES

# 4

## PUBLIC MENTAL HEALTH

Once the state and civil society drives rights-based, intersectional mental health care and support, the foundation can be laid for approaches, services and social safety nets that lead to inclusive public mental health by dint of being accessible to all, irrespective of gender, gender identity, sexual orientation, language, ability, age, class, caste, region and religion.



# Shifting Funding Paradigms

---

*It is NECESSARY for us, at MHI, to stay as focused on our GRANT MAKING PRACTICES as we are on our goals. The HOW of our work is as important as what we do. We believe our approach to grant making must REFLECT THE SAME VALUES that we expect from PARTNERS and collaborators, which is why we pay careful attention to THE POWER EQUATION BETWEEN DONOR AND GRANTEE when we invite applications, implement review processes, or formulate reporting guidelines.*

Process  
Power  
Ethics  
Transparency  
Accessibility

*Our first move had to do with nomenclature: 'grantee' and 'beneficiary' were at odds with our philosophy; 'partner' worked better.*

This is also a key consideration in our professional interactions with individuals and organizations. We have, for instance, conducted meetings with partners in Hindi and Marathi when these are their preferred languages, rather than wholly in English.

### **ethics**

From the start, we have expected partners to adhere to certain ethical models – confidentiality measures, administrative and organizational ethics, and taking cognizance of the needs of the marginalized communities in which they work. Indeed, one of the first documents shared with potential partners spells out our ethics policy.

### **funding focus**

MHI's core funding focus includes organizations and collectives working within communities, as well as researchers, activists, caregivers. We are keen on projects with comprehensive approaches to mental health, that work to evolve innovative methodologies. Our funding approach is non-traditional with regard to the mental health sector, guided as it is by the foundational premises of universal access, destigmatization, and diverse methodologies for capacity building.

Among the key values we emphasize is transparency: information on our funding approach, and on who our partners are, is publicly available. Besides making our grant processes public, we also had to make them accessible. This meant careful thinking about the first point of contact, the website. Building an accessible website calls for special care, so that images, links, and navigation are easy for all to use, so that persons with disabilities – for instance, people with varying ranges of sight, or those relying on keyboard navigation because they are unable to use a mouse – are able, equally, to access the site.

Our grant making processes are continually modified and refined so that applicants need not expend unnecessary amounts of time and energy on proposals. A concept note is usually sufficient, along with specific details that may be required – with support from MHI through the proposal process.

Funders, generally, place enormous burdens on grantees, with reports and other requirements meant to establish accountability for funds received. MHI asks for quarterly or half-yearly reports from partners – based on their existing timelines with other donors, if any. We also endeavor to work with existing report formats already in use by partners.

MHI aims to keep refining its grant making procedures, so as to be able to accept applications in multiple languages, ease reporting requirements, and explore how we might support each partner's vision – working from the premise that our grant making must not be solely about funding, but about long-term, sustainable changes in the area of mental health in India.



# Balancing Power Dynamics

PARTNER  MHI

1 Transparent  
funding  
principles

2 Conduct meetings  
in partner's  
preferred language

3 Request a  
concept note first  
rather than a full  
proposal

4 Accept partner's  
existing reporting  
formats

5 Ensure fit  
between ethics  
policies

# Chronology

---

MUMBAI-BASED  
BUSINESSMAN HARSH  
MARIWALA *founded the*  
MARIWALA HEALTH  
INITIATIVE (MHI) in 2015.  
*He was broadly interested in the*  
FIELDS OF HEALTH AND  
EDUCATION, *and from the*  
*outset intended an IN-DEPTH,*  
LONG-TERM COMMITMENT.  
*Consultations with RAJVI*  
MARIWALA, *now Director of*  
MHI, *led to their IDENTIFYING*  
MENTAL HEALTH AS A  
SECTOR that was under-  
*represented, under-funded,*  
*and underserved. However,*  
*they brought in DIFFERENT*  
STANDPOINTS.

*Marginalized communities  
are particularly vulnerable –  
stigma, invisibilization, and  
discrimination, all affect mental  
well-being.*

Harsh was keen on a philanthropic venture that would serve to redistribute his wealth. Rajvi wanted to move beyond traditional philanthropy – which can be paternalistic, and reinforce problematic power dynamics – and wished the initiative to be, rather than a charity or welfare activity, an exercise in social justice. They were both drawn to innovative solutions, including innovation within the field of philanthropy itself.

Mental health seems an amorphous subject – it is hard to pin down what it is or what mental healthcare does. There is a huge gap between the need for, and availability of, mental health professionals; there are also shortcomings in the delivery of quality services. Marginalized communities are particularly vulnerable – stigma, invisibilization, and discrimination, all affect mental well-being. Rajvi wanted to ensure mental healthcare was accessible and affordable for those at the margins. When the MHI team started to consider affordable mental health services, it soon realized

that scaling up existing innovative services made more sense than trying to reinvent the wheel. It set out to partner with existing or planned initiatives that were cognizant of systemic inequalities, used a human rights approach, and were focused on accessibility and social transformation.

While much research and many statistics relating to mental health exist, they tell only part of the story. A psychosocial approach to mental health requires an understanding of how context-specific lived realities form mental health experiences.

# Insighting Exercise

To explore the multiple perspectives and positionalities that would comprise a sound mental health ecosystem, mental health practitioner Shruti Chakravarty, Chief Advisor, MHI, led the team on an 'insighting exercise'.



**participants** Harsh Mariwala / Rajvi Mariwala / Shruti Chakravarty / Devika Shetty (former CDO)

**topics** MHI spoke to a variety of stakeholders about their interactions with MH systems, their beliefs, perceived need gaps, and what they would expect from a partnership with a funding organization. Our aim was to glean on-ground realities, existing challenges as well as potential areas for innovation.

**stakeholders** The team spoke to:

- Survivors
- Psychologists
- Psychiatrists
- Academics
- Counselors
- Lawyers
- Social entrepreneurs
- Cancer survivors
- Clinical psychologists
- Disability rights activists
- Users of MH services
- Service providers of existing MH helplines
- Rural community-based program coordinators
- Therapists working within communities
- People engaging with community-based MH interventions
- People leading non-profit MH initiatives
- People working in innovations in the social sector

And then we sat down together to draw upon these multiple conversations, and determine the best way(s) forward.

**key findings** A huge gap between need and supply when it came to mental health services; diverse marginalized communities facing barriers in access to mental health; notable shortcomings in the delivery of quality services were included in the key findings.

**conceptual drivers** Innovation, preventive health, and scaling up emerged as significant conceptual drivers for MHI.

# Timeline

With expertise from Chief Advisor Shruti Chakravarty, MHI began its first partnership in 2015 by funding the telephone helpline iCALL. About a year later, using iCALL as a pilot, and applying the learnings from it, MHI partnered with two other organizations – Bapu Trust, and Centre for Mental Health Law and Policy. Since then, we have added more partners, while working to build and refine our grant making practices. After three years in the field, feeling the need to assess MHI practices, and its journey towards its goals, we began constructing a monitoring and evaluation (M&E) framework. (This report, a move towards self-accountability and transparency, is an outcome of the M&E exercise.)

**september** Meeting to discuss the importance of creating a funding body for projects/initiatives in the area of mental health.

**january** Talking to stakeholders – mental health professionals, users, service providers – to glean insights about mental health, and existing need gaps.

**february** MHI Chief Advisor Shruti Chakravarty suggests and initiates funding of iCall, an existing service based in Tata Institute of Social Sciences (TISS), Mumbai, that offers free telephone and email-based counseling services, countrywide, to individuals in emotional and psychological distress.

**april** A strategic partnership with iCall begins, with an agreement to wholly fund their services, and also to promote iCall in mainstream English and non-English media in order to improve the service's reach. Enabled National Consultative Meet of Tele Counseling Helplines, organized by iCall.

**august** Building MHI approach & strategies: who, what and how to fund mental health initiatives for quantum change.

**december** Enabled and facilitated National Consultative Meet of LBT Collectives & MHPs at TISS, Mumbai

2014

2015

**august** Partnered with Bapu Trust, Pune. Bapu Trust works with stakeholders in the development sector to encourage the inclusion of persons with mental health issues and psychosocial disabilities.

**november** Sponsored the INTAR (International Network for Treatment Alternatives and Recovery) Conference of Mental Health Activists and Practitioners, organized by Bapu Trust at Lavasa near Pune city.

**december** Partnered with Centre for Mental Health Law and Policy, Pune. CMHLP builds awareness of and advocates rights-based approach to mental health policy and legislation

**april** Sponsored iCall's 'Fostering Strengths Course' for helping mental health professionals working with young people.

**may** Partnered with Anjali, Kolkata, an organization working with persons who suffer from chronic mental illnesses, living in state institutions for care and treatment.

**june** Sponsored Bapu Trust's arts-based therapy course for practitioners: a certificate course in Arts-Based Therapy (ABT) with a focus on psychosocial health, mental health and disabilities.

**october** MHI website launched. The site was built centering accessibility. Web accessibility refers to the inclusive practice of removing barriers that prevent interaction with, or access to websites, by people with disabilities. When sites are correctly designed, developed, and edited, all users have equal access to information and functionality.

**november** Facilitated and sponsored iCall partnership with Maharashtra Police Force to build awareness around mental health.

**march** Completed framing of indicators to monitor and evaluate processes and performance, with a focus on self-assessment and transparency, and with a view to encouraging wider funding in the area of mental health.

**may** Sponsored trainings conducted by CMHLP on Mental Health Care Act 2017 for a range of stakeholders.

**june** Partnered with Anubhuti Trust to support 'Community Development Committees' comprising local youth, to lead counseling, trainings, awareness drives, as well as advocacy with local and municipal government on development concerns of their area. Their mandate includes the provision of inclusive, accessible and non-discriminatory mental health services within the community.

**july** Project to provide Family Court Counseling Centers for marital concerns and stressors experienced by litigants of family courts in Maharashtra, and to develop counseling and other interventions for the 11 Family Courts across the state.

2016

2017

2018

# Partners

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## MHI'S PARTNER ORGANIZATIONS

*have varied channels through which they function, and diverse communities in which they operate. Each organization has directed attention to mental health in significant ways, and vastly increased overall dialogue.*

iCALL *Service delivery through telephone, email and chat counseling*

ATMIYATA *Rural service delivery through Community-based mental health*

BAPU TRUST *Inclusion and mental wellness in urban bastis*

ANJALI *Deinstitutionalisation & mental healthcare kiosks in urban areas*

## NEW PARTNERS

*Anubhuti, Family Courts, Training on the Mental Healthcare Act, 2017*

Communities  
Advocacy  
Lived Experience  
Awareness  
Capacity Building

# Highlights

Working toward concerted long-term change in mental health requires a series of smaller stepping-stones. Mental health projects need to record and evaluate a series of short-term indicators, intermediate term indicators and long-term benefits. The following indicators were selected because they are measurable outcomes of both short and intermediate term. This view looks at individuals, communities and intersectoral linkages for the time period of May 2015 to April 2017. Such data is critical for evidence, to build research, and for capturing of best practices.

## Awareness

<b>PARTNER</b>	<b>REACH</b>
iCall	25000 persons
Atmiyata	+ 10438 persons
Bapu Trust	+ 23587 persons
Anjali	+ 512 persons
<b>TOTAL</b>	<b>59537 persons</b>

Spreading awareness about mental health means different things in different contexts. Some mediums and methods reach a vast audience, while others focus on smaller groups and institutions. Since MHI began funding iCall in 2015, iCall has conducted over 50 outreach activities, including consultancies, trainings, workshops, writing and distributing newsletters, and two social media campaigns. They have sensitized 25,000 people to issues of mental health. Similarly, the Bapu Trust has been able to reach out to 23,587 people through 2,024 meetings and poster exhibitions. Additionally, they have conducted 7 awareness programs with women's groups and schools, and they encourage the celebration of World Mental Health Day and Erwadi Day. Since 2016, The Atmiyata Project has spread awareness amongst 10,438 persons over their pilot and first stages. Their two-tiered approach ensures community-level awareness, as well as knowledge amongst service providers like public healthcare facilities, district hospitals, and district authorities. Anjali disseminates knowledge about psychosocial disabilities, through its community-based and institution-based programs, and has been able to reach 512 people. Thanks to our partner organizations, 59,537 people now have better knowledge about mental health.

## Service Delivery

<b>PARTNER</b>	<b>REACH</b>
iCall	64,423 persons
Atmiyata	+ 399 persons
Bapu Trust	+ 9764 persons
Anjali	+ 1113 persons
<b>TOTAL</b>	<b>75519 persons</b>

iCall has attended 57,964 calls as of December 2017, and counselors have also responded to 6199 emails and 80 chats. They have delivered services to over 64,243 people from 27 states, 6 union territories, and 20 countries.

The Bapu trust has 6 centers, where 7,873 clients have received services, and 345 group sessions have also taken place, thus providing services to 9,764 people. Atmiyata's Champions and Mitras have been able to reach out to 399 people in their community. Anjali has provided services for 1,113 people, including those living in institutions.

A total of 75,519 people have been rendered services and support by our partners.

## Training & Capacity Building

<b>PARTNER</b>	<b>REACH</b>
iCall	3193 persons
Atmiyata	+ 841 persons
Bapu Trust	+ 8281 persons
Anjali	+ 125 persons
<b>TOTAL</b>	<b>12440 persons</b>

iCall has trained 3193 people, including 1900 Maharashtra police officers, 543 counselors and other helplines, 430 peer counselors and mentors, and 220 HR heads from NGOs and CBOs. The Bapu Trust has conducted training and capacity-building workshops with 8,281 participants through 28 training sessions, including an Art Based Therapy course for mental health professionals, and trainings based on the CRPD (Convention on the Rights of Persons with Disabilities). Atmiyata has trained 841 Champions and Mitras in the Mehsana district of Gujarat. Anjali has trained 125 persons based on a psychosocial model of disability rights-based framework. In all, the training and capacity building aspects of our partners has ensured 12,440 people are better equipped to support mental health initiatives in their communities.

# Referrals & Linkages

<b>PARTNER</b>	<b>REACH</b>
iCall	130 links
Atmiyata	+ 72 links
Bapu Trust	+ 536 links
Anjali	+ 225 links
<b>TOTAL</b>	<b>963 links</b>

Referrals and linkages are the heart of a sustainable mental health ecosystem. iCall has created a crowd-sourced list of 130 trustworthy mental health professionals, including psychiatrists and psychologists, from 12 states. The Bapu Trust has made 536 referrals for reasons ranging from livelihood and vocational training, health issues, de-addiction, education, official certificates, and social schemes. Atmiyata has made 72 referrals; their two-tier model connects various groups from within the community, through Champions and Mitras, to public healthcare facilities, social justice systems, as well as to the iCall helpline. Anjali has made 225 referrals, connecting with the government, NGOs and Community-based organizations, media and citizens' forum to engage in conversations around mental health policies and guidelines. 963 connections have been made between our partners and other organizations, resources, and professionals.

# Research

## PRESENTATIONS AND PUBLICATIONS

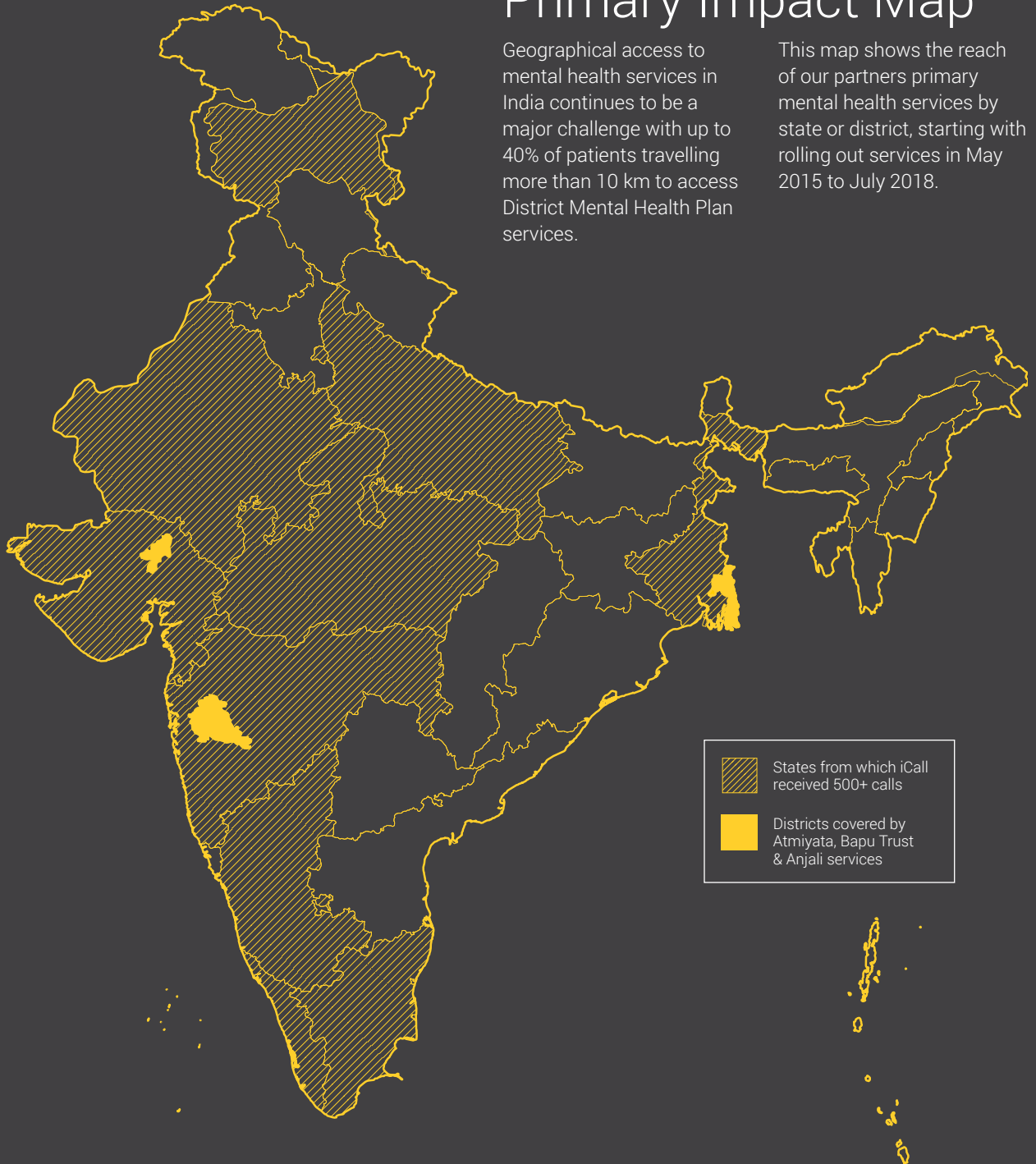
<b>PARTNER</b>	<b>RESEARCH</b>
iCall	39
Atmiyata	+ 10
<b>TOTAL</b>	<b>49</b>

Our partners have published and presented a total of 45 papers and briefs. iCall's 39 papers include 'Mental Health Stressors and Service Needs of Lesbian, Bisexual and Transgender Individuals in India', 'Providing psychosocial interventions through email based counselling', and 'Responding to the Psychosocial Needs of Adolescents and Youth in India'. Atmiyata has been involved in 10 research related activities including, publishing policy briefs, conference presentations and dissemination meetings.

# Primary Impact Map

Geographical access to mental health services in India continues to be a major challenge with up to 40% of patients travelling more than 10 km to access District Mental Health Plan services.

This map shows the reach of our partners primary mental health services by state or district, starting with rolling out services in May 2015 to July 2018.



# Demographic Snapshot

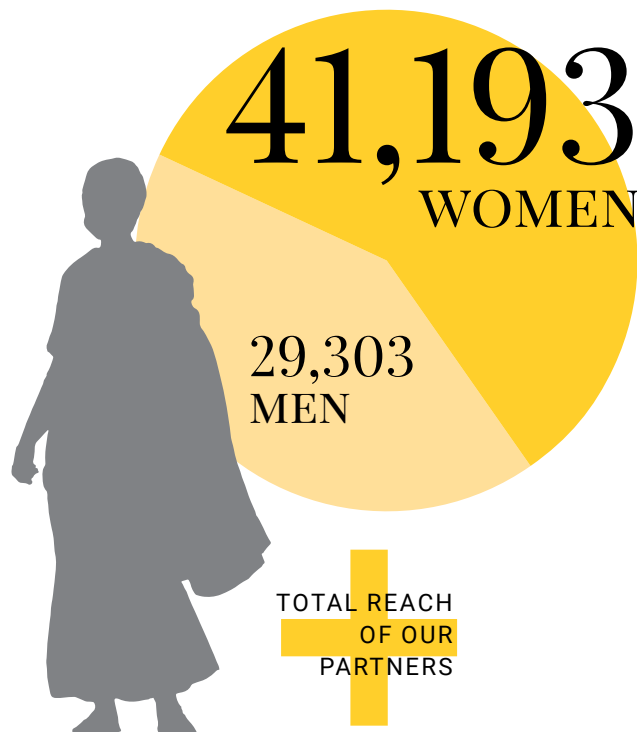
Overall, iCall has reached 92,566 people, The Bapu Trust has reached 42,168, The Atmiyata Project has reached 11,750, and Anjali has reached 1975. The overall outreach is 1,48,459 people.

Bapu Trust + Anjali  
23,930 + 266

**24,196**

## ECONOMICALLY VULNERABLE

All our partners provide free-of-cost or very highly subsidized services, and our funding has supported The Bapu Trust and Anjali to deliver services to 24,196 people from economically vulnerable communities. Our partner organizations have also worked with unemployed people, homeless people, and single parent households.



## GENDER & SEXUALITY

Gender sensitization is central to MHI's mission, and our partner organizations all strive to be accessible, supportive, resources that are cognizant of gender biases and inequality in mental health. Our partners worked directly with a total of 41,193 women, and 29,303 men. This is significant because women, as a vulnerable population, have comparably less access to health resources than men.

iCall team has been sensitized to issues faced by the LGBTQIA+ community, and they have provided services to 40 people from the community.

iCall + Bapu Trust  
6,237 + 1,227

7,464



**AGE**

iCall, through their Fostering Strengths program, and The Bapu Trust, work with adolescents, and together they have supported a total of 7,464 adolescents and youth.

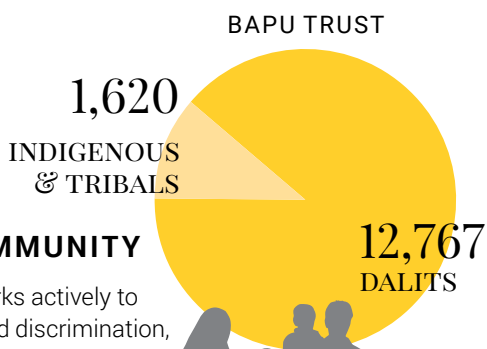
Bapu Trust + Anjali

4,336



**RELIGION**

Anjali and The Bapu Trust have provided direct services to 4,336 people from minority religions.



**CASTE & COMMUNITY**

The Bapu Trust works actively to counter caste-based discrimination, which is a barrier to accessing quality mental healthcare; it has worked with 12,767 persons from Dalit communities. Atmiyata and Anjali have also worked with Dalit communities, bringing the total number of Dalit persons who have received services to 12,848.



The Bapu Trust has reached out to 1,620 people from indigenous and tribal communities.

Bapu Trust + The Atmiyata Project + Anjali

624

**ABILITY**

The Bapu trust, The Atmiyata Project, and Anjali, have collectively worked with 624 persons with disabilities.



# Partner Challenges

Issues MHI's  
Partners' address

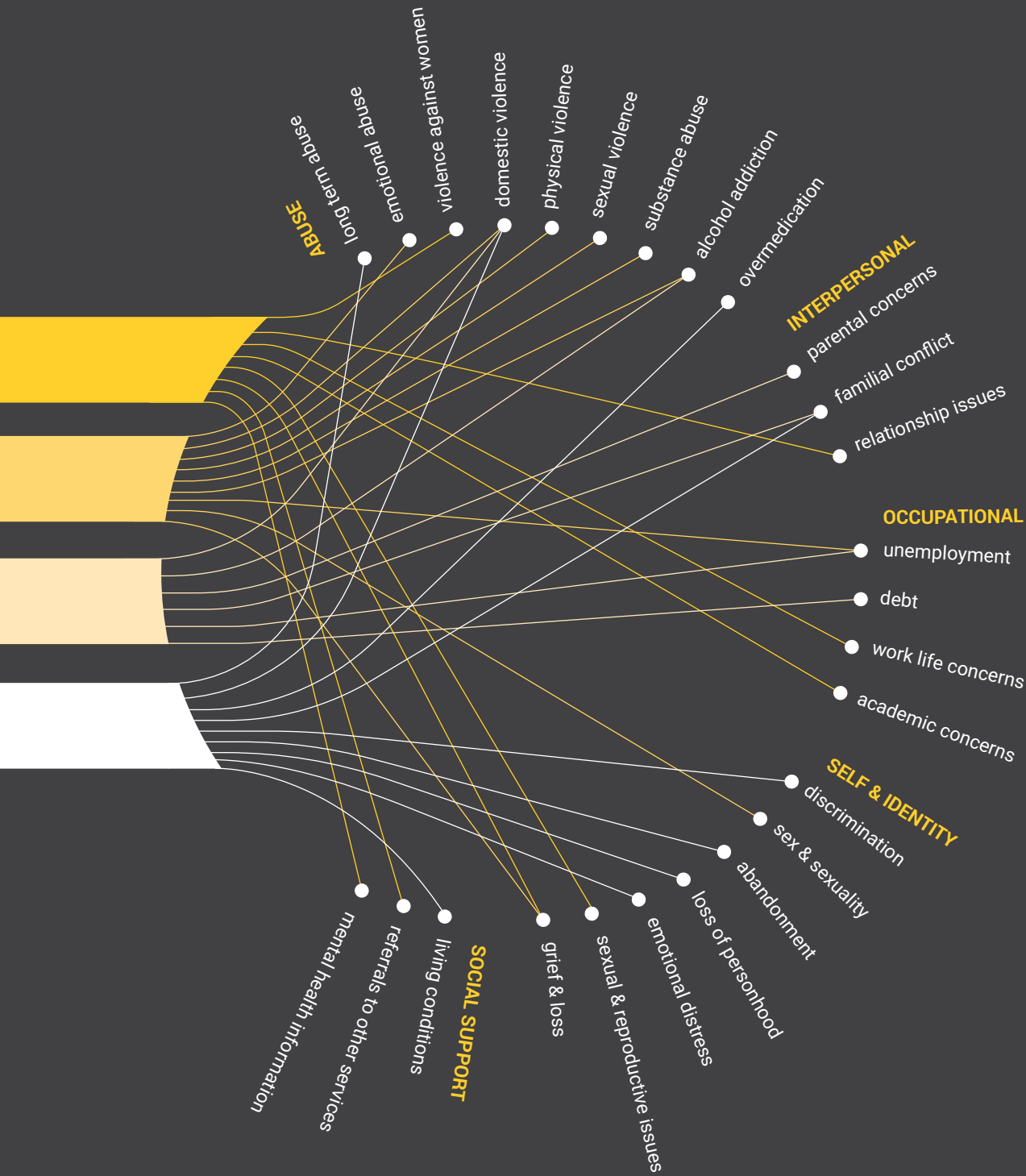
iCALL

Bapu Trust

The Atmiyata Project

Anjali





# iCALL

*Service delivery through telephone, email and chat counselling*

## ACHIEVEMENTS

Trained over 5000 counselors

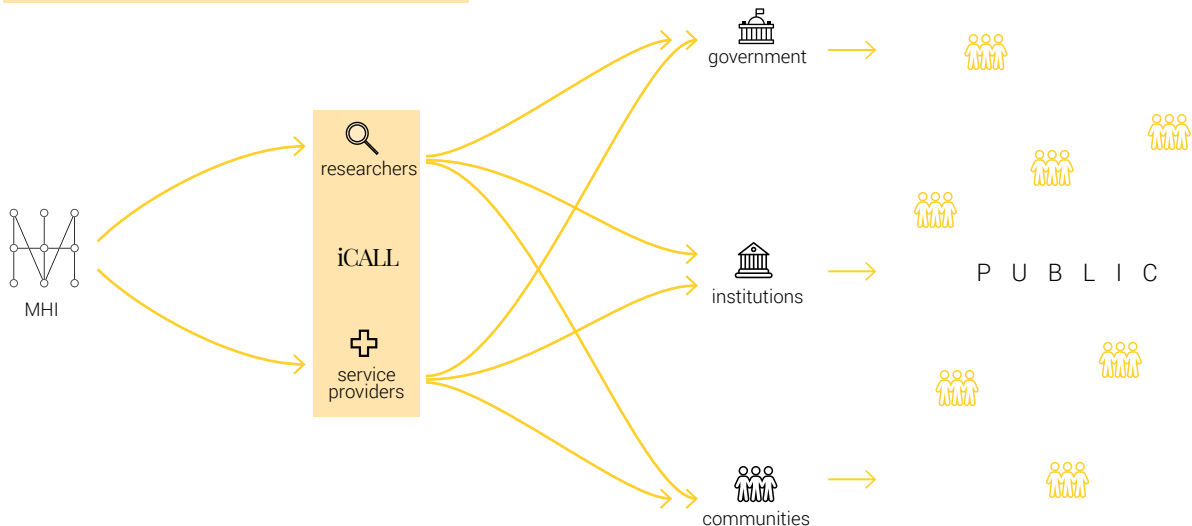
## LOCATION

Pan India

## THEMES

Capacity Building, Research

iCall began as a Field Action Project of TISS (Tata Institute of Social Sciences), Mumbai, in 2012. A psychosocial helpline, it offers professional and confidential counseling via email, telephone, and chat, to anyone in need of emotional support, irrespective of age, gender, sexual orientation, or regional location.



## approach

iCALL's counseling is a non-traditional form of providing mental health support. It helps in eliminating geographical limitations, is free and completely confidential. iCALL's counseling services are run by professional, trained counsellors, from Monday to Saturday, 8.00 a.m. to 10.00 p.m and offered in Hindi, English, Marathi, Gujarati, Punjabi, Bengali, Tamil, Telugu, Malayalam and Konkani. iCALL also has partnerships and collaborations with academic institutions, corporates, government, and non-government bodies.

## partnership with mhi

In 2015, MHI became sole funder for iCall, which has since expanded the scope of its activities, going beyond service provision to work in the areas of advocacy, research, capacity building, and networking. With MHI's financial and strategic support, iCall made significant additions to its technological infrastructure to ensure effective service delivery – refining the quality of, and enabling greater access to, its services. Sustained support from MHI has helped iCall extend their on-job training period for counselors to three months (from a week), and implement policies for

self-care and burnout prevention at the workplace.

Using MHI's networks and expertise, we have been facilitators and advisors for iCall on multiple occasions. Initially, we used our contacts in the non-English-medium press to spread the word about iCall. The first review as well as strategic thinking and planning exercise for iCall was initiated and partly conducted through MHI. We facilitated iCall's partnering with Maharashtra Police to conduct mental health workshops, and with the newspaper Dainik Bhaskar for enhancing students' well-being in Kota, Rajasthan. MHI also advises iCall on fundraising through other sources.

## achievements

iCall has directly trained more than 5000 counselors and mental health professionals through its capacity building efforts. These have involved a range of stakeholders across the country in academic institutions, government bodies, as well as NGOs and CBOs.

Additionally, iCall has compiled an extensive crowd-sourced list from 12 states, of "Mental Health

Professionals we can trust". This list is available online, and indicates which mental health professionals charge fees on a flexible or sliding scale, are LGBT-friendly, non-judgmental, and so on. Each professional on the list has been vetted by a user of their services – in keeping with MHI's approach, which centers user-survivor experiences. iCall also maintains a referral directory, and can provide recommendations if a caller wishes to see a mental health professional in their locality. The referral network is also invaluable in crisis situations, when individuals require urgent support.

iCall has undertaken a significant amount of research, leading to publications and conference presentations. They have presented more than 10 papers in conferences across India, brought out over 30 newsletters, and, in 2016, contributed to a book published by Springer, under the aegis of the School of Human Ecology at TISS. The research papers presented include 'Providing Psychosocial Interventions through Email-Based Counselling', and 'Ethical Frameworks Followed by and Ethical Dilemmas Faced by Helplines'. iCall has also

disseminated findings from different projects, using various media, and are currently working on four more papers for publication.

### **community focus** **Communities Marginalized by Gender and Sexuality**

iCall trains its counselors on matters of gender and sexuality, introducing trainees to diverse perspectives. Activists, academicians, and other experts in the fields are frequently called upon to conduct classes and workshops. The training includes practicing mock calls, and shadowing senior counselors. This equips trainees to address issues around gender identity, sexual orientation, violence in intimate relationships, familial conflicts, gender confirmation coming out, and so on.

In 2015, MHI facilitated a national-level consultation of LBT (Lesbian, Bisexual, Transgender) collectives and practitioners, on behalf of iCall, to highlight the unique stressors and mental health issues experienced by LBT individuals. iCall has, since, presented research on 'Mental Health Stressors and Service Needs of Lesbian, Bisexual and Transgender Individuals in India'.

### **Adolescent Mental Health**

iCall, jointly with Vishakha, an NGO in Rajasthan, offered a short-term course on 'Fostering Strengths: Skills and Perspectives for Enhancing Psychosocial Wellbeing of Adolescents and Young People'. The first run of this course, with 17 participants, was from April to September 2017 at TISS, Mumbai, and was facilitated by a team of experts specializing in different areas concerning adolescents and young adults. The course was intended for professionals working with these age groups, and aimed to equip them with contextualized, evidence-based, multi-level skills and intervention methods.

Informed by a participatory, empowerment-oriented approach, the course is delivered through a nine-day residential institute, followed by a three-month practicum (field) component with weekly supervision, and finally a three-day contact class. The nine-day syllabus includes frameworks, values and perspectives to set the context for working with adolescents and young people in India; the psychosocial concerns of these groups; and foundational counseling skills for working with them. A key objective

of the follow-up contact session is to create a platform where participants are encouraged to share the unique psychosocial interventions they designed and implemented in the course of their fieldwork. Another important aspect is to provide additional training sessions, based on the specific needs felt and challenges faced by participants during the practicum.

Course modules impart an understanding of: gender and sexuality; relationship concerns; abuse, violence and trauma; addictions – substance-related, and habitual; suicidal and non-suicidal self-harm; academic and career-related concerns. The course also, significantly, emphasizes the need for self-care for the mental health professionals themselves.

iCall takes an affirmative stand when engaging with minors, protecting their right to privacy while apprising them of all options they have in crisis situations. It uses its referral system to connect adolescents with other resources – for example, with state board helplines for immediate redressal of their academic queries and concerns. They also inform clients about their legal rights, and

about how they may access the services provided under the Mental Health Care Act.

'Responding to the Psychosocial Needs of Adolescents and Youth in India: iCall Psychosocial Helpline' and 'Profiling Adolescent Stress in Kota, Rajasthan: Findings from a Psychosocial Helpline' are research papers that emerged from these engagements.

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## case study

### Context/ Background

The caller is 25, male, connecting with iCall over the past year and a half, from a location in Maharashtra. He reached out initially for help with managing his studies. The caller had been diagnosed with Bipolar Disorder six years ago, and had been experiencing cycles of manic and depressive episodes since, but had not had any symptoms in the last two years. However, he said that he had recently been experiencing spurts of mania again. This made him anxious, as he dreaded an escalation into a full-blown manic episode. The recurrence of his symptoms, and the consequent apprehension and anxiety, had severely affected his ability to cope with academics.

### Work in the sessions

The counselor was able to identify that a significant amount of the distress stemmed from the client's own beliefs and ideas connected with the symptoms. The client spoke about the feelings of shame, embarrassment and fear associated with his manic episodes in the past. These feelings had prevented his being able to talk about his troubles, or ask for help. One of the insights gained from the sessions was about the client's pattern of social withdrawal and self-isolation during his manic episodes, so as to cope with shame, and with the fear of being judged.

### Psychosocial interventions

- Psycho-educating the client about the symptoms and nature of the disorder
- Working with the client to identify red flags to help anticipate manic episodes, and keeping coping strategies ready
- Practising self-help skills and techniques to manage current distress
- Identifying and strengthening social support systems to encourage help-seeking behavior
- Encouraging adherence to ongoing medical treatment

### Outcomes

The client reported that he felt encouraged to seek help from his parents, doctor, and social support system, and to practise the self-help techniques which helped him manage day-to-day distress. As a result, he was able to concentrate on academics. Insights gained through psycho-education helped him understand warning signs and triggers, and he learned to apply coping strategies in response to manic symptoms. In conclusion, he reported feeling more empowered, in better control of his current distress, with a marked improvement in overall mental well-being.

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# The Atmiyata Project

*Rural service delivery through community-based mental health*

## ACHIEVEMENTS

Services to 300 villages

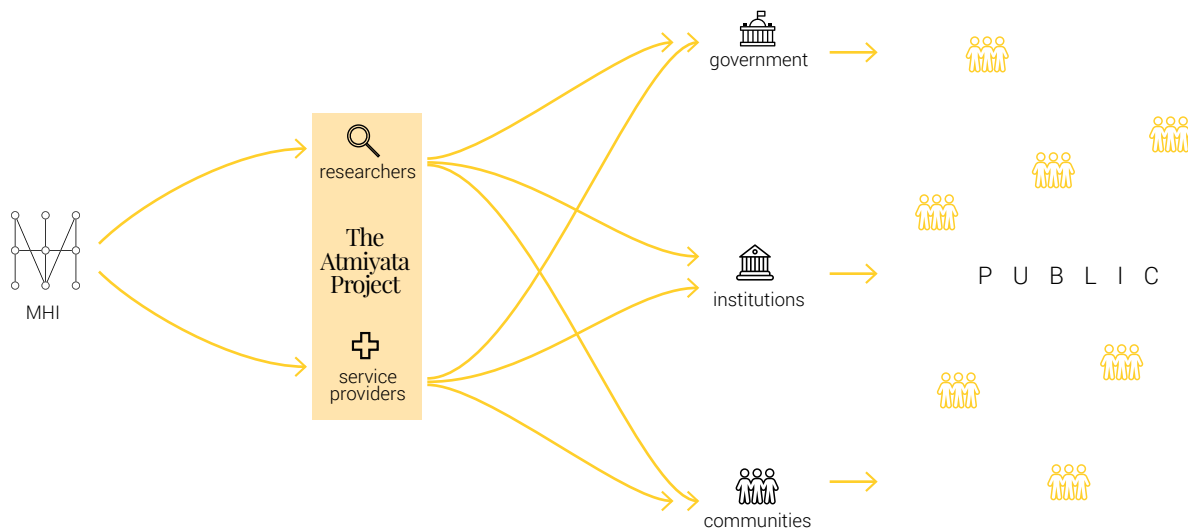
## LOCATION

Mehsana, Gujarat

## THEMES

Capacity Building, Research

The Atmiyata Project was initiated by the Centre for Mental Health Law & Policy (CMHLP) of the Indian Law Society, to protect and promote rights of persons with mental health challenges through capacity building, engaging civil society, strategic litigation against discrimination, and working to implement rights in community and public health systems.



Atmiyata is a low-cost, high-impact, two-tier, community-led mental health model, that develops the capacity of community volunteers to identify and provide primary support and counseling to persons with emotional stress and common mental health disorders, and make referrals to the public health system in instances of severe mental illness.

## approach

The Project imparts training in its philosophy, to its Community Facilitators, 'Atmiyata Champions', and 'Mitras' (friends), ensuring that both theoretical knowledge and practical tools are made available. The trainees are coached to navigate difficult situations that may arise in the field, and to create awareness about mental health in sensitive and easy-to-comprehend ways. The Champions and Mitras receive training for seven days and one day, respectively, and this is followed up with refresher courses. The ratio of Champions is 1 per 1000 persons in the villages, and they are mentored and supported by Community Facilitators (CFs), 1 for every 60 Champions. The Champions work closely with the Mitras.

The Project uses a software application for Champions to record their work, and another for CFs to review the data collected, resulting in continuous mentoring and support, with a view to assuring quality services. Pre- and post-training assessment tools have been designed to measure regional changes in attitude, as well as knowledge of issues to do with MH.

Atmiyata's two-tier model engages with a number of stakeholders, and creates a robust referral network within the community, as well as public healthcare facilities.

### Tier 1

Within the community, Champions and Mitras work with pre-existing self-help groups and farmers collectives, creating awareness among members about mental health and well-being. Other stakeholders range from the Sarpanch, Gram Panchayat leaders, Anganwadi workers, ASHA workers, Primary Health Centre staff, and others who are trusted and respected in the community.

### Tier 2

The Project facilitates referrals for mental healthcare needs to public

healthcare facilities and district hospitals, as well as to relevant district authorities in the public health and social justice system. Referrals are also made in cases of domestic violence and substance abuse, for access to legal aid, shelter homes, and employment generation centers.

The Project has partnered with a local non-profit organization called Altruist, which works on implementing the District Mental Health Program in collaboration with the Dept of Health and Family Welfare, Govt of Gujarat. Links have also been forged with one of MHI's other partners, the iCall Helpline.

Atmiyata uses the Reach, Effectiveness, Adoption, Implementation and Maintenance (RE-AIM) framework to evaluate implementation processes followed in its interventions. RE-AIM enables a systematic assessment that can inform scaling up to include other districts in Gujarat. The primary objective is to assess the effectiveness of counseling packages delivered by community volunteers to reduce mental health distress, and improve the quality of life for people with common mental

disorders (CMD), enhance social participation for people with mental health issues, increase satisfaction with the mental healthcare services delivered by community volunteers, and, ultimately, reduce overall stigma around mental health in the community.

### **partnership with mhi**

MHI is a co-funder for Atmiyata along with Grand Challenges Canada, with which it will be matching funds over the 2016-2019 period. By March 2019, Atmiyata will have been implemented in 500 villages. Beyond its funding role, MHI has lent support to the Atmiyata Project through its contacts and innovation networks. The Technological team at Marico, at MHI's behest, reviewed the Project's smartphone- and tablet-based application for Champions and Community Facilitators, and advised Atmiyata on their concerns with their current technological partners, and their scaling up plans.

Atmiyata is also working towards identifying challenges in their documentation and reporting processes, on advice from the Marico Sales team, with the latter scheduled to visit the Project site in September 2018 to offer practical solutions and

suggestions. MHI has also been involved in discussions on ways to find more sources of funding for CMHLP.

### **achievements**

In 2016-2017, the Project reached out to **7,600** people in a population of **14,000** in its pilot phase implemented in Nashik. Currently, **300** villages in Gujarat's Mehsana district have been covered. In 2017-2018, the Project successfully trained **364** Champions, including **168** women, and **477** Mitras.

### **community focus**

Mehsana is a politically active district with visible barriers based on caste, gender, and religion. Since the Atmiyata Project is implemented primarily through volunteers and facilitators, it is imperative to engage with these multiple factors, and their intersections, both when identifying volunteers, and during training and outreach. Community Facilitators are trained to identify volunteers who can negotiate social and cultural barriers and thus reach out to the community more effectively.

At the recruitment stage, the Project ensures representation from all sections, actively seeking to enlist

members of the Dalit community. At the training stage, the trainers frequently focus on the concept of social justice, and address subtle biases such as the 'savior complex' sometimes seen in upper caste volunteers and facilitators. The process also addresses gender bias, and a significant number of the participants are women. Volunteers and facilitators are also introduced to disability from a rights-based perspective during their training. They learn the basics of how best to broach difficult and sensitive issues related to mental health, and are also equipped with referrals they can use if necessary.

Looking at mental health in a developmental context, the Atmiyata field staff also aids the client in availing of disability certificates and social benefits, also providing information on social benefits available for caregivers.

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### **case study**

#### **Context/ Background**

Sangitaben is an Atmiyata Champion from the village of Kamili, in Unjha taluka, Mehsana, Gujarat. During the Champion's seven day training, Sangitaben had identified a person



in her neighbourhood that she wanted to approach and work with. The prospective client used to run a beauty salon but had stopped going to work a couple of months earlier due to domestic struggles. She reported that her husband had become suspicious of her since she began working and ultimately she stopped stepping out of her home entirely.

### **Work in the Sessions**

Sangitaben heard the client's story patiently and realized that the client was under immense stress. She decided to use the skills of active listening and behavioral activation she had learned during the Atmiyata training. Sangitaben asked the client detailed questions about the distress that she was facing, understood the history of her distress and what she would like to do to address her issues. Sangitaben had also sensed that the client's confidence in herself had weakened and it had to be rebuilt so she could eventually consider going back to work. To do this, Sangitaben encouraged the client to take a short walk with her a few times and eventually, they agreed to begin visiting her old salon. Slowly, Sangitaben gently coaxed the client on working with a few people at the

salon and helped her build greater confidence to go back to her work at the salon.

### **Psychosocial Interventions**

- Going over the client's history
- Discussing the stressors being experienced with the client and helping her understand them better
- Using behavioural activation to help client engage in activities that can be enjoyable (like taking walks)
- Encourage the client to continue their therapeutic treatment

### **Outcomes**

The client has now gone back to her work at the salon for two hours every day and has reported that while her struggles at home continue, she feels more confident and hopeful about being able to take care of herself and her children.

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# Bapu Trust

The Bapu Trust for Research on Mind & Discourse, a registered NGO based in Pune since 1999, envisions a world where emotional well-being is experienced in a holistic manner, in healing environments that use creative, non-violent, non-hazardous, playful methods, with every person using their own capacity to make choices. The Trust works with multiple stakeholders within the development sector, in areas that include disability, poverty, and other marginalizations; gender; livelihoods; social justice; health education; and policy and law.

*Inclusion and mental wellness in urban bastis*

## ACHIEVEMENTS

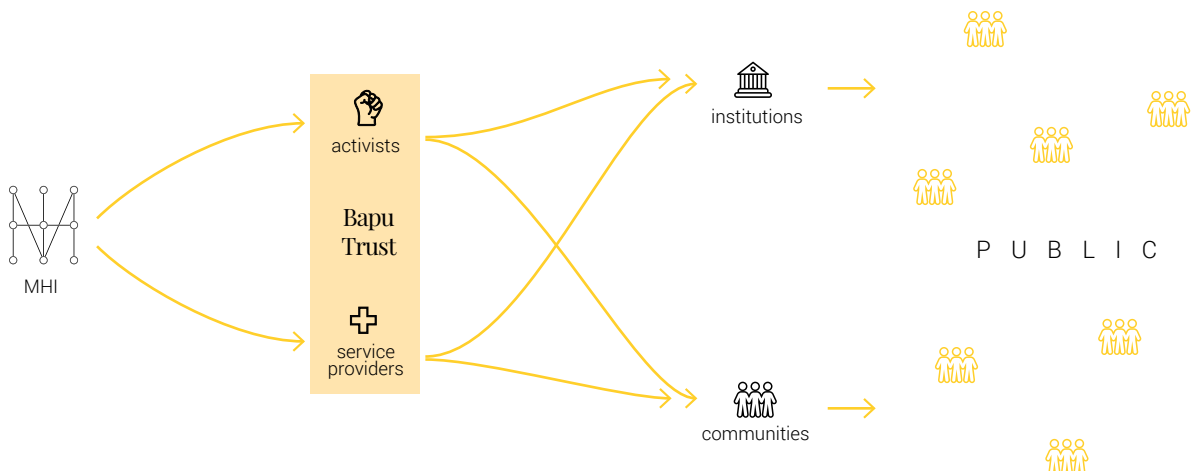
Provided services to over 10,000 people

## LOCATION

Pune, Maharashtra

## THEMES

Advocacy, Lived Experiences



## approach

The team conducts an internal seminar every month, to discuss issues ranging from sexuality, domestic violence, and menstruation, to mental health recovery and inclusion. These sessions help sensitize the team to many aspects of mental health, and are self-reflexive exercises to help staff acknowledge and address biases and prejudices they may unconsciously harbor. The senior staff has trained counselors and field workers first to question their own judgments and preconceived ideas around sexuality and power, and then, through advocacy, awareness, and counseling efforts, demystify ideas around sexuality and intimacy prevalent in the community.

The Trust has always straddled two universes of practice – non-medical healing practice, and social justice practice. In building synergy across these two dynamic universes, the Trust rests firmly on the two pillars of contemporary healing arts and disability thinking – Arts-Based Therapy (ABT), and the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).

## partnership with mhi

MHI has extended strategic advice on multiple occasions to Bapu Trust, along with financially supporting the INTAR (International Network Towards Alternatives and Recovery) India Conference in 2016, and the 2017 edition of the ABT (Arts-Based Therapy) Course.

Bapu Trust's scaling up plans have benefited from periodic meetings with Harsh Mariwala, Founder, MHI, for planning towards their future goals of accelerating capacity building and training in the field, besides their current role as a major service provider in the area of mental health. As a first step, MHI facilitated a planning and vision exercise with human resource expert, Pankaj Bhargava. This spanned multiple exchanges with an array of stakeholders. MHI's Human Resource team facilitated a budgeting and finance session for the Trust, and assisted them in choosing suitable partners for their scaling up and expansion efforts.

## Seher

Bapu Trust has developed a 'model' service program, Seher, that links development, disability, communities, and mental health. Through its

Community Wellness Centres, Seher has been working in the area of urban community mental health, in collaboration with the Pune Municipal Corporation.

Seher (which means dawn) is a comprehensive urban mental health program that envisions sustainable psychological health through community development, and aims to facilitate the creation of caring communities through multi-level actions, and a broad range of partnerships. The program builds on principles of social entrepreneurship to enable the full inclusion and participation of people with diverse needs. The underlying belief is that, like money and other material or natural resources, emotional resources, too, may be transacted across people and associations. The Trust's partnership with MHI entails upscaling and replicating the Seher model in five slum pockets of Pune city, with the active collaboration of the Municipality (Departments of Health, Urban Community Development, Disability), and a variety of local partners. The program will work with numerous strategies: multiplying emotional resources through the development of psychosocial support and

caregiving networks, both formal and non-formal; provision of specific mental health and well-being services to address diverse mental health needs; partnerships with local government, non-state organizations, and community actors; preparing grassroots communities for care and support. Every service delivery component has a research component as well. Self-evolution practices will facilitate the continuous upgrading and professional development of staff.

### **Arts-Based Therapy (ABT)**

Arts-Based Therapy' is a term that was coined by WCCL Foundation in 2001, to represent the use of multiple art forms (music, drama, visual arts) and their combinations in therapy. ABT is the evidence-based use of art forms, integrated so as to offer choices to people with mental health problems and psychosocial disabilities, for achieving their own mental health goals within a safe, recovery-oriented, therapeutic relationship.

Experience shows that ABT can be used to address the diverse support needs of persons with mental health issues and psychosocial disabilities, including high support needs during

crises. It is considered a safe way of approaching deep-rooted habitual behaviors, and building insight, empathy and connection among individuals and families.

Being person-centered, ABT empowers individuals to become independent and active agents with regard to their own lives and choices, rather than 'beneficiaries' of some service program. ABT also enables others – family members, friends – to give necessary support, besides other basic psychosocial interventions. In its ABT practice, Bapu Trust successfully uses an eight-point Recovery Framework, addressing multiple social determinants, and working on six main domains of personal experience (self, body, cognition, emotion, the social, health, and nutrition). The Trust also offers an ABT Certificate Course for MH practitioners.

### **achievements**

Its significant research contributions include:

- A Mental Health Policy draft for Gujarat
- Books, reports, workshops and conferences relating to women, caste, culture and mental health
- Published papers on traditional

and indigenous community healing approaches to mental health; papers on disability rights, law and mental health

- Collaborations with state governments and universities
- Bapu Trust has hosted local, national, and international training programs for mental health professionals, government agencies, family court counselors and judges, and primary caregivers, besides other constituencies.

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### **case study**

#### **Context/ Background**

The client, a woman in her 40s had confined herself to her house for a month, didn't speak to anyone, and threw utensils at those who attempted to talk to her. She hurled abuses at people, and drove them off. It also appeared that she had not been eating properly for days. Initially, a field worker approached the client's house and tried talking to her through the window, not showing her face, about Bapu Trust's work with people in her community. The client was quite hostile and asked the field worker to leave.

The field worker, however, said that she will drop in the next day anyway

to say hello. This activity of simply dropping by, talking to the client through the window, never asking her to show her face or open the door, went on for several consecutive days. Eventually the client began engaging with the field worker and started keeping her door open for the community worker to walk in.

The client lived alone, in a house with no electricity or gas, and limited food provisions and was very depressed. She had been duped financially by a relative on the pretext of marriage and when pregnant, was forced to undergo an abortion. Her parents were no more and a younger brother had completed suicide. She was unable to trust anyone, feared people, and had no support system. She was also unemployed and had no money to buy food.

### Work in the Sessions

The counselor focused on providing the client with a safe space to share her story and express her anger. Work was also done with her neighbours and they were sensitized to her situation and eventually, they built a small circle of support and care around the client. Using their referral network with hospitals, grocery vendors and other

stakeholders, Bapu Trust ensured that monthly food and grocery provisions were made available to the client. The counselor also took care to conduct sessions with the client at a slow, non-intrusive pace, to accommodate her needs.

### Psychosocial Interventions

- **Self & self-care** encouraging her to start drawing and coloring, reading and writing, stepping out of the house and meeting people, talking to neighbors
- **Nutrition** vitamin supplements, food provisions, arranging tiffins, eating with her
- **Community** sensitizing neighbors and distant relatives to solicit their support
- **Individual counseling** lay counseling sessions, grief work, reducing stigma
- **Health care** referral to hospital for general health complaints, help for medicines
- **Inclusion referrals** compiling documentation to apply for electricity connection

### Outcomes

Bapu Trust continues to work with the client and is helping her address her issues of dealing with grief, self-image and self-worth, improving her

circle of care, and talking with local employers to enable her financial independence.

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# Anjali

*Deinstitutionalisation & mental healthcare kiosks in urban areas*

## ACHIEVEMENTS

Mental health kiosks in 3 municipalities and 108 women trained

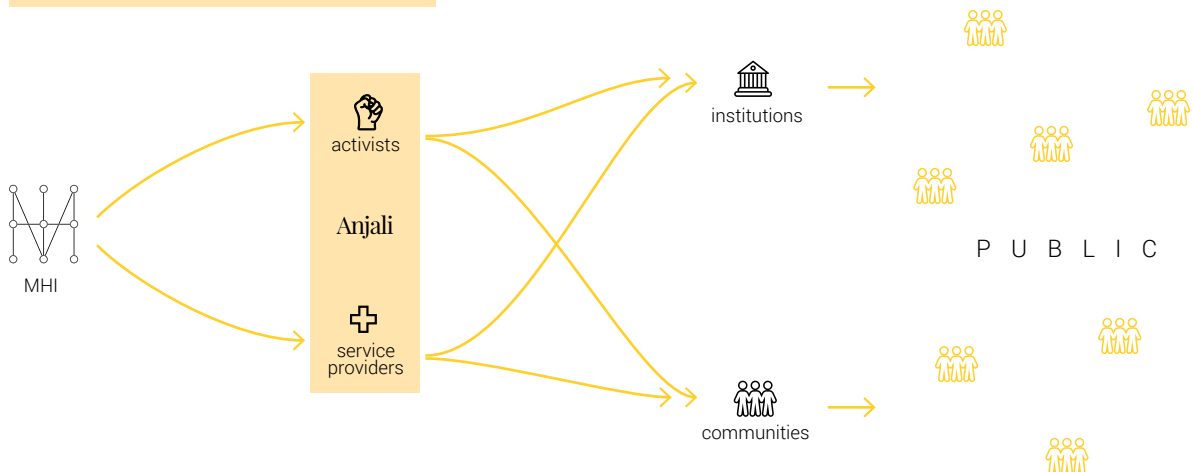
## LOCATION

West Bengal

## THEMES

Advocacy, Lived Experiences

Established in Kolkata in 2001, Anjali is the first Civil Society Organization (CSO) in India to partner with government with the aim of making state-run mental hospitals inclusive and humane, even as it strives to bring mental illness firmly into the mainstream health paradigm in the country.



Anjali continues to work in the three Govt Mental Hospitals in West Bengal where it first launched its initiatives – Calcutta Pavlov Hospital and Lumbini Park Mental Hospital in Kolkata, and Behrampore Mental Hospital in Murshidabad district. More than 90% of the participants are women from resource-poor communities, and the vast majority are unemployed.

### **approach**

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

- To establish mental health within the mainstream health and development discourse in India
- To build new identities for people with psychosocial disabilities so that they are perceived as 'full citizens', by ensuring progressive shifts in the dignity and quality of their lives within institutions, families, and communities
- To foster trainings, networks, and collaborations between individuals and organizations in criminal justice and health- and rights-based CSOs, thereby encouraging new talent, perspectives, and leaders to emerge in the mental health sector

### **partnership with mhi Voices**

The Voices initiative began as a response to the unbridled abuse, scarcity of food and water, inadequate general healthcare services, and the apathy of hospital staff and their demeaning treatment of patients. The rehabilitation of patients and their reintegration into families was not part of the agenda of government-run facilities – many people were left to languish in institutions for life. Conditions inside the overcrowded wards were extremely unhygienic. Women patients were routinely given electroconvulsive therapy (ECT), and subjected to physical abuse.

First launched in Calcutta Pavlov Hospital, where Anjali had been working with patients and staff for some years, Voices is now an ongoing, institution-based capacity building program, with 90 residents in three government-run facilities. Its chief objectives include: redesigning all services by the institutions, while centering a human-rights approach; and developing a replicable model that can be adopted by different state governments.

The focus is to de-institutionalize participants and relocate them back in their communities, while ensuring their participation and consent in all decisions related to their lives. The program managers and counselors attend a training program that familiarizes them with the social model of disability, and with a rights-based approach towards mental health. Sessions follow a comprehensive curriculum that focuses on building communication and leadership skills with the participants.

The program components are: capacity building to provide cognitive and life skills, empowering people with psychosocial disabilities to speak up for their rights; social inclusion of participants as rightful citizens within their communities and society at large; enabling gainful engagement for participants, thereby breaking the prevalent notion that people with severe mental illness are unemployable.

### **Janamanas**

The Janamanas Community Health Program aims to create a community hub to enable isolated communities to secure mental health, with a special focus on women and adolescents.

Anjali developed Janamanas (collective mind) as a model of community-based mental healthcare, working in partnership with urban municipal wards. The program envisions coordinating with government bodies in order to mainstream mental health services in the public health service delivery system. The aim is to demonstrate the possibilities of empathetic, community-owned care, and the integration of persons with psychosocial disabilities in ways that are affordable and accessible for the most marginalized sections.

Janamanas was initiated in 2007 in three municipalities, with 108 women from the North Dum Dum community being trained in phases to operate Community Mental Health Kiosks. The program, which expanded over the years to cover two more municipalities, connects up with Anjali's existing dialogue-based mental healthcare service through kiosks managed by trained, resource-poor women in underdeveloped urban localities. The project includes counseling of family members, and advocacy by community workers for the inclusion of those with psychosocial disabilities in municipal planning, services, and facilities. It

entails continuous capacity building, trainings, and workshops for community workers, and events like awareness camps. The program also has a three-month training period that incorporates mental health, the self and rights, gender and sexuality, and society and leadership.

The Janamanas Program trains its counselors through a comprehensive curriculum that draws from the psychosocial model of disability and mental health, and uses a rights-based approach. Anjali also emphasizes self-care for the trainers – building resilience through mindfulness and other self-care techniques. Additionally, it works towards the reintegration of formerly institutionalized women with their families and communities. The team collaborates with the local Municipal Corporation, police officials, panchayat members, and community leaders, to create support networks for clients. It is led and managed by women from rural and semi-urban localities, thus encouraging community agency, and centering community narratives.

### **achievements**

Anjali has implemented two livelihood initiatives at Calcutta

Pavlov Hospital: 'Cha Ghar' where recovered women from the female ward run a tea canteen; and 'Dhobi Ghar' where recovered men and women from the hospital run a fully automated commercial laundry. Since 2018, they also have a Block Printing Unit, which is intended to become self-sustainable.

Under the Voices program, more than 550 training sessions have been conducted between 2017-2018. Janamanas has been recognized as a 'best practice model' by the Govt of India and in as well as in an Institutional Review Board study.

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### **case study**

#### **Context/ background**

The West Bengal government has reported that at any point of time approximately 63% of bed strength of Govt. Mental hospitals in West Bengal is occupied by recovered long staying patients who are abandoned by their families. Persons with mental illness are subjected to extreme forms of stigma and discrimination and their reintegration into social life post institutionalization is wrought with challenges. Persons with mental illness find it very difficult to find a job, owing to their history



of psychiatric treatment. In order to build a sense of self and personhood within persons with mental health issues, Anjali started a Block Printing Unit at Pavlov Hospital in Kolkata. The objective of the initiative was to gainfully engage those residents of mental institutions who are long staying but recovered.

### **Details of the Initiative**

The Unit is set up within the male ward of the hospital. The program, initiated in April 2017 began with several focus group discussions, to understand the interest of the male residents towards block printing. A group of 15-16 men went through an intensive 2 month training following which 11 participants were selected to work in the unit. The 11 male participants of the unit engage with a skilled trainer to collaboratively design and create block printed products. Unique designs created by the participants are curated and constructed into wooden blocks used for the production of these items.

### **Outcomes**

The Block Printing Unit has been immensely well- received by the participants and has helped foster purpose, discipline, team-work and camaraderie. It has also led

to the participants feeling a sense of greater financial independence and higher self- worth. Owing to the success of this unit, Anjali is now exploring partnerships with organisations to be able to showcase and promote the products prepared block printing unit team.

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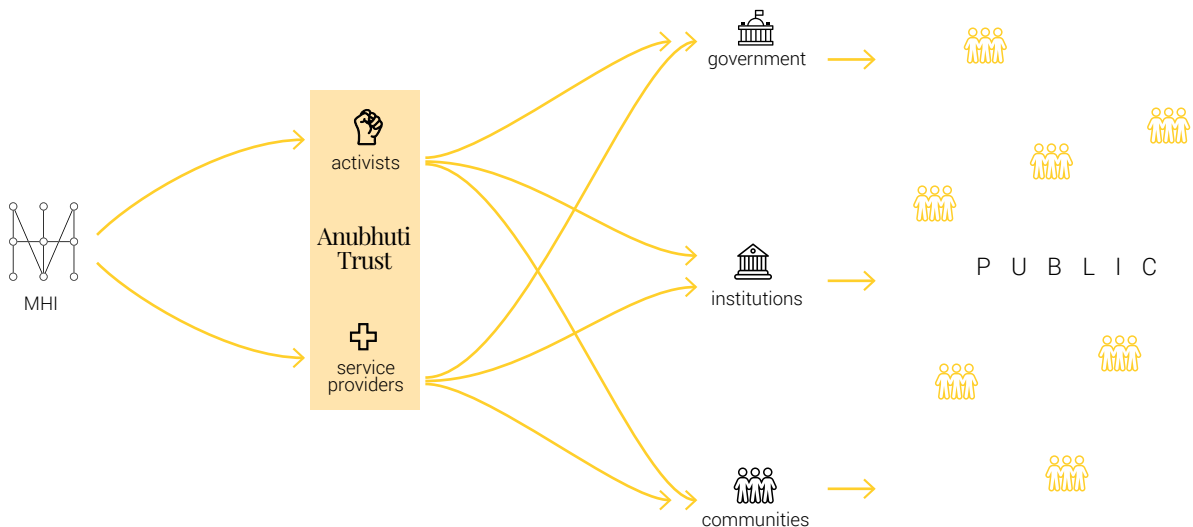
# New Partners

## anubhuti trust

Anubhuti Trust, an organization formed and led by young women, works in the areas of youth leadership, stakeholder sensitization, awareness, and advocacy. In order to promote youth leadership, Anubhuti aims to reach out to young people across sectors – communities, schools, colleges, NGOs, youth groups and political parties. Mental health is a significant aspect of Anubhuti's work – its Community

Development Committees, comprising trained local youth, lead counseling and awareness drives, besides advocacy with local and municipal government for development-related issues affecting their localities. Encouraged by the success of its mental health interventions in two communities, Anubhuti plans to expand this aspect of its work to include the semi-rural Kalyan-Dombivali locality in Thane district, and to the urban

Vile Parle neighborhood of Mumbai city. The project has several components: inculcating in its Community Development Committee members a feminist understanding of mental health; reaching out to entire communities in order to destigmatize mental illness; reaching the most marginalized, including the adivasi settlements on the periphery of its chosen field locations.

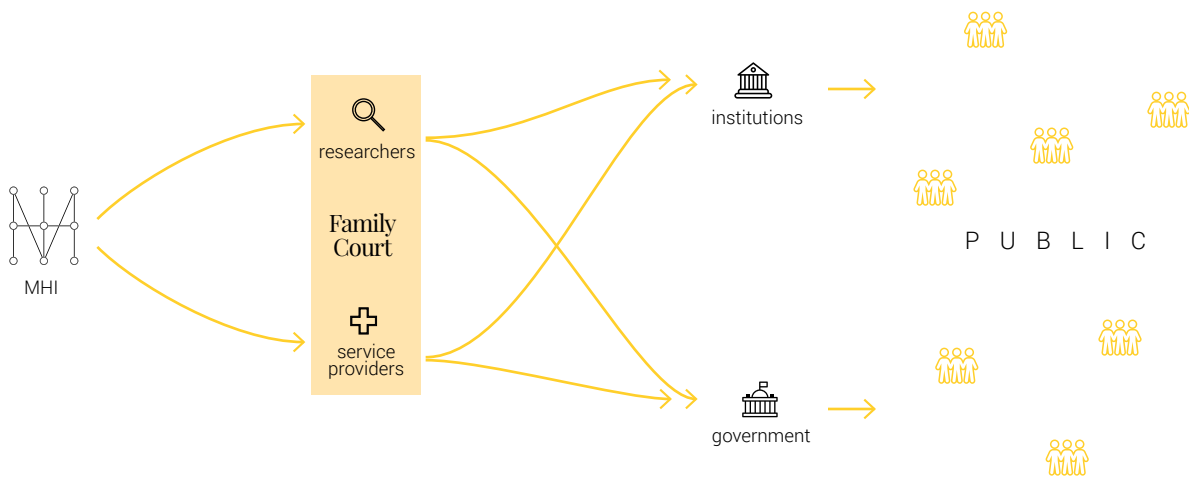


### family court counseling centers

This project, like iCall, was initiated as a Field Action Project of TISS (Tata Institute of Social Sciences), Mumbai, with MHI as its sole funder. Its broad aim is to understand the marital concerns and stressors experienced by litigants in Maharashtra’s family courts, and to develop counseling and other interventions to address these. The long-term plan is to expand this model to all 11 family

courts in the state. The project is aimed at establishing, counseling services that address conflicts experienced by couples, and related emotional distress, using an approach that is gender sensitive, rights-based, non- pathologizing- anthropologizing, and empowering. Such a service would operate from a perspective that recognizes, and helps couples negotiate, issues of gender and power. MHI support will also help initiate a research study on

the interventions made – the findings will be used to share knowledge, and help build replicable models for effective couple counseling interventions.

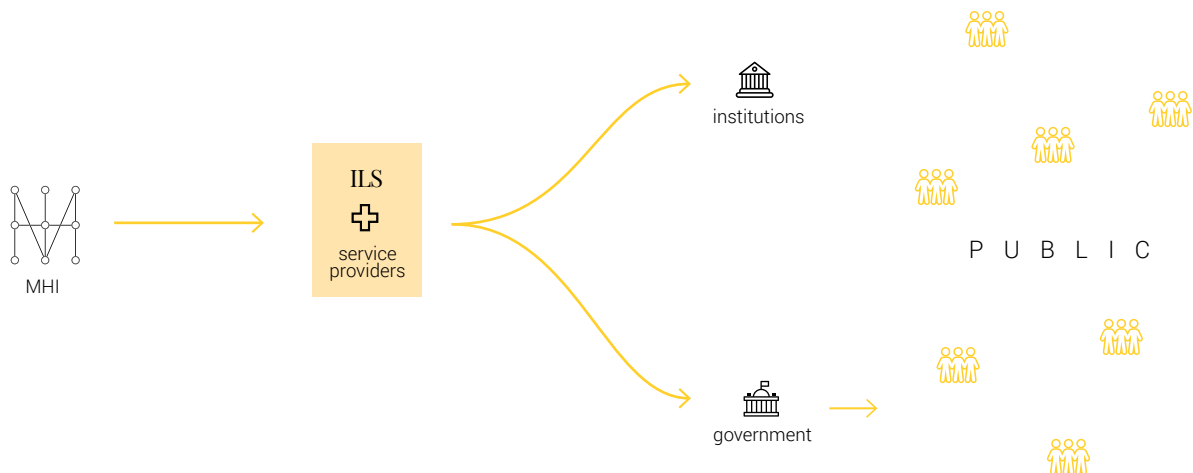


## training on implementation of the mental healthcare act, 2017

Developed under the aegis of the Indian Law Society, Pune, this project is intended to help build capacities for a range of stakeholders affected by the Mental Healthcare Act (MHA). Customized training modules are to be designed for paralegals, mental health professionals, and

other service providers, such as caregivers, service users, and government authorities. The project plan includes the development of a mobile application for MHA, contextualized for local use, and providing information on the systems set up under the Act. MHI envisions this project as leading to a paradigm shift in the way diverse stakeholders in the country

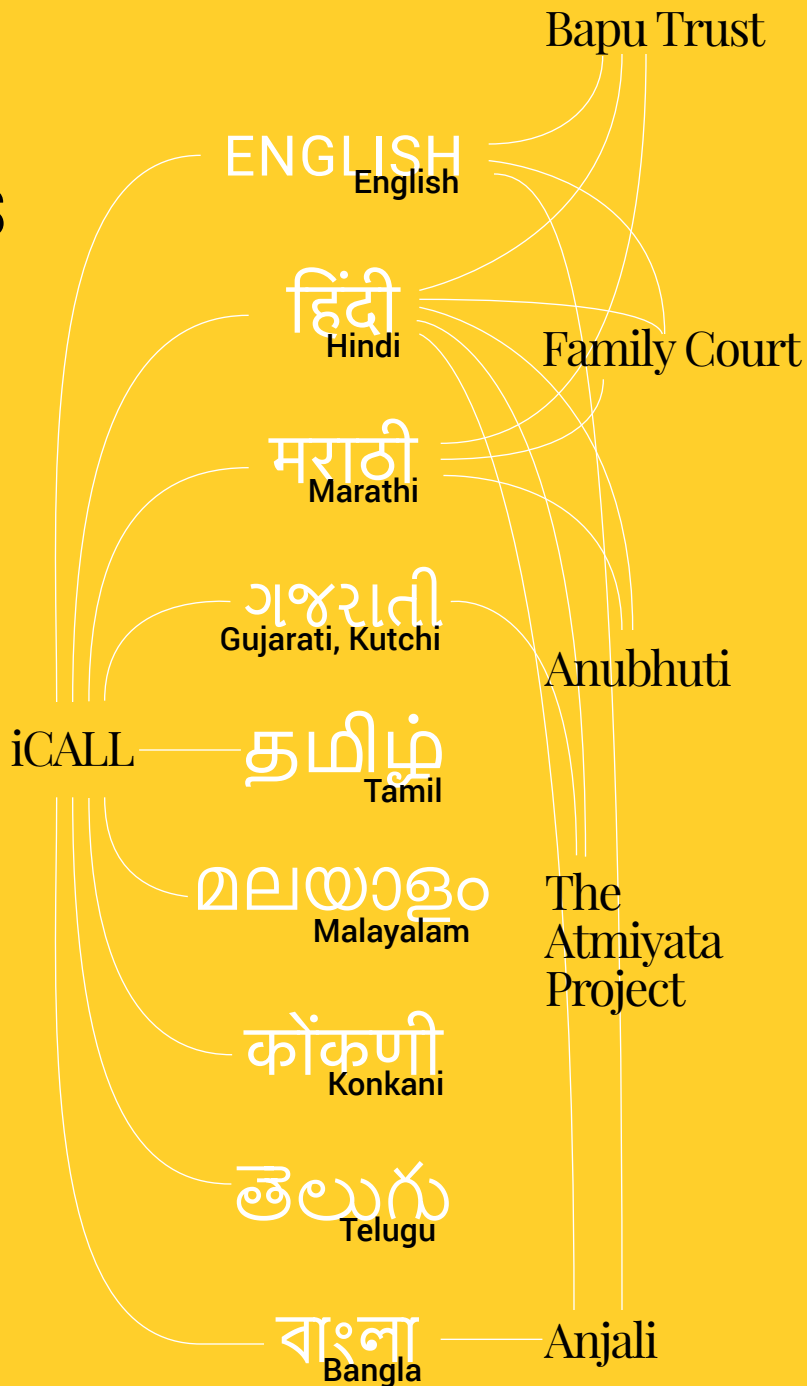
approach mental health, and helping to bridge the gap between law and policy-level dialogues on the one hand, and ground realities on the other.



# Languages

## the importance of linguistic diversity

Language barriers can impede access and delivery of health care. Linguistic barriers in mental health care can be pivotal since terminology, training and usage of direct communication is central to access and provision of mental health care versus other schools of health that may use machines or 'objective' tests for diagnosis and treatment. Thus, provision of mental health capacity building as well as service delivery in multiple languages is necessary to reach marginalised communities.



# Revisioning Impact

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*Perhaps the most important reason for ADVOCATING ROBUST MONITORING AND EVALUATION (M&E) SYSTEMS in the mental health field is the need to ENSURE ACCOUNTABILITY, for all stakeholders. The obligation to ASSESS, AND DEMONSTRATE, how far outlined goals and objectives are being met should be incumbent UPON BOTH FUNDERS AND PARTNERS. We need systems to TRACK OUR OWN PROGRESS, and the IMPACT of our partners' work.*

An M&E framework lays out the steps for assessing the impact of a project during implementation and after completion. Simply put, monitoring refers to the regular tracking of a project, while evaluation takes place at the end of the project to assess the effectiveness, in this context, of the mental health intervention or, in our case, of our grant making.

The key factors in evaluating mental health are: social inclusion; freedom from discrimination and violence; and access to economic participation.

These very factors contribute to making mental health an elusive, amorphous phenomenon, less easy to measure than, say, quantifiable inequalities in the education or public health sectors. At MHI, we had to look outside the usual indicators, and customize our indicators and processes to local contexts, allowing for multiple layers of vulnerability and marginalization.

Besides structural inequalities, the mental health of a community could well be affected by external factors such as natural disasters, drought, or war. Evidently, then, a comprehensive M&E framework, not

limited to quantitative assessment, is required to evaluate changes and improvements in the mental health and well-being of a community.

We needed to build an M&E system to hold ourselves accountable, and to highlight both qualitative and quantitative realities. As first steps towards this process, we devised a “mind map” of sorts, comprising multiple factors that could affect an individual’s mental health: income level; housing status; the lack of infrastructure in the community; a lack of social and cultural capital; severe social distress – as experienced by marginalized communities; the inability to access government welfare schemes. The mapping exercise helped us break down MHI’s mission statement in terms of processes as well as outcome indicators, which in turn helped us develop reporting processes for our partners.

We realized that lived experiences of emotional, psychological and social well-being needed, also, to be part of the narrative underpinning of our M&E system. This was why we created reporting processes that not just record data, but also provide

space to our partners to discuss strategies that have worked or failed, so as to promote knowledge sharing within the wider mental health community.

Our partners have already begun reporting in accordance with our processes, gathering data and documenting the voices of individuals, communities, organizations, and institutions. Our M&E systems are still evolving, but we hope to foreground marginalized voices qualitatively, while continually assessing how effectively we are fulfilling the MHI mandate.



# Evaluating Mental Health

## key factors

1

Social inclusion

2

Freedom from  
discrimination and  
violence

3

Access to economic  
participation<sup>[6]</sup>



# Future Plans

## **expansion of mhi**

Until now, we have been working as a very small team. However, as we move into new projects, with new partners, we need to hire more team members, using affirmative action as an important guide. We are aware of our limited engagement with Dalit, Bahujan, Adivasi voices, and hope to build a more diverse team. Simultaneously, we need to examine and strengthen our overall governance structures and financial management.

## **a mental health and disability friendly workplace**

Currently, MHI has monthly mental health allowances as well as flexible work plans or work from home in place. However, we need to devise and implement robust internal structures in consonance with these affirmative policies.

## **advisory committee**

As part of our accountability measures, we hope to have an Advisory Committee in place, to oversee our work and provide strategic direction. The Committee would comprise mental health professionals, persons who have worked in social justice, as well as individuals who are representative of the communities with which we would like to work.

## **monitoring and evaluation tool kit**

Mental health is not a popular sector for funders. We hope to increase visibility and reduce barriers to mental health funding by creating a tool kit that we can then share with individuals and organizations working in the mental health field.

## **working with caregivers**

As a result of the general stigma, in India, that attaches to mental health concerns, caregivers of persons with mental illness or psychosocial disabilities often do not receive the support they need, or have avenues to express themselves – and can end up feeling isolated. MHI hopes to work with this essential set of stakeholders.

## **conference on community-based mental health for marginalized communities**

We hope to bring together our partners and multiple stakeholders to share experiences and knowledge, and to discuss the ethical aspects of the work we do with communities marginalized by structural inequalities across caste, class, ability, gender, sexuality, and other axes of disprivilege.

# Team MHI

MHI, being committed to having a diverse team from various marginalized locations, pays close attention to hiring and staffing practices.

Team MHI is currently made up of cis women, gender non-conforming women, queer women and non-binary persons, identifying with a range of sexualities. In addition, we have worked solely with women consultants from diverse religious backgrounds and different sexualities. The majority of us in Team MHI, consultants included, are regular users of mental health services, survivors, neurodivergent. However, we are all predominantly savarna, and middle or upper class. MHI consciously seeks to expand this base; to engage with, and employ, persons from marginalized caste, class, and linguistic communities.

**HUSAINA PARVIN** is our Communications Officer. An alumnus of Lady Shri Ram College, Delhi, and Tata Institute of Social Sciences, Mumbai. After a post-graduation in clinical psychology, she focused on community-based and user-survivor led mental health practices. She is also a keen photographer.

**PARIGYA SHARMA** is our Lead Program Officer, managing MHI's grant making and networking strategies. As a feminist researcher, she studies gender, sexuality, and mental health using an intersectional lens, and is committed to advocacy for social justice and human rights in her work.

**PRITI SRIDHAR** is the Chief Development Officer at MHI. Since the last two years, she has been working with grassroots NGOs that work with a rights-based approach to social issues. She is passionate about women's rights, mental health, and child rights. Prior to this, she has 18 years of corporate experience in Finance, Corporate Credit & HR. Priti is an alumnus of TISS and XLRI and has been training in Transactional Analysis for last 5 years.

**RAJVI MARIWALA** is our Director, with an educational background in Business Economics and International Relations. After gaining an MBA degree, Rajvi worked for some years with Marico Industries, and is currently a board member of Parcham, an NGO that works with adolescent girls through sports, in Mumbra, Thane. Working with refugees, immigrants and low-income US citizens to support their small businesses at Mercy Corps International was one of Rajvi's most enriching work experiences.

**SHRUTI CHAKRAVARTY** is our Chief Advisor. Her areas of engagement include mental health, gender, sexuality, and human rights. With 15 years of experience in the non-profit sector as a mental health practitioner, researcher, trainer, and social worker, she is currently a PhD scholar at Tata Institute Of Social Sciences (TISS), Mumbai, and has an independent therapy practice.

# Financial Data

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<b>ACTIVITY IN RS LAKHS</b>	<b>FY. 2015-16</b>	<b>FY. 2016-17</b>	<b>FY. 2017-18</b>
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## **PARTNERS**

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Awareness & Service Delivery	53	152	164
Capacity Building Courses	2	19	4

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## **MHI**

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Administrative costs	10	8	10
Support services + capital expenditures	3	4	4

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<b>TOTAL</b>	<b>68</b>	<b>183</b>	<b>182</b>
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# Glossary

**BIOMEDICAL APPROACH TO MENTAL HEALTH** An approach towards mental health issues based on a disease-prevention model that prioritizes the use of medication for treatment and situates mental health issues in the 'brain' while ignoring experiences of abuse, poverty, racial, caste and gender inequalities.

**COMMUNITY-BASED INTERVENTIONS** Community-based interventions help implement a decentralized pattern of mental health care and services for people with mental illnesses. They are more accessible and responsive to needs of the local community and reduce need for costly inpatient mental health care delivered in hospitals. Community mental health services promote social inclusion of persons with mental illness and uphold their dignity and human rights that are often at risk of neglect and abuse in mental hospitals.

**DEINSTITUTIONALIZATION** This refers to actively promoting non-discriminatory and inclusive stay and care facilities for persons with mental health issues and / or disabilities and supporting them to lead their lives as they deem fit. Institutions are characterized by segregation and no respect for bodily rights and personal space of the users. Deinstitutionalization aims to change that.

**INTERSECTIONALITY** This approach recognizes that multiple levels of oppression (gender, race, class, caste, sexual identity, sexual orientation, ability) may intersect and interact with each other, affecting the health and overall well-being of an individual. For instance, a lesbian Dalit woman will experience oppression stemming from not just her gender but will also on her caste and sexual orientation. An intersectional understanding of mental health ensures that stakeholders understand that there are many sites of oppression and all of them, singularly or as a sum of a few marginalized identities, affect an individual's access, choice and rights to mental health systems.

**MENTAL HEALTH ECOSYSTEM** Refers to creating a large mental health community in India, bringing together a diverse cross section of stakeholders. This includes grassroots and community-based organizations, counselors, psychologists, psychiatrists, activists, researchers, caregivers, user-survivors, policy makers and governmental institutions. A mental health ecosystem will help foster a culture of constant interaction, dialogue and networking between these varied groups of stakeholders.

**PATHOLOGIZATION** This refers to a) branding persons with mental health issues as 'ill' b) over-reliance on medication and 'expert' diagnosis of one's mental health. This often puts persons with mental health issues at risk of abusive, unethical and involuntary treatments and forced institutionalization.

**PSYCHOSOCIAL APPROACH** Mental health counseling or program intervention should account for one's emotional and psychological vulnerabilities, feelings of isolation and exclusion and everyday struggles with education and employment. This approach avoids a narrow perspective that views a person with mental illness from a biological and medical lens and instead, really attempts to 'see' one as a sum of the myriad emotions and experiences of their daily lives.

# References

**RIGHTS-BASED APPROACH** This approach promotes and protects human rights of all persons and actively recognizes and works to dismantle existing unequal power relations. This approach does not discriminate on the basis of race, caste, class, religion, nationality, gender, language, gender identity, sexual orientation and ability. A rights-based approach to mental health ensures that every person has the capacity to make decisions regarding their mental healthcare and treatment plans and give or withhold consent to any medical procedures. It will also require advocating for laws that can help secure the rights of persons with mental illness and recognizing that their rights will be legally enforceable.

**SOCIAL INCLUSION** People with disabilities and/ or mental illness are often denied opportunities to work, play, learn and develop social relationships with others (particularly with people without disabilities). They are excluded from communities, their identities are ignored or invisibilized and their sexualities and desires infantilized or criminalized. Social inclusion encourages the establishment of humane, mutually supportive systems, centres the desires and aspirations of marginalized and disabled persons and ensures that people are not prevented from being active participants of society on the basis of gender, race, gender identity, sexual orientation, caste, religion, ethnicity and disability status.

**SOCIAL MODEL OF DISABILITY** This model says that disability is caused by social attitudes that prevent persons with disabilities from accessing their right to equal opportunities. While the medical model of disability focuses on fixing and treatment, the social model advocates removing any barriers that stop persons with disabilities from achieving their goals and living a full life.

**STRUCTURAL INEQUALITY** This refers to inequalities and biases deeply embedded in social, political and economic institutions, arising out of dominant ideas around gender, race, caste, religion and sexuality, that lead to systematic oppression of those at the margins, thereby denying them access to and opportunities for growth and justice.

**USER-SURVIVOR APPROACH** This refers to persons with lived experiences of (currently or formerly) and those who may have survived mental health issues, psychosocial disabilities, psychiatric and mental health services and institutions. A user survivor approach centers the voices and experiences of these persons.

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