Manual 1

Tridal overview

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Tridal overview

What is Tridal?

Tridal: The concept

Literally, *Tridal* is a Sanskrit (ancient Indian language of the Classics) word meaning an arrangement of three leaves or a Triad. *Tri* means 'three' and *dal* is leaves. Tridal is also another name given to the leaf of the *Bael* (*Aegle marmelos*) tree, which has the medicinal properties of antipsychotic medicines.

Tridal is a three-pronged approach developed by the Institute for Psychological Health (IPH) to deal with the social rehabilitation process for persons recovering from schizophrenia and other severe psychotic spectrum conditions. This approach helps by providing people living with schizophrenia and other severe mental disorders an active and encouraging location to help them create a routine, give them a sense of purpose and help them lead as normal a life as is possible. At IPH we call these patients *Shubharthis.* (The word *Shubharthi*s aptly describes persons on their journey to recovery and well being, and has been widely used by IPH and others in publications and dialogues, both in India as well as overseas. The publications listed at the end of this manual reflect this. In the light of the pejorative implications of a diagnostic label, this has been IPH's effort to de-stigmatize and reflect an inclusive attitude.)

The Tridal model has features of an Activity center and to a limited extent those of a Sheltered workshop, tailored to the cultural milieu in which it exists and the demographics of its *Shubharthis*. An explanation of both terms is given below.

What is a sheltered workshop?

Persons with Disability are offered a safe environment in which to work, and earn some amount of remuneration for their time and effort. The positive aspects of such a place are that they offer persons with disabilities an opportunity to work, develop a sense of pride and achievement about their contribution to society, and develop social networks within and beyond the workshop, with colleagues working there, volunteers, consumers of their products, among others. Some negative aspects that are often critiqued are that people

with disabilities are segregated, may not get opportunities to advance and feel entrapped in the setting after a while; many feel they are discriminatory.

What is an activity centre?

This is a community based facility that can offer skill training and care through some hours of the day. The aim in activity centres is to slowly nudge persons with disabilities towards independence, and equip them with skills of daily living. Community living is also encouraged and strengthened. In the case of persons who have been through episodes of chronic psychosis, this process can begin after active psychotic symptoms remit at least partially or even fully, and the person tries to revert to a life that they were leading before their illness.

So is Tridal an activity centre or a sheltered workshop?

The features of Tridal fit those of an activity centre better, since the Shubharthis stay busy through their time spent here, and participate in everything ranging from supervised production of materials, to games, yoga, and relaxation. They also go out on picnics, watch and discuss films together and celebrate festivals jointly. Some of the activities are described in detail in Manual 3 to enable other centres to carry them out, or plan similar ones.

Shubharthis earn some honorarium from the products they make, which are sold and the proceeds are used to replenish stocks for more production and are also shared with Shubharthis depending on how much they contributed in terms of work. Hence, though they are not "employed" here, they experience a sense of pride at having earned a specific sum of money.

At Tridal, we also attempt to create a work-like atmosphere with biometric recording of attendance, and travel to and fro by either a dedicated vehicle like a company bus, or organized pick ups and drops for persons who cannot come on their own. There is a Tridal logo present on products they work on, and this gives the Shubharthis a sense of contributing their work force towards something socially useful.

The *Tri* or "three" embedded in the word Tridal stands for the three important components of rehabilitation –

- Person suffering from schizophrenia

- Professionals / service providers and Family members of the person,
- The community.

The *Tridal* experience shows that this model can emerge as an essential part of out-patient based services for persons with severe mental disorder. In this context, we speak of Tridal as a concept and not just as an activity centre. Several mental health initiatives share that they often hold back from starting a centre like Tridal because they feel they do not have enough space, or funding, or personnel. At IPH, Tridal activities began on a very small scale, even when there was no dedicated space to work from.

Group meetings could be held regularly, and the common problems faced by Shubharthis and their caregivers could be discussed. The social benefits that accrued from these were visible even before IPH could afford to have a dedicated space for Tridal. We have operated out of very small rented accommodations, and even now, Tridal is housed in a space owned by Government of Maharashtra, which is supportive of this community based model. This space outside the premises of the Regional Psychiatric Hospital is Tridal's current home, but by now IPH team is confident that it can operate out of any alternative space as well. The current experiment with Hangout Café is described later.

There is now ample evidence of improved socialization, increased abilities in learning new skills, structured routine, friendships, etc. You will see at the end of this Manual the various publications and presentations that have emerged in the course of our work, which help document the gains to the Shubharthis and their caregivers. This documentation helps establish that *Tridal* has significant benefits to people suffering from severe mental health conditions. Visitors to the organization from within and beyond India have reviewed the systems and processes being followed and report them to be appropriate, well designed and sensitively managed.

There is a need to replicate these efforts across other centres, in order to establish proof of the concept, and learn the various adaptations required as per the demands of each locale.

Set of four manuals

This Manual, which is the first of a set of four, is being designed under a Paul Hamlyn Foundation India funded project. The aim is to attempt to lay down a blueprint for setting up activity centres such as *Tridal* in diverse parts of Maharashtra and India. The need for such services is very high, and the process need not be a difficult one provided some basic lessons that IPH learned over the years, are replicated or adapted to the region of the new set up.

The manuals developed by the IPH team will remain as an open source resource for others who wish to create such a service on their premises. It is hoped that they provide a roadmap which will help others avoid the pitfalls IPH had to negotiate as we built Tridal through much trial and error.

The IPH team hopes that this manual which focuses on Tridal offers some pointers or do's and don'ts as one sets up a *Shubharthi* service. It is designed to serve as a go-to resource every time one hits a roadblock and feels the need for some direction.

The fact that this will happen often is a given. Nobody said rehabilitation services are easy work. They involve much patience, slow and painstaking tallies of small victories and successes. In the long run, this work is very satisfying for *Shubharthis*, as well as *Shubhankar*s or caregivers, as well as the professionals involved.

More about Tridal

Tridal: The approach we chose at IPH

Tridal is more than just a patient service. It is an ecosystem that emerges from local needs, practices, requirements and resources. It has to flow from the availability of trained personnel, which may differ across various centres and geographical regions. As each centre develops, different roles may emerge for the persons active there, including the mental health professionals, the volunteers, the *Shubhankars* or family members of persons recovering from long term mental illness, and the *Shubharthis.*

What is the bare minimum expertise required in any Tridal team?

Every new Tridal activity centre that is set up could begin with a small group of like minded family members of persons with chronic psychosis, at least one psychiatrist and one psychologist or psychiatric social worker, and a small number of dedicated volunteers. The first step would always be to get the family members together and start a regular meeting schedule according to their convenience. That is how their felt needs will emerge and can be curated. They could share contacts with each other and begin staying in touch, start planning a few activities for themselves and their Shubharthis.

The mental health professionals in the team should have a good understanding of their feelings and needs, know their background and history, and share a warm, empathic relationship with them. They also need to slowly begin training up the volunteers to work with the Shubharthis. The IPH experience has been that the best predictor of success for this step is to select volunteers very carefully. We use short case vignettes which volunteers respond to, and use their answers to decide who has good insight into Shubharthi behaviour, who is highly motivated to work, who has empathy and understanding, etc.

Initial training sessions then need to be conducted for these volunteers to get them to a thorough understanding of the illness process in the various chronic conditions faced by the Shubharthis.

How will this happen?

As the patient profile of long term chronic mental illness changes and evolves, there is a need to weave in the science of psychological rehabilitation of chronic mental health conditions involving psychosis. We at IPH recognize that with our blend of academia and community mental health, skill domains in both, research and praxis, we were able

to derive solutions organically, but have not documented these adequately over time. Hence the current effort. The scientific underpinnings of psychological and social rehabilitation of persons with chronic psychiatric conditions will be found in other manuals which are being written alongside. This manual focusses on practical tips and nuts and bolts of setting up a *Tridal* like service in any locale.

Each centre will probably evolve organically from the social milieu in which it has developed. Some tips may help, however. IPH has undertaken a Fellowship program to train representatives from other centres to build up *Tridal*-like activities on their own premises.

This manual is created as a roadmap for the Fellowship project funded by PHF, for the duration of 2023 and 2024. The attempt herein is to handhold partner organizations to help build similar ecosystems in their own location, so that similar handholding becomes available to more psychosis affected families over a larger geographical footprint.

The manuals will include Tips to Fellows who wish to set up a *Tridal* like activity in their own premises, anywhere in the State or the country. These tips will appear in text boxes through the manual.

Tip 1:

You do not have to name your project *Tridal*. IPH is not looking for cookie cutter replications.

- Choose an evocative name in your regional language that is meaningful and easy to remember.
- Choose a venue that will be accessible and central, so that your *Shubharthis* can travel there with ease.

The venue has to attract the age group that your users comprise of. Eg. our earlier Shubharthis are now of an older age group and feel drawn to a quiet, verdant place. With early diagnosis and early intervention, we are now likely to cater to a younger age group who will look for a more colourful, vibrant setting, a flexible space which can accommodate different activities ranging from healing to artistic endeavors.

Essential ingredients:

- Person suffering from schizophrenia (in some scenarios he/she can be suffering from any chronic mental disorder)
- Professionals / service providers, (which will include trained community volunteers also)
- Family members of the person, and
- The community.

Try to develop new venues for the activity only once your main base is firm and you have a dedicated group working in it.

Definitely organize at least one major event at your new venue to begin with, and after that at least one every quarter to ensure footfalls.

Ensure that your team members write for the local press, contributing articles that underline the importance of rehabilitation and the science behind it.

Your activity centre could have two goals in mind

- A safe and cheerful place for Shubharthis to meet and work together, play, and re-learn the process of social interaction.
- Each activity should be planned and documented carefully and should be geared towards cognitive and social rehabilitation.

Do all "Tridals" have to be alike?

Not at all.

In fact, emergence of new experiments and ideas occurs constantly in a project like *Tridal*, as the team adjusts to ground realities and shifting demographics of S*hubharthis*. There is also an ongoing attempt to broaden and widen the base of the population served by the projects, as the nature of chronic mental illness changes and evolves over time.

The example of Tridal Hangouts Café

With earlier detection of psychotic conditions, better pharmacological molecules to handle the condition and a better understanding of psychosocial interventions, the needs of *Shubharthis* and their caregivers constantly evolve. There will be attempts to track some of these ongoing attempts as we create these manuals. Online open source versions will also be updated in the future, as more such efforts evolve over time.

This broadened vision of helping those who have been through the experience of severe mental illness and require a safe space as they traverse their path to recovery is dubbed Tridal Hangouts Café. This space is also located in Thane, in a less congested and quieter, more verdant space, and helps IPH cater to a variety of groups other than Shubharthis, thereby ensuring more inclusivity. The space is also often opened up to college students for activities such as poster competitions during Mental Health Week, thereby ensuring footfalls of persons other than those living with severe mental illness, and such mingling helps reduce social distance and social stigma. More detailing about the same will be available in manual 3. There is ample literature on similar Happiness Hangouts in academic as well as service institutions, and this will be reviewed in Manual 2.

The example of Tridal divided into Tridal A and B

This alphabetical nomenclature is merely temporary, since some attractive names always emerge after discussion with stakeholders.

In this case, Tridal A is effectively a vocational sheltered workshop and the focus is on production of items that are in high demand and will keep Shubharthis busy at work and help the project earn revenue. The latter can then be paid to Shubharthis and this also gives them a sense of pride and achievement.
Tridal B has a cognitive retraining focus, which was always there since the inception of Tridal. These are Shubharthis who require these inputs, but are not yet high functioning enough to be able to work with deadlines in mind. Placing them with Tridal A would

- Create unwanted pressure on them to perform when they are not in a condition to do so
- Render the high functioning Shubharthis impatient and feel "held back"
- The high functioning Shubharthis would not get compensated enough for their work because the proceeds would be shared among all. This would reduce motivation.

This division of *Tridal* into two arms is a very recent development and will be reviewed more thoroughly in Manual 2 and in later drafts of Manual 1, after we begin to learn from the shift. IPH sees Tridal as a form of action research, and has always used stakeholder feedback and experiential learning to improve services.

Summary:
So in sum, the Tridal activity centre is a physical space. It can be small or large, depending on availability. The personnel would include at least a psychiatrist and a psychiatrist or a social worker, a few volunteers who will be trained up.
Rather than wait for the space or funds to become available, just begin by gathering a few caregivers, beginning their group, and then getting Shubharthis together. Even a small number is fine. The scale can be ramped up slowly, the IPH Tridal experience is spread over more than two decades.

One has to have the will to do this, and be confident that it is going to help the Shubharthis and the caregivers. There is no hurry at all. Volunteers will come and go, but we try to keep the good ones, the sensitive ones, with us, and that is easier if you select them well in the first place. Remember, one can have volunteers who are family members of Shubharthis and also volunteers who do not have any affected family member but merely want to help, and learn how that can be done.

This Fellowship project has, for the first time, offered a platform when the vokunteers and caregivers can be trained up and where they can bring their questions and difficulties.

The Tridal fellowship

Plans lined up for Tridal Fellows

In the course of the Fellowship under PHF funding, the selected Fellows will visit each of these venues, and can take pictures, note down their experiences at each to take back home. Some of these would be incorporated into the manuals as qualitative inputs. Hence, these manuals are works in progress.

Each partner institute has been invited to carefully select their own Fellows, who would be with IPH for a span of time (say two months), learn the ropes of setting up *Tridal* and go back and attempt to set it up at their own site.

Tip 2

IPH experience has shown that careful selection of people who will take any project forward as Volunteers is a very important step.

These Volunteers have to have

- Adequate free time to devote to the project.
- Residence preferably not far from the site of the project
- Adequate health and mobility to travel to and from the venue and be there for long hours.
- Passion to take the activity from strength to strength
- Empathy in order to be able to connect with users
- Willingness to learn basic facts about the psychological condition of their users.

A copy of the initial Brochure sent out to potential Fellowship candidates is attached as Figure 1.

Figure 1. Brochure for welcoming Fellows to Tridal

Establish your own activity center and support group for persons with chronic psychiatric conditions

The Institute for Psychological Health (IPH) is rolling out a novel and unique Fellowship Program for like-minded mental health organizations who also wish to work in the space of Rehabilitation for persons with chronic psychiatric conditions such as Schizophrenia. You are aware that IPH has made good headway in this domain and has a thriving project Tridal which provides a stimulating activity center for persons with mental illness, support for their caregivers, and awareness and information for the community at large.

We have partnered with Paul Hamlyn Foundation (PHF-India) - a prominent name in the field of philanthropy directed towards socially meaningful efforts for wellness. This will be a project of two years duration and will involve ongoing work with Tridal activities as well as a Fellowship program as mentioned above.

We request you to please depute one or two members from your organization to attend the Fellowship program at Tridal, Thane. The details are given below.

- We would appreciate a quick, yet well thought through response, since it would be best if you chose members who are sure to remain with you and take your ongoing work forward. We will also be sending a google form from our end to gather details about your organization and about the fellow(s) you depute for our own record, and for documentation purposes for the project. In addition, IPH will conduct a screening to ensure that we get the right candidates

  DETAILS ABOUT THE FELLOWSHIP:

- The Fellowship program will be of about three months duration.
- One or two members can be deputed from your organization
- Their living arrangements and hospitality will be arranged by IPH. Travel would be arranged by the individuals or your organization.
- The Fellow profile would ideally be: preferably a caregiver (professional or family member), under age 50 and with minimum qualification graduation.

History of Tridal

Tridal has been active for over 16 years as we write this in 2023. It has functioned successfully across three locations of the IPH main center, as we shifted base till a permanent place was found for the organization. It has also transitioned successfully to a new location, which is a shared space with the State run Regional Psychiatric Hospital facility for long stay psychiatric patients at Thane, Maharashtra.

To trace the course of Tridal in brief, on 27th May 1990 the first ever public seminar on Schizophrenia in the State was held by IPH. Its unique feature was that persons recovering from schizophrenia and their family members were invited to attend. The event was dubbed the Schizophrenia Conference because it marked a remarkable step in the process of inclusion of persons with disabilities and mental health issues. Even today, the movement to include persons with lived experience of mental illness is struggling forward against the predominant medical model which caters to service providers but not persons with lived experience.

The location was Sahayog Mandir Hall and the doyen presiding over the conference was Professor L.P. Shah, who has been a faculty member at the prestigious G.S. Medical College and K.E.M. Hospital and trained generations of Psychiatry graduates. The experience provided great insights to all the professionals at IPH who were instrumental in conducting it. Dr. Anuradha Sovani, one of the members of the team, was about to submit her Doctoral work on the very same subject in September 1990, and the Schizophrenia conference added value to this as well as to the Doctoral defense in October 1991. Her research guide was Dr. Shubha Thatte, whose own Doctoral work, too had been in the area of schizophrenia, and will be detailed in manual 4, based on key research findings of the IPH team and Doctoral students.

Participants of this Schizophrenia Conference, both persons with mental illness and their caregivers, lauded the effort since it offered them explanations in simple language and in the local language Marathi, to help them understand their condition. The audience was permitted to ask questions after each talk, and subjects ranged from “What is schizophrenia?” and “How the brain and neurotransmitters are affected in Schizophrenia” to “Psychosocial interventions for schizophrenia” and “Myths and Misconceptions about mental illness”.

A full day workshop for persons recovering from Schizophrenia was held on 20th October 1991, (immediately after the Doctoral viva voce of Dr. Sovani!) and focused on helping persons with mental illness understand their condition and give them tools to help deal with it. This was another milestone in inclusive practices at IPH. The participants voiced their appreciation of the agency given to them, and the fact that the trainers were acknowledging their reality rather than relegating the voices and images they see and hear to the realms of psychotic symptomatology.

Other similar workshops were held in 2000, 2001 and 2003, and helped band together groups of caregivers, as well as of persons with lived experience of mental illness. Another landmark event was the Schizophrenia Rights Conference held at Gadkari Rangayatan in 1996, another milestone in the journey towards Inclusion and patient rights. More about these events will be detailed in Manual 3 which focusses on Lived experiences. *Tridal* activities began in 2005 and have grown from strength to strength ever since.

The location where *Tridal* is active at present is in actuality outside the Regional Mental Hospital premises, adjoining the premises but across the road, and there is an MoU in place between the State Department of Health and Mental Health and the Institute for Psychological health to ratify this partnership. The premises are verdant and quiet, and create a pleasing backdrop for the day to day activities of *Tridal.*

These activities include efforts made to engage the *Shubharthis* as well as their caregivers, and will be elaborated later in this manual. A large workforce within *Tridal* is the Volunteers. These could be either family members of persons with severe mental illness, or empathic community volunteers who wish to give time for a worthwhile project and are willing to be trained for the same. The caregivers are dubbed *Shubhankars*, or well-wishers. Removing stigmatizing labels tying the person to the condition can slow down the progress of well-being. This movement to remove pejorative labels from mental illness is now worldwide.

Shubharthis, Shubhankars and Volunteers are the pillars of the Tridal rehabilitation process. Professionals giving guidance to the process is an integral part of Tridal, but the true spirit of the rehabilitation project and the activity center is held up by these volunteers, and the Shubharthis themselves.

Tip 3

Activities chosen for *Shubharthis*: what did not work and why

- **Vegetable cleaning and packing**- Vegetables were cleaned, cut, and packed in packs of 250 and 500 gms. They were then sold on a small counter near the activity center. Cut vegetables are always a household requirement in Mumbai and Thane area where the life is very busy 24x7. This attempt of selling packets of cut vegetables was not profit making. Bringing vegetables from wholesale markets in the early mornings was very challenging as the *Shubharthis* were not in a position to wake up early and go with the volunteers, due to the side effects of their medications, and their other cognitive deficits.
- Secondly while selling the packets, if the left over packets of earlier day were added to the fresh lot , our *Shubharthis* would very genuinely say which were fresh or stale. This lack of judgement or 'smartness' of *Shubharthis* resulted in increase of unsold vegetables and loss. As vegetables are perishable and have less shelf-life we had to abandon this experiment.
- **Decorative articles**: Making *torans* or garlands/ door festoons with artificial flowers was tried. We got a good response for it in the market. We continued with this product for around four to five years but then had to discontinue. As compared to the efforts involved, the profit margin was much less. More importantly, after being in Tridal for a few years, te Shubharthis' level of functioning and ability to learn new skills had improved, This enabled Tridal to shift to more complex tasks.
- **Artificial Jewellery making**: Our attempt at artificial jewellery making was not at all successful. It was observed that our *Shubharthis* were had been on heavy medication; as a side effect of this, their fine motor movements were affected to a very great extent. A few of them also had tremors in their hands. These were the major hurdles in making beautiful and attractive artificial jewellery which could be sold in the competitive market. Our product lacked finesse and polish. We stopped making artificial jewellery after six months.
- **Candle Making**: making decorative candles was attempted. Balancing the cost of raw material and the final selling price was a challenge.

It is as important to learn from these "failures" as it is to design one's own program based on *Tridal* successes. As famous scientist Thomas A. Edison said, "I never once failed at making a light bulb. I just found out 99 ways not to make one."

In different settings, different activities may succeed or not do as well as expected. Things take time, that is one lesson we have learned over three decades. Our team is always there at hand to brainstorm about what perhaps went wrong, what needs to be tried differently.

What is exciting to us is, today our *Shubharthis* are in a position to comment on the products they work on. They can highlight in discussion what are the strong and weak points of these products. (Cognitive processing). They take pride in the quality of the product and its utility to the consumers. (Emotional processing). They can even suggest better ways to market them, although all the suggestions may not be viable. (Problem solving and decision making).

The latter is clearly a frontal lobe task, and our research, reported briefly in Manual 4, shows that this level of functioning is difficult to restore in persons who have gone through a chronic mental illness such a schizophrenia. Volunteers may want to understand these research findings by discussing them with the professionals in their team, as we do at IPH.

Tip 4 in the text box below takes the reader through some of the activities that have in fact taken off and are doing very well at *Tridal*. Once again, it is important to understand that the nature of the tasks, rather than the products themselves, are what one can learn and pick up pointers from. Do go through the text box below and refer to our videos or identify the steps the *Shubharthis* go through before the product is ready for sale.

Tridal is fairly financially independent thanks to these very popular products, which have achieved high sales both in India and abroad. Of course, we are grateful to Paul Hamlyn Foundation-India funding over the years, but we also maintain clear accounts regarding the costs of raw material, transport, as well as other expenses of *Tridal* on the debit side, and sale receipts on the credit side, helping volunteers and Trustees to balance the books.

Tip 4

Activities chosen for Shubharthis : What worked!

Our successes:

4a edible items

- **Calpro**, or porridge mix: Calpro is our star product. It is a porridge mix which is high in proteins and calcium. This product was our first attempt to introduce kitchen made products. It was chosen after consulting our dietician who customised it with proper balance of proteins and carbohydratess . Its shelf life was tested in the lab so being consumable, its sale started increasing . Along with Calpro we also introduced *chutnies* made from garlic, dry coconut, groundnuts, sesame seeds etc. These are used as accompaniments to be used with bread, Indian rotis, rice and dal. Calpro has high demand with St. Jude's hospital for Children with Cancer, and *Graahak Peth*.

- **Snacks,** such as *chutnies* and *chivda*.
  Chivda (a savoury dry mixture made with puffed rice), *ladoos* (balls made from semolina, coconut and sugar), protein bars, *gulpapdi* (made from wheat flour, ghee and jaggery) were gradually introduced. These are sold at the Tridal Shoppee in IPH reception area and on order at Tridal. All have quite a long shelf life and are popular snacks in Maharashtra.

Tip 5

Activities chosen for Shubharthis : What worked!

Our successes:

4 b Decorative and utility items

- **Stitching unit**: Stitching unit was introduced around 2011. There were 3 *Shubharthis* who were very good at stitching. Two others learnt the skill; different items like sling bags, small purses, carry bags, travel pouches, shoe bags, laundry bags, fridge bags were stitched and sold. One volunteer took the responsibility of teaching and getting these items made from *Shubharthis*.

- **Decorative rangolis** and other items: *Rangolis,* (ie small decorative design pieces which adorns your homes in the festive season) though seasonal, are very much in demand. *Shubharthis* and volunteers very enthusiastically design and make new rangoli designs. Rangolis are made of artificial pearls, diamonds, sequins, etc.

  The unique selling point of this product is that they last long, can be stored, and assembled like a jigsaw when they have to be displayed at one's doorstep. They can then be packed and put away for reuse, much like you would do with Christmas tree ornaments or festive light bulbs. Real rangolis are drawn using dry powder and require a lot of skill and dexterity. This makes these ready-to-assemble rangolis very popular and gives them high gifting value.

As there was demand for most of our products we bought a collapsible stall and Shubharthis were trained to manage the stalls . They were trained using role plays for communicating with the customers. In many consumer shoppees & exhibitions our Shubharthis erect this stall & sell our products.

This was our experience using trial & error to zero on to a particular product while trying to replicate this model one may have to think of the feasibility of a particular project for that place / city , the functioning of their Shubharthis , kind of set up they have (space , investing in a product etc.)

Pictures below:

1. Tridal resource persons, Dr. Thatte, Dr. Nadkarni.

2. Tridal volunteers.

3. Origami display

4. Release of Antarang, written by Shubharthis.

Tridal Hangouts Cafe

The newest landmark in the history of Tridal and IPH efforts to create safe spaces for persons with a history of mental health issues, spaces where they can seek wellbeing and find solutions for their personal issues, is the establishment of Tridal Hangouts Café.

This is a novel concept, where IPH has visualized that in Tridal Hangouts Café, young people can be supported to develop independent living and self-management skills, as well as to identify and achieve individual recovery goals across social, health, educational and vocational domains. It is a safe space that vibes with the “cool” hangouts this generation visualizes, and allows for creativity, freedom of expression as well as healing.

What makes Tridal work?

Tridal has always been more of a "family" than a "project". And yet, 'professional' elements have been layered on over time, such as

- biometric attendance,
- ratings for performance and
- performance based honorarium.

IPH and Tridal were successful in getting a 17-seater tempo-traveler for Shubharthis to commute. This bus was given as a CSR initiative by one company with whom IPH was associated for long. This has caused a great convenience to the Shubharthis. Apart from the ease of commuting vehicle also helped them in their self respect as they feel that now they have a routine and are going for some meaningful activity like their sibs

As other IPH staff use bio-metrics for attendance, similarly does *Tridal shubharthis*. They get a feel of going to an office. While calculating Shubharthis honorarium their attendance is one important variable considered.

There is a vehicle using which the Shubharthis commute to *Tridal,* and they have systematic work hours and work orders to meet, for the various *Tridal* products. IPH has ensured permissions for the sale of these products, and quality control.

Tridal as an initiative has been in the public domain for a while, and has been visited by many mental health practitioners. IPH has always been requested for guidance on how such a program can be replicated at other locations.

An effort to do so has been made on occasion, and succeeded to an extent. However, many remain charity initiatives and rarely become self-sustaining. IPH has been working on this question and attempting to be able to answer it more systematically with good evidence to support their contention. From their own analysis IPH feels that more than just the Tridal idea there was an ecosystem that IPH was able to create for the implementation of Tridal that made it effective.

Tip 6

Some pointers that indicated a success in this effort were:

1. Enhanced social and cognitive functioning of *Shubharthis*.

2. Ability of *Tridal* to sustain itself to a large extent on sale of products manufactured by the *Shubharthis.*

3. *Shubharthis* are being able to earn an income some honararium for their work which builds a sense of dignity for them

4. *Shubharthis* have moved up the ladder of challenge offered by tasks they undertake, beginning with being relatively peripheral members of the group, growing more active and finally handling more challenging tasks such as even managing a sales counter of their products.

5. Change of mindset of caregivers. Here we as *Tridal* and IPH team would like more proactive involvement from the caregivers. Often it is observed that the caregivers send the *Shubharthis* to *Tridal* but are not interested in taking any feedback from the team. They are not interested in attending the monthly caregiver meetings which are online since Covid. These caregivers have a high level of burnout or emotional fatigue, and need help, rather than blame.

6. During Covid lockdown some *Shubharthis* were staying independently and were unable to get direct support from the family members. The volunteers took initiative in guiding few male *Shubharthis* in basic cooking. This guidance helped them develop confidence and set a good example of independent living.

Tip 7

Tridal has had its own difficulties, as has this Fellowship program

No new effort is free of hurdles and problems. Tridal has, of course, had its share.

For example, we are still toying with the idea of whether to discontinue the transport for Tridal,

because it can prove to be a white elephant.

The grouping of Tridal into two sections, A and B is still an experiment in progress. Hangouts Café is still picking up. Getting people to know about a new venue can be a challenge.

There are times when we do not have adequate orders for our products and we have to involve the Shubharthis in more activities to keep them engaged.

There are other times when there are so many orders that we have to stop, and draw a line, although satisfying all potential consumers would have been very profitable for Tridal. But that is not the goal.

Ultimately, we have learned, it the goal of "well being and mental health for all" that should drive all activities, and all our decisions. All decisions are guided by a process of mutual discussion and discovery. Well being of every person in the institution should be paramount.

We have learned that if you compromise at any stage of work, there will always be a price to pay later, there will be problems that crop up later which will make you regret the earlier compromise.

This Fellowship program faced its own share of hurdles too. It appeared to us to be a felt need, an idea whose time had come. However, practically, it proved difficult for volunteers from far flung organizations spread all over Maharashtra to come physically to Thane and observe the processes and participate in the training. This led us to arrive at a hybrid mode, where some interactions with centres who wish to undergo Tridal training occur online, whereas some visits can be arranged. Filming some activities at Tridal and sharing the recordings is another option we have exercised.

Only time will tell how much success this program achieves. Meanwhile, we keep working.

***Tridal*, an ecosystem that works**

As we saw, the IPH approach to *Tridal* has not just been the creation of the space. It would be more accurate to describe *Tridal* as a larger ecosystem of empathy that IPH was able to create within the Tridal space.

This is very much in line with the literature on 'joint attention' and 'joint reference processes' in the field of cognitive development. Individual differences in joint attention are known to be related to the intensity of social symptoms, responsiveness to intervention, and long-term social outcomes. Since its inception, Tridal has always been built around a close meshing of volunteer and *Shubharthi* efforts, where changes in *Shubharthi* emotions and behaviour are sensitively and perceptively picked up by the volunteers, and used in directing training and intervention.

Tridal has built its work using this approach and through the development of unique partnerships among the various participants in any *Tridal* initiative. In *Tridal* there is an admixture of skill and academic understanding, empathy (towards the condition) and patience (to handhold) to work with the *Shubharthi* and caregiver through this difficult journey.
The joint reference process benefits the volunteer and professional hand-holder in that it creates an ease of functioning and makes their work seem effortless. It benefits the *Shubharthi* in that he/she feels "understood" and their hard work appreciated.

The training of Fellows will include the sharing of the science as well as the art of these processes of change. On completing of the training, the Fellows will get back to their respective institutions and set up an adapted model of *Tridal* in their location. For this process, IPH will provide hand holding support and oversee the creation of the *Tridal* ecosystem in their areas.

The concept behind the project is not to create replicas of *Tridal* elsewhere, but to allow each project to develop as is suitable to their own ecosystem, using the science of rehabilitation to facilitate its growth.

Rather than additive, it is multiplicative efforts that will take rehabilitation forward in our country. We already have excellent family support systems, now professional support systems need to augment these, and yet not attempt to replicate support systems of western medical and paramedical care.

Tridal over the last two decades

Tridal began as a very small effort to merely bring together persons with a lived experience of severe mental illness, and create support system for them. This was not merely with a humanitarian motive and a spirit of Inclusion, but research findings of Dr. Thatte that will be detailed in Manual 4, which pointed to neuropsychological deficits in attention and other frontal functions in schizophrenia, which could perhaps be remediated with psychosocial interventions; and by research findings of Dr. Sovani that structured interpersonal interaction and verbal feedback inputs can in fact bring about perceptible shifts in emotions and behavior of persons with positive, negative and mixed symptoms of schizophrenia who are in at least partial remission.

Further work on a major research project undertaken by Dr. Thatte and Dr. Sovani with other researchers such as Dr. Deshpande and Kinkar from Pune, pointed clearly to the aspects in which a change can be expected, and these definitely excluded frontal functioning. The findings from this project indicated that Social Provision emerged out as an important predictor of Psychosocial functioning (as per GAF scale) .

Shubharthis who felt cared for and valued by others, had significant others available in times of need and who were satisfied by this relationship had better coping strategies to face the psychosocial stressors . This again highlights the role of Caregivers . The fact that the *Tridal* atmosphere is more like a family and not that of a rehabilitation centre boosts this feeling of being cared for.

The current zeitgeist in world literature also gave clear neuropsychological indications of frontal lobe deficits in schizophrenia, and thus the spotlight fell on caregivers to act as a blueprint to guide behavior and action.

This generated a lot of relevance for the work undertaken by Dr. Savita Apte, where she developed an entire training program for Caregivers and field tested it empirically showing that targeted interventions worked for specific caregiver difficulties such as caregiver burden, burnout and stigma. Her entire contribution to the trainings is documented clearly in Manual 3.

This constituted the first decade of work, by which time IPH realized that mere charity-based intervention is not enough. There is a need to scale up, and create self-sufficiency in the Shubharthi group if they are to experience work satisfaction and dignity, aside from the camaraderie and fellowship of working together.

The next decade of work has been experimental in nature, with trial and error leading to financial independence. IPH also built in the work of other Doctoral students of Dr. Sovani, such as Dr. Shweta Kadaba's work which showed that attention deficits rather than memory issues underlay patient difficulty; Dr. Sunitha Shankar's work which showed that those patients who show neuropsychological deficits are not necessarily those that show poor work performance. There are other, social support factors that play a strong role. Finally, Dr. Priyanka Jagtap's work which brought to light the significant fact that it is not merely family member caregivers who seem to operate under myths and misconceptions surrounding schizophrenia spectrum disorders. Often professional, trained caregivers also harbor these wrong conceptualizations of the condition.

All these researchers have been inducted into the peer review and formulation of the Fellowship program, in an effort to induct science into the processes at *Tridal* replications elsewhere.

Manual #4 will help summarize how this indigenous research built up over time. But here is a brief summary. It is not necessary for any effort similar to *Tridal* to read or study all this academic research, in detail. It is sufficient if the key points learned therein are utilized to the fullest. The text box with Tip 8 highlights some of these key findings.

Document your learnings carefully and scientifically

Tip 8

Key neuropsychological pointers to use

- Both neuropsychology and day to day observation highlights the fact that persons with schizophrenia have issues with attention. They are also not able to "fill in the gaps" and use redundancy in language and other social interactions in the same way that typical persons who do not have any psychiatric disability, can.
- If they are made aware of this deficit, persons recovering from schizophrenia can make efforts to overcome it.
- They can be helped with verbal feedback, and with positive practice in social settings.
- Overlearning helps a great deal
- Scaffolding is also a powerful tool
- Attention deficits are the "real" hurdle. Memory lapses are the outcome.
- Planning deficits can be overcome with Caregiver help and scaffolding.
- Caregivers require as much, if not more support than *Shubharthi*s.
- They need emotion management to help deal with the burnout of caregiving.
- They need practical day to day help and support to overcome burnout
- Regular awareness building and sharing can overcome stigma.
- This holds true for professional caregivers as well as family member caregivers.
- Both categories of caregivers can have myths and misconceptions which need to be clarified.
- *Shubharthis* need to be assessed on a regular basis for functional improvement, since there may not be a correlation between their neuropsychological status, their symptom profile, medicine compliance and response, and their functionality.

One of the lessons we learned at IPH, though we are still not adept at documentation and need to do a great deal more in that direction, was to note down our learnings, and publish them where possible. Science of any kind develops by standing on shoulders of others before you who have learned their lessons the hard way, by experimentation and elimination, by falling down flat and rising again.

This manual ends with an overview of some of the published work pertaining to rehabilitation of severe, chronic mental illness, More details about this work and summaries of findings will also appear in Manual 4.

The last few sections of this manual

In the next section, we have asked our key supervisors to supply **an impression of Tridal**, the activity centre.

What do you see when you walk in? What is the workspace like? What is negotiable, what is non negotiable? How is work organized? How much time is required for each task, and how much time is devoted to recreation or cognitive activities? How does Tridal operate in terms of being a Cost centre, and how are financials negotiated?

Then we have **two stories** of Shubharthis, which help underline how important it is to know a detailed history and background of every beneficiary of Tridal.

Tridal :The Activity Centre: A thumbnail sketch

A key factor that everybody notes about Tridal is the buzz of activity and the camaraderie that pervades the space. The space itself is just about functional, but every inch of it is well utilized. Even the covered balcony as one enters is used for meetings, discussions and activities. Floor seating is common, on clean mats and dhurries, with a few chairs and stools arranged for convenience for those who need them.

It is assumed that all members will make an effort to come on time, and biometric record is a norm. Motivators are arranged to reward punctuality, hard work, hygiene, and regularity.

Tasks are distributed as per individual capacity of each Tridal member. Volunteers have developed a keen eye for ups and downs in the current condition of each member visa

vis mental health, and allowances are made for the same. This also helps in nudging Shubharthis towards a regular regimen of psychotropic drug dosage.

What is remarkable is that even volunteers unschooled in symptomatology and mental health issues are quick to pick up cognitive lapses and behavior changes. They nevertheless remain non-judgmental, and merely note these shifts for smooth running of Tridal, and for the wellbeing of the Shubharthi. This is rendered possible by frequent discussions and trainings with subject experts from the field of mental health, and sharing between less and more experienced volunteers.

All "work" related tasks are interspersed with recreation, yoga, relaxation and cognitive games and rehearsal. Gratitude and mindfulness and part and parcel of the regimen, and every effort is made to nudge Shubharthis into activities that will push frontal functioning and emotion responsivity, eg film viewing and appreciation.

Financial rewards are titrated by dividing the members into two groups, A and B, respectively demonstrating high and low functioning, but labelled thus to remain non pejorative. The low functioning group is engaged in activities but not monetarily rewarded for product creation, whereas group A does get well earned monetary rewards commensurate to work put in. This also motivates group B Shubharthis to remain on a proper medical and therapy regimen, so that they can move up" into group A as soon as possible.

IPH is proud that Tridal is now financially on its own feet and is able to generate financial reserves through product sales.

A couple of Shubharthi stories

R.S. is a 46 year old Shubharthi who started coming to Tridal in 2016. He stays alone at Kalwa , a small township on the border of Thane city, and his younger sister (five years younger than him) stays in the same locality. He is the third born in the family and has three sisters, two of whom are older than him and one younger.

The family was earlier staying at Mahim in Mumbai where his father was a taxi driver and his mother a home maker. He attended a prestigious school at Shivaji Park, Dadar and was average in studies but very good in cricket. In fact he played for the junior team in school.

He remembers those days with a twinkle in his eyes as he had many friends and his game was appreciated by all. When he was studying in standard X, he started feeling

paranoid about his classmates and was afraid to talk to strangers. He became a recluse. After a major psychotic breakdown he was taken to KEM Hospital, Mumbai where he was admitted, diagnosed as schizophrenia and psychiatric treatment was started.

He had to miss one year of school at that time but then he passed SSC with just about passing marks and joined a commerce college for further studies.

Due to his father's failing eyesight after cataract surgery he was compelled to stop driving his taxi, and RS started working in the evening as a compounder in a dispensary to augment family income, although he continued attending college. His elder sister had completed graduation, took up a job and began working to support the family.

After completing his graduation, the doctor where RS was working sincerely as a compounder for 5 years recommended him to one of his friends who had his own pharmaceutical unit. RS started working with him at Girgaum. He used to travel from Mahim to Girgaum by train and was managing his duties well. These consisted of looking after the stores, receiving orders and dispatching parcels, assigning people for delivery of the same.

He worked there for 5 years. Unfortunately his father's health deteriorated and he expired, and their premises were taken for redevelopment. RS and his mother had to shift to Thane, renting a small room near her younger sister's house. He had to leave the job as he could not travel so far to manage the job. He expresses gratitude towards his mother who used to accompany him to the psychiatrist every month and was a pillar of strength for him.

He is also very thankful to his three sisters who care for him and never say a word about his illness, but rather appreciate even a very small helpful deed from him. His mother's death was another big blow for him. She was not ill for long, and expired within a week after she was diagnosed with kidney failure.

All his sisters had been very supportive to him during that time. His elder sister who is in Bangalore took leave for a month and stayed with him during that difficult time. She heard about IPH and brought him to Tridal.

According to him he is almost a changed person after he started attending Tridal . Now he can manage stall well and carries out all kinds of chores. At present, he wishes to work in the Stitching department as well.

Looking at history of work records he seems to be a high functioning Shubharthi who can take up more responsibilities and can be placed in a better job as he is a fast learner.

N.P. is a 49 yrs. old Shubharthi with Tridal for more than ten years. He is very shy and unassuming but a hard worker and has been managing the Tridal stall in and around Thane very well. During school days NP was very good in all the subjects (80 % marks) except in Mathematics. He could not complete SSC as he could not clear Mathematics paper even after two attempts; he dropped out of school studies after that.

The family was staying in an apartment flat in Thane until he lost his father in 1998. His uncle managed to sell the apartment to provide for him and NP shifted to a one room apartment since then. His father was a civil engineer in PWD and his mother was a homemaker. He has one sister who is ten years younger than him and a software engineer. She is married and lives in Thane with her family. NP is quite attached to her and her son who is ten years old.

NP was very attached to his mother who expired in 1992, after which his father took voluntary retirement to manage home and children. His uncle who was in US noticed NP's odd behaviour (muttering to self , lack of self care , locking himself in one room etc.) during his visit to India, and talked to his father about it, after which NP was taken to psychiatrist.

His treatment started in 1997. After his father expired in 1998, and during his relapse later he was admitted to Thane Regional Mental Hospital three times as the medication was intermittent. After he started coming to Tridal his medication has been continuous. He takes it on his own and there had been no relapse since then.

He cannot manage any work with complex steps and instructions at Tridal but he attended classes for six months & appeared for MS-CIT three yrs. back and got 80% marks.

He is an asset to Tridal as he is willing to do any kind of work , is very soft spoken and caring and helpful to everyone.

Tip 9

Finally, a few key learnings

- It is important to encourage and facilitate the felt need for a support group.
- This will provide a starting point for other activities to emerge.
- The existence of a strong group bond will disperse worries about “What after us?”
- The quantum of space does not matter. Begin small, but ensure that it is a warm, welcoming space, and the meetings happen with regularity.
- Give attractive names to activities and groups, fitting the locale where your group belongs. These names can be created through discussion and discovery but they give the group an identity and help all identify with it.
- Hurdles will always be there. Do not get demotivated by them. Think together of ways to overcome them.
- Consistency is key. Meet regularly, even if there are no burning questions to discuss. Bonhomie and group bonding are important. Shubharthis and Shubhankars should WANT to meet.
- Create what you can sustain. Start small and build up slowly.
- Value what you do for the group. That engenders respect for the activity.
- The value to be integrated is that of mutual respect. There needs to be a rights perspective, not a charity perspective.
- Ensure that everybody has a voice: the professionals, volunteers, caregivers and Shubharthis.
- Neither the group delivering services (the professionals, volunteers), nor the consumers of the service (Shubharthis, caregivers) should feel entitled. Each is as essential to the activity as the other.
- Financials should be the last thing to worry about. IPH does not charge for services, and there have never been issues over finances. Paid services give the sense of a creche or a day care centre, not an activity centre. Rather, if possible, pay Shubharthis for their production once it reaches a threshold of self sufficiency. That engenders respect and self esteem.

Summing up:

Some key guidelines to start a rehabilitation unit:

- Interested mental health professionals, caregivers, high functioning *Shubharthis*, lay-people interested in the betterment of people suffering from schizophrenia or chronic mental illness come together. (Here they can take help of IPH team or follow this manual).
- A team is formed, guidelines for action plan noted and target with deadlines set. *Tridal* started with aim to help low-functioning *Shubharthis*. The team can define for whom they will work. It will be better to be more inclusive while doing such an experiment in the small towns or villages. This is mainly because mental health services are scarce in such areas and many families can get an opportunity to take benefit of such an initiative.
- With help of the treating psychiatrist, first get access to the caregivers of schizophrenia patients. Form a support group for the caregivers and schedule meetings.
- With help of the psychiatrist make a list of low-functioning *Shubharthis*. Motivate them to start coming to the centre (assigned location) and meet other people who are suffering similarly. This will be a gradual start of support group and activity group for the low-functioning *Shubharthis.*
- Try and fix a date and time which members will find convenient and easy to remember. The more automatic and routine the activity becomes, the better.
- Slowly activities can be introduced for the group which can now meet thrice a week for two hours or so.
- Activities need to be designed considering the chronicity of illness, side-effects of the medication experienced by the *Shubharthis*, their educational qualifications, occupational experience if any, skill-sets that the *Shubharthis* have, monetary requirement, etc.
- Initial activities can be group games focusing on their socialization. Profit making activities will come later depending on the consistency, persistence and motivation of the group.

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