Activity Report

2018 – 2019

UDAAN

An Initiative of TATA TRUSTS

RG MANUDHANE FOUNDATION FOR EXCELLENCE

TEAM UDAAN

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** Resigned from Tata Trusts during the year*

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LIST OF ABBREVIATIONS

ASHA	Accredited Social Health Activist
AUD	Alcohol Use Disorder(s)
CMD	Common Mental Disorder(s)
COPSI	Community Care for People with Schizophrenia in India
CS	Civil Surgeon
CSR	Corporate Social Responsibility
DDHS	Deputy Director, Health Services
DMHP	District Mental Health Programme
ECT	Electroconvulsive Therapy
IPD	Inpatients Department
JMSP	Jan Man Swasthya Programme
K10	Kessler Psychological Distress Scale
MANAS	Manashanti Sudhar Shodh
MHCA	The Mental Healthcare Act
MS	Medical Superintendent
NIMHANS	National Institute of Mental Health and Neurosciences
NMHS	National Mental Health Survey
OPD	Outpatients Department
OT	Occupational Therapy
PHC	Primary Health Centre
PREMIUM	Program for Effective Mental health Interventions in Under-resourced health systems
PRIME	Programme for Improving Mental Health Care
PWD	Public Works Department
RMHN	Regional Mental Hospital, Nagpur
RH	Rural Hospital
SAA	Schizophrenia Awareness Association
SCARF	Schizophrenia Research Foundation
SDH	Sub-District Hospital
SMD	Severe Mental Disorder(s)
SOP	Standard Operating Procedure
UPHC	Urban Primary Health Centre
VISHRAM	Vidarbha Stress and Health Program

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- Dr Anand Bang, Honorary Advisor on Health to the Chief Minister of Maharashtra: for continued guidance and support

- Officials of the Tata Trusts – Managing Trustee, Mr R Venkataramanan: for his far-reaching vision that made Udaan possible; CFO, Mr Ashish Deshpande, and Director, Health, Mr HSD Srinivas: for their guidance and support; and Dr Biranchi Jena: for the unfailing technical support extended to the programme

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- Tata Motors and Jaika Motors: for their contribution to the food truck; the Tata Strive team: for facilitating the acquisition of the truck

- Signet Library, Rajaram Sitaram Dixit Library, Navyug Library, Rashtriya Vachanalaya (all of Nagpur), and Ms Aparna Dubey (staff member): for donating books to the RMHN library for service users

- Mrs Durgawati Mannulalji Sharma: for the donation of a water cooler for service users

- The staff of RMHN: for taking the reform process forward in a highly collaborative manner

- SCARF: for technical partnership

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- The Maharashtra PWD: for their well co-ordinated efforts in the structural reform component of the hospital

- Mr James George of the Heritage Hotel, Nagpur: for being our hospitality partner and supporting our endeavour

Team Udaan

EXECUTIVE SUMMARY



INTRODUCTION

The Udaan project – a joint initiative of Tata Trusts and the Government of Maharashtra – took flight in mid-2016, with the ambitious goal of transforming mental health care in India by enhancing the quality of care – and thereby the quality of life – of people living with mental illness. In the first stage of the project, Udaan focused on initiating a multitude of activities at the Regional Mental Hospital, Nagpur (RMHN): from infrastructural and process reform and reform in clinical processes to capacity building of staff and strengthening individual care services. This year, Udaan took a giant leap forward by accepting the invitation of the Government of Maharashtra to collaborate in designing and implementing the District Mental Health Programme (DMHP) to deliver mental health care services at community level.

UDAAN AND THE DISTRICT MENTAL HEALTH PROGRAMME

The District Mental Health Programme

The District Mental Health Programme in India has been in existence since 1996 and has been implemented in many states, albeit not with much success. There is enough evidence from trials to know that it is possible to offer mental health services at grassroots level. And yet, such services have not translated into reality not just in India but also in other low- and middle-income countries. It is in this context that Udaan-DMHP assumes significance.

Udaan-DMHP: Goal and Objectives

The goal of Udaan-DMHP is to provide a robust community mental health intervention across the district, delivered through the health care system, to improve individual outcomes for people accessing care. Its objectives include designing and implementing a collaborative community mental health programme for priority conditions in partnership with the public health system at the district level; demonstrating key elements of the DMHP as important components of the programme to improve individual patient outcomes; and building the capacity of the public health system to deliver mental health care services at all levels.

The Geography of Udaan-DMHP

The programme will be operationalized first in the 13 rural blocks of the district of Nagpur, and also cover the Nagpur urban block.

Programme Design

The design of Udaan-DMHP was developed in discussion with government officials through several joint meetings, and after evaluations of the DMHPs in Karnataka and Kerala, in order to make it as robust and efficient as possible. The key elements of the design are described below.

Udaan-DMHP will be implemented at the community level by ASHAs, who are the frontline workers for the delivery of several public health programmes and services. One goal that the ASHAs will help achieve is at least 80% one-time coverage of the population through household screening in order to identify mental illness.

Udaan-DMHP has begun the task of training the ASHAs to identify mental illness through the process of screening. After a comprehensive literature review of community screening, a set of four forms has been developed as part of the screening process. The ASHAs are trained to create a comfortable environment in which to carry out the screening process. Screening is supervised by an Udaan team comprising community health workers and block co-ordinators. The screening process has been completed in Kalmeshwar block and is underway in two other blocks – Mouda and Hingna.

The second element of the Udaan-DMHP design involves conducting at least one psychiatric OPD clinic once every fortnight at a particular service point (a secondary level facility) in each block. A Facility Assessment Tool was developed and visits undertaken to different facilities, in order to ensure that the facility selected for each block was equipped to integrate high quality care services. Based on the results of the facility assessment and discussion with government officials, one service point per block was selected.

The first psychiatric OPD clinic was inaugurated in Kalmeshwar block on 16 October 2018. Subsequently, clinics were also inaugurated in two other blocks – in Mouda on 1 February 2019, and in Hingna on 4 February 2019.

Another element in the Udaan-DMHP design is capacity building of ASHAs as well as other cadres in the public health system to understand their new roles in the delivery of mental health care services, through a series of graded training programmes specially designed for each cadre.

While one round of training of medical officers and paramedical staff has taken place, the focus so far has been on the training of ASHAs since they are the key programme personnel at the community level. So far, the ASHAs of three blocks – Kalmeshwar, Hingna and Mouda – have undergone a one-day training programme.

Enhancement of human resources at various levels is another key programme component. Additional human resources are being recruited in phases, especially at block level, to ensure grassroots activation of the programme. These personnel include block co-ordinators, training co-ordinators, and community health workers.

DMHPs all over the country are nested in the psychiatric department of government medical colleges. However, these units do not have a wide community footprint. A psychiatric institution, on the other hand, is focused only on mental health, and thus has more scope to serve the community. It is by design, therefore, that the nucleus of Udaan-DMHP nests in the Regional Mental Hospital, Nagpur (RMHN).

Another departure from the norm is that Udaan-DMHP connects community health care to institutional reform, so that those in the community who are on the road to recovery have opportunities for employment and rehabilitation.

An emphasis on community engagement is an integral part of the programme. The ASHAs will be the first interface with the community and their role will be broadened to become a presence in the community that is well-informed about mental health. As the programme rolls out, and especially in year two, other key stakeholders in the community will also be co-opted as change agents in the mission to reach mental health care services to the grassroots.

One Year of Udaan-DMHP

One of the biggest learnings in the first year of Udaan-DMHP was about the power of collaboration: that while Tata Trusts can call upon a wide spectrum of expertise from its various departments and also from the many Tata companies, it still needs not only the clout of the government but also its wide infrastructure to reach scale. Another learning was that different elements of the public health system fall under the purview of different departments and officials, and that these elements have to be brought together to enable the programme to use the resources of the health system and collaborate with it effectively. The programme also learnt that only a government official with a high level of authority can bring these elements together.

The major achievements of Udaan-DMHP in the first year include the activation of the programme in three rural blocks; screening of 41,018 households and 1,25,883 individuals; treatment of 826 service users in the three psychiatric OPD clinics; training of 598 members of staff; school intervention programmes in 100 schools for 17,045 students; and treatment of 224 individuals through the prison outreach programme.

Despite the achievements, it was important that the programme take stock of and reflect on all that had transpired in the first year. The first Advisory Board meeting of Udaan-DMHP was convened on 10 January 2019 at RMHN. The major takeaway from the meeting was the validation of the work done so far by Udaan-DMHP, with some specific pointers as regards streamlining the protocol.

The second year of Udaan-DMHP will see many more frontline workers trained, many more blocks and many more clinics activated as per the complex timeline that has been worked out. New programmes that can be layered on to Udaan-DMHP, and that meet the specific and urgent needs of various groups in the community are also planned. These include specific programmes for the youth, for the ageing population, and for women.

UDAAN AT THE REGIONAL MENTAL HOSPITAL, NAGPUR

Reform of Clinical Processes

The findings of the clinical audit report commissioned last year, along with the key recommendations for strengthening clinical processes, were disseminated to the RMHN staff on 23 August 2018. Based on the audit recommendations, four protocols have been developed; four more protocols and two training modules for staff are currently under preparation.

One of the problems faced by service users in the OPD was that they did not understand or remember the instructions regarding the medications given by the pharmacist. The Udaan team devised a simple but effective method to address this problem: the medicines are now put into envelopes and instructions written on them, in addition to a team member explaining the dosage of each drug.

To address the issue of shortage of drug stocks, the Udaan team, with the help of the authorities, evolved a system of providing monthly drug stock updates; the team also monitors stocks and follows up with the authorities to ensure that sufficient stocks are always available.

Automation of records was another activity undertaken by Udaan – a standardized case history module was developed, and now registration of all new service users is done directly on the computer, using the new software. Records of old service users have also been computerized.

Udaan has developed a protocol on suicide risk assessment and management, which will be translated into a training module for RMHN staff. As recommended by the clinical audit team, a change has been introduced in the mealtimes of service users due to receive ECT in the morning, so that the gap between meals (before and after ECT) is not excessive.

Structural and Process Reform

The scheme piloted last year to replace preset meal trays with a buffet system was extended to two more wards this year. The new system allows service users to eat the food items they like, without a restriction on quantity; it has reduced wastage and also made it possible to use leftovers for those who are hungry between meals.

Construction of four new wards – the Step-down ward, the Acute ward, the Recovery ward, and the Family ward – was completed this year. Several other small but impactful infrastructural improvements were also made, including the construction of new stone benches and dinner sheds, and the installation of mosquito nets in the wards.

The installation of mirrors – initially plastic mirrors and now large glass mirrors in the stable wards – is another innovation that Udaan has introduced in the hospital.

New handwashing platforms constructed during the year took forward the effort to improve sanitation and hygiene. However, the challenges related to the creation of a proper sewage line – identified as a critical need early on – continued this year.

The hair salon for men and the beauty parlour for women – both inaugurated last year – continued to be popular, with the number of users increasing steadily. Another significant step in promoting user dignity was the stopping of unnecessary tonsuring of service users.

The OPD was given a facelift this year. Apart from being freshly painted, the OPD also saw the refurbishment of the porch, new flooring, and installation of new signage and information boards, making the area more user-friendly.

The efforts towards automation were given a fillip, with the initiation of a system of paperless entries during registration. Testing of the IPD software module has also been completed along with the initiation of real-time entries for demonstration purposes.

Capacity Building

As part of Udaan's ongoing activities for capacity building, hospital staff were trained on the Mental Healthcare Act, 2017; 22 staff members were also trained in the newly developed protocols for ECT administration, sentinel events, family wards, and clinical prescription. Six members of staff – not part of the Udaan-RMHN team – were trained on the pre-measurement of service users for individual case management.

Individual Care Services

The construction of a library and a meditation hall is part of Udaan's effort to engage service users in activities that are both relaxing and educative. In addition to approaching libraries for donations, Udaan has purchased books that are intended specially for people with intellectual disability and cognitive difficulties. Service users enjoy the colourful pictures on the walls of the library, and all the users – including those who are unable to read – enjoy going through the picture books and magazines. Case managers motivate service users to attend the sessions in the meditation hall, where they learn techniques of breathing and meditation.

This year saw some important steps in Udaan's efforts to create employment pathways for service users: the strengthening of agricultural activities, and the setting up of a mobile cafeteria, a bakery, and a tailoring unit.

Farming remains the most important activity for employment generation. Cultivation of the land cleared in the previous year continued this year, with a good yield of bananas (which were sold to a vendor), papaya, and vegetables. While 6.5 acres are being farmed currently, an additional 3 acres have also been identified for clearing and cultivation in the near future. A total of 57 male service users were employed in agricultural activities during the year; six women have also now been identified for employment in agricultural work.

After some discussion and getting the necessary permissions from the hospital authorities, the Udaan team identified a suitable space within the hospital premises for setting up a bakery. With the help of the PWD, the required infrastructure is now ready, and the plan is to secure government funding or use CSR funds to buy the remaining equipment. While professional staff will be recruited and trained to do the main tasks, service users will be trained in packaging the baked products.

The mobile cafeteria provides yet another avenue for employment and revenue generation. A truck was procured at a subsidized rate from Tata Motors through a Nagpur-based dealer; it was remodelled and refurbished. The food truck – named *Chai Nashta* – was then made visually attractive with cheerful drawings on the outside; the tagline – *Khao Piyo, Khush Raho* – expresses its purpose perfectly! The mobile cafeteria is expected to become functional in a few months.

With the idea of using the 10 sewing machines received as a donation, the Udaan team identified service users who could be trained to make bags; five women and three men have been trained enough to make six to 10 bags a day. While the tailoring unit has made it possible for at least a small number of service users to build some skills, the challenge now is to find a way to sell the bags at a competitive price.

As part of its effort towards financial inclusion of service users, this year Udaan has initiated an internal banking system at RMHN. Each service user who is employed has been provided with a passbook. Remuneration due to the service user is noted in the passbook. The total amount due to the employees is deposited in an external bank, where an account has been opened in the name of Prayas Banking. Anyone wanting to access their savings can approach the Udaan team to help them withdraw the required amount.

INDICATORS OF IMPACT

Since the Udaan project is the first of its kind – a partnership between a state government and a private philanthropy in the mental health sector – there are no readymade indicators to measure its impact. It took a long time, and several iterations, for Udaan to develop a set of indicators that would measure the impact of the reforms undertaken. These indicators, along with the impact measured so far, are explained in detail in the report.

THE POWER OF PARTNERSHIP

This year, Udaan was once again witness to the power of partnership. The collaborative spirit has grown stronger at RMHN; it has also empowered the newly launched DMHP to achieve a great deal in a relatively short time.

The Deputy Director, Health Services, Nagpur Circle, Dr Sanjay Jaiswal, brought the different elements of the public health system together, so that Udaan-DMHP could effectively use the resources of the health system. The Civil Surgeon, Dr Devendra Paturkar, became the programme's mentor and guide; his willingness to use his authority to solve problems and make the system deliver has been invaluable in enabling the programme to forge ahead. Even departments like the PWD, that had initially been tough to work with, have become allies and lent their power to the collaborative engine.

The involvement of Mr Jayant Zoting, Deputy General Manager, TAL Manufacturing Solutions Ltd., Nagpur, set off a ripple effect of giving – from providing a JCB to supporting the programme as the company's CSR activity to roping in colleagues and friends to support Udaan. Mr Ashish Adhau broadened the circle of giving by persuading suppliers to provide items at cost price.

The Udaan team is daily strengthened by such goodwill. Their hope is for more people and more organizations to get on board and make a commitment, however small, to the larger good.

INTRODUCTION



It is with a deep sense of satisfaction that we present the report of the activities undertaken in the year 2018–2019 by the Udaan project – a joint initiative of Tata Trusts and the Government of Maharashtra.

After several months of intensive groundwork, Udaan took flight in mid-2016, with the ambitious goal of transforming mental health care in India by enhancing the quality of care – and thereby the quality of life – of people living with mental illness. In the initial stage of the project, Udaan focused on undertaking a multitude of activities at the Regional Mental Hospital, Nagpur (RMHN), with the aim of developing it as a centre of excellence that would serve as a model for other psychiatric institutions seeking change.

The first two years of the project saw the initiation of several efforts covering a gamut of reform areas – from infrastructural and process reform and reform in clinical processes to capacity building of hospital staff and building and strengthening individual care services. These were years of hard work and struggle; they were also years of tremendous satisfaction and growth.

This year – the third year of the project – Udaan took a giant leap forward. It was a leap of faith – and hope. Faith in the power and promise of collaboration to impact not a single institution but an entire district. And hope that the collaboration would create a model that could transform community-based mental health care services in our country.

The availability of mental health services at community level is critical, especially in low- and middle-income countries like India where, for a variety of reasons, these services do not reach those that need them the most. Many individuals who may have a mental disorder are not even perceived as needing medical care and treatment; and even in families in which there is awareness of mental illness, access to reliable and organized services poses a huge problem. Families do the best that they can, but sooner or later their meagre resources get depleted; they feel overburdened, helpless, and disheartened as their family member continues to suffer. Mental illness therefore takes a toll not only on the person with the illness but on the entire family as well.

It was this bleak scenario of grossly inadequate mental health services at grassroots level that prompted Tata Trusts to accept the invitation of the Government of Maharashtra to collaborate in designing and implementing the District Mental Health Programme (DMHP). The Memorandum of Understanding was signed in December 2017 and Udaan-DMHP came into being.

Udaan's readiness to partner with the public health system to design and deliver mental health care services at grassroots level was based on many factors. Long before Udaan took flight, Tata Trusts had conceptualized and co-implemented the Jan Man Swasthya Programme (JMSP). This was a community-based mental health service delivery programme conducted in seven different sites across the country and covering a large population base.

The experience of implementing JMSP had much to teach the Udaan team. The team had learnt that the development and integration of mental health into the community domain needed work at multiple levels: it needed work at community level; it needed work with the public health system; it also needed work in the area of capacity building of various cadres involved in the delivery of mental health services.

Another major factor that gave Udaan the confidence to take on the DMHP was the first two years of reform work at RMHN. During this period, Udaan had forged relationships with key officials of the government. A rapport was built with the psychiatric department of RMHN. And the Udaan team had taken shape and gained experience in working with the deep-end spectrum of mental illness.

Udaan sees a link between institutional reform and community mental health programmes. It believes that unless services are offered at community level, the inflow into the institution is not likely to come down. Therefore, if one of its missions is institutional reform at RMHN, then it must also partner in the bigger and much more challenging mission – the integration of mental health services at community level in the district of Nagpur.

Yet another factor that emboldened Udaan was the fact that it could count on expertise and support from the various programmes of Tata Trusts and also from the Tata Group of Companies. Their contributions to institutional reform at RMHN – in the farming initiative, in creating employment pathways, in setting up the archives, and in the digitization of hospital records – have been monumental.

Udaan had also learnt through experience about the trust and goodwill that the Tata brand generates. This invaluable resource would also go a long way in empowering Udaan to undertake this enormous challenge – of taking on not just one or two or even five blocks, but an entire district. This scale was essential if Udaan-DMHP was to become a model that other districts could learn from and adapt.

Tata Trusts officials provide on-ground support to the programme

The first part of this report explains in detail the rationale of the DMHP and Udaan's role in it; it describes the objectives and design of Udaan-DMHP, and elaborates the activities undertaken so far to achieve these objectives. It also discusses some of the challenges that the team had to overcome, and the learnings along the way.

The second part of the report provides information on Udaan's reform activities at RMHN – ongoing activities as well as significant new efforts.

The Udaan project is a first-of-its kind partnership in the mental health sector – one between a state government and a private philanthropy. Given that Udaan is a pioneering effort, how do we measure its impact? What are the indicators to be used? The third section of the report explores these issues, and also provides an overview of all that has been achieved so far, both at RMHN and in the DMHP.

Udaan would not have been able to achieve what it has without the active participation and involvement of a range of stakeholders – government, non-government organizations, Tata Group companies, as well as other private institutions. In addition to acknowledging all these contributions, a few noteworthy instances are described in the concluding part of the report.

SECTION 1

UDAAN

AND

THE DISTRICT MENTAL HEALTH PROGRAMME

The District Mental Health Programme in India

The District Mental Health Programme (DMHP) in India has been in existence since 1996. But decades before that, ever since India became independent, it had recognized the need for community-based mental health services and had struggled to evolve various models that could reduce the *treatment gap*. This term (expressed as a percentage) refers to the number of individuals with an illness who need treatment but do not receive it.

In 1982, India announced the National Mental Health Programme and in 1985, NIMHANS launched the Bellary community mental health programme for a period of five years. This programme formed the basis for the DMHP launched in 1996.

Since then many states have implemented the DMHP. However, the programme in its totality has not met with much success.

There is enough evidence from trials to know that it is possible to offer mental health services at grassroots level. And yet, such services have not translated into reality not just in India but also in other low- and middle-income countries.

It is in this context that Udaan's involvement in the DMHP assumes significance.

Udaan-DMHP: Goal and Objectives

The goal of Udaan-DMHP is to provide a robust community mental health intervention across the district, delivered through the health care system, to improve individual outcomes for people accessing care.

The objectives of the programme are:

To design and implement a collaborative community mental health programme for priority conditions (SMD, CMD, AUD, and convulsive epilepsy) in partnership with the public health system at the district level

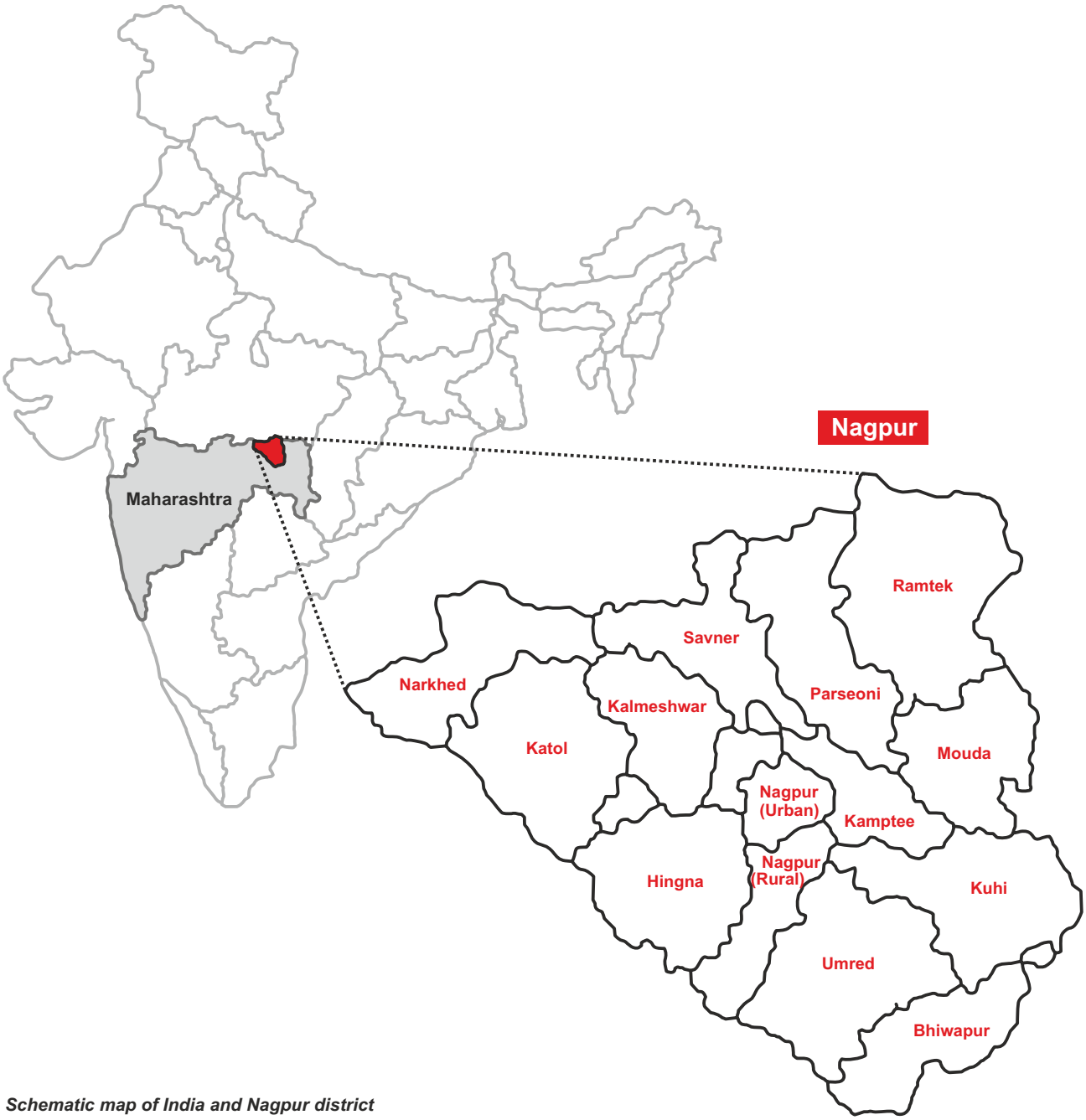
To demonstrate key elements of the DMHP such as mental health helpline, day care centre and half-way homes as important components of the programme to improve individual patient outcomes

To build the capacity of the public health system to deliver mental health care services at all levels

The Geography of Udaan-DMHP

The programme will be operationalized first in the 13 rural blocks of the district of Nagpur.

Udaan-DMHP will also cover the Nagpur Urban block. Through a separate agreement signed with Nagpur Municipal Corporation, Tata Trusts has undertaken to enhance the overall primary health care services offered by the 26 UPHCs. Udaan-DMHP will layer mental health services in these UPHCs.



Schematic map of India and Nagpur district

Nagpur District

Number of Blocks **14**

NO. OF HOUSEHOLDS

Total	Rural	Urban
1,041,544	339,997	701,547

POPULATION

Total	Rural	Urban
46,53,570	14,74,811	31,78,759

NO. OF REVENUE VILLAGES

778

NO. OF SERVICE POINTS

Sub-Centres	PHCs	SDHs	RHs
316	49	2	9

Number of people anticipated to be **living with mental illness**

4,93,278

Programme Design

The DMHP has many components and elements. In its first year, however, Udaan-DMHP chose to focus on a few essential elements and implement them in an innovative manner. As Udaan-DMHP rolls out, other elements will be added to create a uniquely designed and holistic programme.

The design of Udaan-DMHP was developed in discussion with government officials through several joint meetings with the Civil Surgeon, the District Health Officer, and the Deputy Director, Health Services for the Nagpur circle. Meetings were held with the Joint Director, Non-Communicable Diseases, at state level. These meetings also helped with understanding budget allocation – funds that the government could earmark for this programme and additional funds that would have to be raised.

At the same time, evaluations of the DMHP in India were studied and field visits undertaken to district mental health programmes in Karnataka and Kerala.

The design went through several changes in order to make Udaan-DMHP as robust, efficient, and manageable as possible. The elements of the design as it stands currently are highlighted on the following pages.

Using a non-specialized workforce of Accredited Social Health Activists (ASHAs) to create a touchpoint in every household and thus uniformly embed the programme at community level

Udaan-DMHP will be implemented at the community level by the ASHAs, who are the frontline workers for the delivery of several public health programmes and services. The ASHAs are eminently suited to perform this important role for many reasons: they belong to the community that they serve; they are 'insiders' and have earned the trust of the community; they are equipped with some basic information on health, especially on maternal and child health. The ASHAs are also a huge workforce; the block of Kalmeshwar alone has 100 ASHAs serving it.

One goal that the ASHAs will help achieve is at least 80% one-time coverage of the population through household screening in order to identify mental illness. As the programme builds up and the ASHAs receive more and more training inputs, they will be ready to perform other tasks: they will link the person with mental illness to the specialist available at block level and they will also undertake case management at community level.

Although screening is a high resource activity, it serves an important function in the programme. Udaan-DMHP strongly believes that unless the ASHAs go directly into the homes, the goal of uniformly embedding the programme at community level will not be achieved. Screening will create pathways for appropriate care, and ensure that people who are most in need of services are linked to care, especially for the harder-to-recognize CMDs. Screening will also help flag emergencies and get adequate help to the person as quickly as possible. An indirect benefit is that screening will generate reliable data about household coverage and provide a quantifiable measure of the reach of the programme in the community.

It must be emphasized that the programme carefully considered using community awareness as a replacement for screening. However, despite all efforts to protocolize it, the fact remains that community awareness programmes do not reach all the people, especially those who need the services the most. A complex interplay of various socio-economic and disability-related issues may leave out the most marginalized from receiving the benefits of community awareness programmes.

Udaan-DMHP has begun the task of training ASHAs to identify mental illness through the process of screening. This activity has been planned and executed in a structured manner by

- developing a protocol for screening at household level
- training the ASHAs to understand and practise the implementation of the protocol
- activating the implementation of the protocol by the ASHAs
- supervising the ASHAs in the process of implementation.

The protocol also includes a component of awareness on mental health along with information on where to seek help. As the ASHAs get trained, they will also serve as an immediate response system for emergencies.

Tools developed for screening

After a comprehensive literature review of community screening, a set of four forms has been developed as part of the screening process: an informed consent form; a socio-demographic tool to track and understand the composition of each household; a checklist to determine the prevalence of severe mental disorders using a key informant approach; and the K10 for the screening of common mental disorders.

These tools are developed such that the screening process is easy to administer in as short a time period as possible; the ASHAs are also trained to create a comfortable environment in which to carry out the screening process.

Steps involved in the screening process

- A list of households is derived from the block office
- Informed consent of the head of the household is taken prior to initiating screening
- Socio-demographic details of the household are recorded on the form
- Key informant based SMD checklist is filled for the household
- The K10 is administered to individual members of the family
- Two repeat visits are made to complete the K10 for each family member
- Feedback from the screening is provided to the family within 15 days

Supervision of the screening process

Screening is supervised by an Udaan team comprising community health workers and block co-ordinators. They ensure that the set of forms submitted by the ASHAs is complete. The incomplete forms are sent back to the respective ASHAs who then revisit the household on the same day or on the next working day. Since automation is not yet operationalized, the scoring for the K10 and SMDs is done manually by the block co-ordinators. The feedback loop is closed when the families of the individuals who have screened positive are visited by the respective ASHA within 15 days.

During this visit, the ASHA motivates the family to seek help from the psychiatric OPD clinic that takes place on a designated day once every fortnight. She leaves behind an OPD referral card that gives information about the clinic – where it takes place, on which day of the week; she also writes down her name and contact details on the referral card.

Both the screening process as well as the process that takes place after the screening have in-built mechanisms for quality control as well as for checking data validity and reliability.

The screening process has been completed in Kalmeshwar block and is underway in two other blocks – Mouda and Hingna.

At first we felt that this survey work was very very difficult and because of that we did not want to do it. Then we got training and we learnt how to fill the forms; our Madam also convinced us that we should do the screening, and so we did it.

In the beginning, when we started going to the households for screening, we were apprehensive but the people gave us a lot of support; yes, there were some people who laughed at us and did not take us seriously. There were also others who said whatever came to their mind. That would upset me but then my screening detected people who were having mental health problems and when they started going to the OPD, they saved a lot of money, almost ₹2,000/- to ₹3,000/- per month, which is what they had been spending on private treatment. In our OPD they got free treatment and the entire household rejoiced and I also felt happy that I had done the screening. People come and ask me questions; I want the people of my village to get treatment, I want them to be well.

Pramila Kale, ASHA, Village Pilkapar, Mohpa PHC, Kalmeshwar

Conducting at least one psychiatric OPD clinic once every fortnight at a particular service point in each block

After several deliberations with the government at local level, it was decided that the OPD clinic should be in a secondary level facility in the block – either in a sub-district hospital or a rural hospital, or in a community health centre.

However, comprehensive facility assessment was required to ensure that the facility selected for each block was equipped to integrate high quality care services.

A list of facilities to be visited was developed and the facilities intimated one month prior to the visit through a letter from the Civil Surgeon. Facility assessment was undertaken by a four-member team from Udaan-DMHP. The team used the Facility Assessment Tool to map the services, infrastructure, and human resource availability, and identify gaps in these areas.

The Facility Assessment Tool was developed using the framework of Indian Public Standards, to which other relevant variables were added.

The Facility Assessment team undertook an observation round of the facility and conducted a detailed interview with the Medical Officer or the Medical Superintendent of the facility. They also had discussions with the pharmacist on issues related to medicines and pharmacy operations.

The broad parameters of the Facility Assessment were

- Space availability
- Drug availability and functioning of the pharmacy
- Availability of information technology infrastructure
- Manpower/personnel recruited and their skill level
- Laboratory investigations and process thereof
- Availability of doctors
- OPD case load
- Mental health OPD case load

Based on the results of the facility assessment and discussion with government officials, one service point per block was selected. Space allocation for the psychiatric clinic within the facility was discussed with the Medical Officer of the selected facility. Formal approval for allocation of space was issued by the Civil Surgeon to the facility.

The drug supply for the clinic is planned and maintained in coordination with the office of the Civil Surgeon. Gaps are addressed through innovative means, including cross lending from other government facilities such as the Regional Mental Hospital, Nagpur and the DMHP of Bhandara.

While such co-operation is a great help, the programme has to find ways and means to streamline medication supply; the process for this has already been initiated with the Chief Minister's office.

The first psychiatric OPD clinic was inaugurated in Kalmeshwar block on 16 October 2018. Since Tuesday is market day for this area, the clinic is also held every other Tuesday, so as to maximize footfalls.

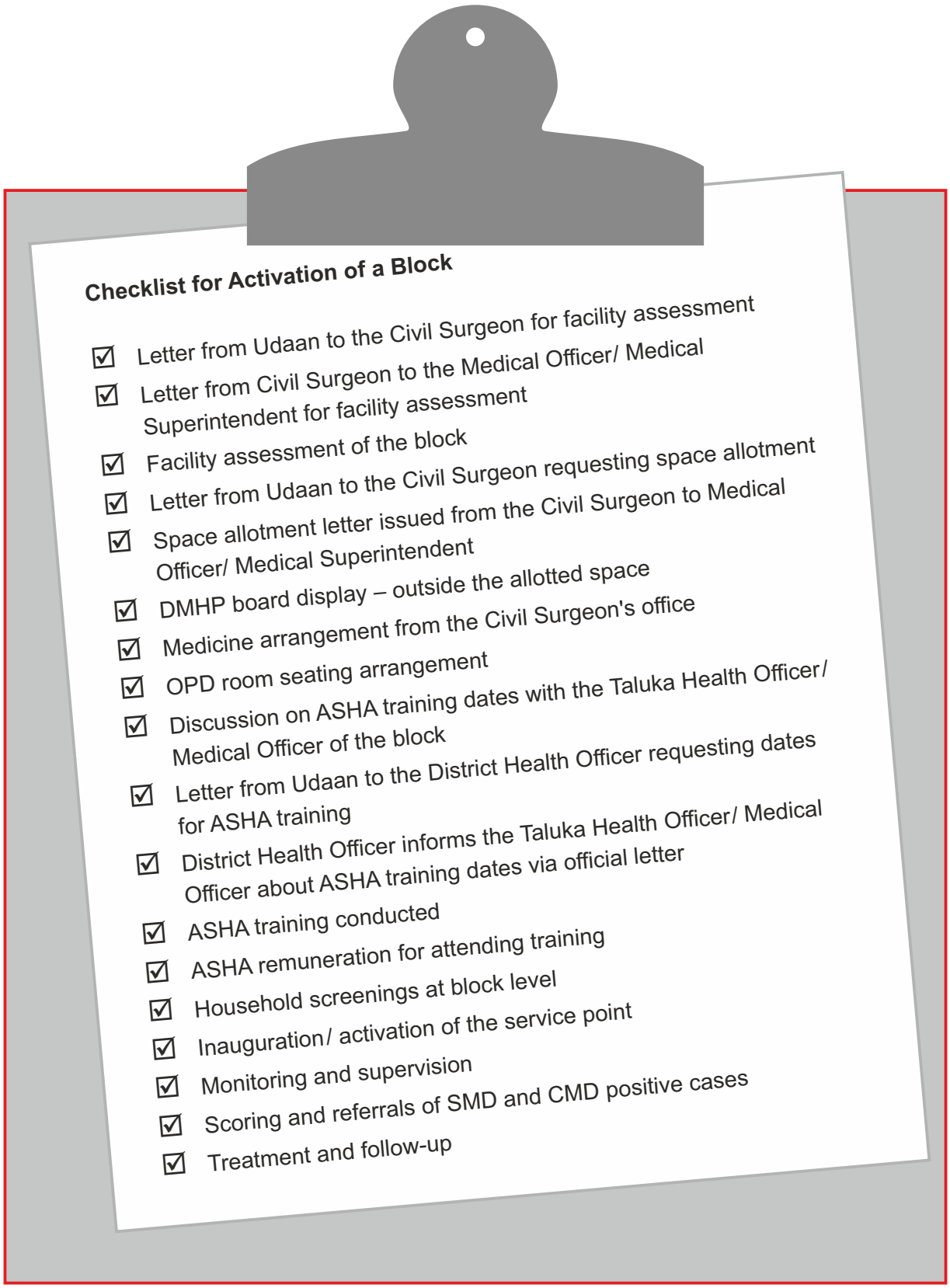
Subsequently, psychiatric OPD clinics were also inaugurated in two other blocks – in Mouda on 1 February 2019, and in Hingna on 4 February 2019.

Campaigning for the psychiatric OPD clinic and the inaugural function

Two days before the inauguration of the psychiatric OPD clinic, Udaan-DMHP members spread the word about the inauguration of the clinic. A vehicle with a microphone goes from village to village; the date and time of the inaugural function is announced and villagers invited to attend in large numbers.

The Udaan-DMHP team invites all local level government officials to the function. The Civil Surgeon makes it a point to attend every inauguration, despite his busy schedule.

Care is taken to create a festive environment with due pomp and ceremony: an inaugural lamp is lit, and speeches delivered by local leaders and government officials. The message communicated through all this is that the partnering organizers are serious in their efforts to reach mental health facilities to their doorstep and that these high quality facilities should be used by one and all. The clinic is also formally inaugurated with a high level official cutting the ribbon and declaring the clinic open to the public.



Checklist for Activation of a Block

- ☑ Letter from Udaan to the Civil Surgeon for facility assessment
- ☑ Letter from Civil Surgeon to the Medical Officer/ Medical Superintendent for facility assessment
- ☑ Facility assessment of the block
- ☑ Letter from Udaan to the Civil Surgeon requesting space allotment
- ☑ Space allotment letter issued from the Civil Surgeon to Medical Officer/ Medical Superintendent
- ☑ DMHP board display – outside the allotted space
- ☑ Medicine arrangement from the Civil Surgeon's office
- ☑ OPD room seating arrangement
- ☑ Discussion on ASHA training dates with the Taluka Health Officer/ Medical Officer of the block
- ☑ Letter from Udaan to the District Health Officer requesting dates for ASHA training
- ☑ District Health Officer informs the Taluka Health Officer/ Medical Officer about ASHA training dates via official letter
- ☑ ASHA training conducted
- ☑ ASHA remuneration for attending training
- ☑ Household screenings at block level
- ☑ Inauguration/ activation of the service point
- ☑ Monitoring and supervision
- ☑ Scoring and referrals of SMD and CMD positive cases
- ☑ Treatment and follow-up

Psychiatric OPD clinics in operation

Capacity building of ASHAs as well as other cadres in the public health system to understand their new roles in the delivery of mental health care services, through a series of graded training programmes specially designed for each cadre

Capacity building and training is a critical component for many reasons.

First of all, public health personnel have received little or no training so far, either in mental health, wellness, and illness or in mental health care service delivery. So the training has to first lay this foundation and then add more inputs that have to do with the new roles and responsibilities that will have to be undertaken by each cadre.

Secondly, the programme envisages the use of the principles of task shifting and task sharing in which the task of the specialist is shared by shifting it downwards to other human resources in the team. The task of the specialist then goes through a transition as the specialist takes on the role of trainer-mentor-supervisor. This means that capacity building becomes critical at several levels – ASHAs, Tehsil Health Officers, Community Health Workers, Medical Officers.

As the programme rolls out, it is envisaged, for example, that the Medical Officer at the block facility will be able to provide the bulk of psychiatric care and that the facility will no longer have to depend on a psychiatrist. However, this can only happen through capacity building, which involves classroom teaching, experiential learning, as well as continuous hand-holding to address practical matters. Further, all aspects of training have to be protocolized, so that the content and quality of the inputs do not depend only on the person providing the inputs.

Operationalizing the training is equally complex. Several government officials have to be kept in the loop and the training calendar has to be worked such that best use is made of the existing government resources set aside for the ASHAs.

The trainings are modular, with specific themes handled in individual modules. Most of the content and the methodology for the training modules is developed in-house. However, training modules from Tata Trusts' programmes of JMSP and VISHRAM as well as other programmes such as MANAS, COPSI, PREMIUM, and PRIME are also used as references for adaptation.

While one round of training of medical officers and paramedical staff has taken place, the focus so far has been on the training of ASHAs since they are the key programme personnel at the community level.

So far, the ASHAs of three blocks – Kalmeshwar, Hingna and Mouda – have undergone a one-day training programme.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Objectives of the ASHA training module

- To develop a basic understanding of mental health and mental illness
- To introduce the Udaan-DMHP
- To explain and clarify the new roles and tasks that the ASHAs will undertake in this programme, with specific emphasis on their task of household screening
- To enable the ASHAs to understand the set of four screening tools
- To provide practice to the ASHAs in administering the screening tools

The ASHAs will continue to undergo training in the next few years as their role gets enlarged and they become well-informed change agents in the community.

At first we found this work of survey very tough but as we started getting training, slowly slowly it became easier. It took time, but did get easier as we started doing the screening and filling the forms. I was also able to recognize the symptoms and I understood that there are people who need to go to the Regional Hospital. I felt happy when the persons started taking medicines. It looks as if they will be able to interact with others and talk and behave just like any of us.

Vaishali Mahurkar, ASHA, Village Zilpi, Tisti PHC, Kalmeshwar

Enhancement of human resources at various levels

Udaan-DMHP is setting out to reach 80% of a population of approximately five million people, and that too with a comprehensive care package. This requires human resources far greater than the regular DMHP allotment of seven officials.

Additional human resources are being recruited in phases, especially at block level, to ensure grassroots activation of the programme. These personnel include block co-ordinators, training co-ordinators, and community health workers.

It is the skills and strengths of all these personnel that will ensure that the comprehensive services benefit not only the maximum number of people but also those that need the services the most. It is hoped that as the Udaan-DMHP model begins to show results, it will pave the way for making provision for additional human resources while planning any DMHP in the future.

Nesting the programme within a mental health institution

DMHPs all over the country are nested in the psychiatric department of government medical colleges. However, these units do not have a wide community footprint. A psychiatric institution, on the other hand, is focused only on mental health and thus has more scope to serve the community.

It is by design, therefore, that the nucleus of Udaan-DMHP nests in the Regional Mental Hospital, Nagpur. There are several advantages to this.

The programme envisages RMHN as a fallback mechanism that can lend support in a variety of ways. For example, as of now, Udaan-DMHP has only one psychiatrist. When this person needs emergency leave, the psychiatrist from RMHN is requested to step in to conduct the clinic. The availability of such support is critical: a gap in services and people being turned away does not bode well for a new programme in which trust building with the community is of vital importance. Another example: when there is a shortage of medicines, RHMN steps in to make up the deficit. In fact, RHMN is constantly stepping in to ensure that Udaan-DMHP continues to be effective despite the many challenges it faces on a daily basis.

In turn, Udaan-DMHP has offered its specialized expertise to RMHN. For example, it will absorb and implement RMHN's prison outreach programme.

It must be noted that mental hospitals have a regional presence. However, technology can be optimally used to extend the reach of these regional entities to serve the districts. In this way, district mental health programmes can still avail of the many benefits of nesting the programme within a mental health institution.

Connecting community health care to institutional reform, so that those in the community who are on the road to recovery have opportunities for employment and rehabilitation

Udaan's involvement in institutional reform at RMHN, and the relationship of co-operation, support, and trust that has slowly but surely been established, will not just strengthen Udaan-DMHP but also make it innovative.

For instance, people from the community who have SMDs and who are on the road to recovery will be able to access the many employment pathways, such as farming, that are already in place at RMHN. They can also access other pathways that are in the pipeline – including coffee vending, photocopying, and operating the mobile cafeteria and the bakery.

Another pathway for rehabilitation is the Day Care Centre at RMHN. This too will be activated shortly to become a single integrated space for rehabilitation for people from the community as well as from inside the hospital.

Emphasis on community engagement as an integral part of the programme

Udaan-DMHP's vision of community engagement is broad and substantive. The ASHAs will be the first interface with the community and their role will be broadened to become a presence in the community that is well informed about mental health.

As the programme rolls out, and especially in year two, the key stakeholders in the community – panchayat and gram sabha, chemists, farmers' groups, mahila mandals, and faith healers – will also be co-opted as change agents in the mission to reach mental health care services to the grassroots.

It is not enough to spread general awareness about mental health and mental illness. While this is an important preliminary activity, what is also needed is the creation of strategies and tools, different for each stakeholder group, to motivate them to become proactive; specific action points will be worked out for each stakeholder group so that they know in concrete terms what they can do in their new avatar as change agents.

Innovative Features of the Udaan-DMHP Design

Collaboration is at the centre of the programme that sits within the health care system and is co-implemented by the health care system in partnership with Udaan. Such a collaborative programme for designing and implementing a DMHP is indeed the first of its kind.

The programme makes a distinctive use of the non-specialized workforce of the ASHAs at district level; it envisages an ever-enlarging role for the ASHAs.

The ASHAs create a touchpoint in every household through the screening process; this enables the programme to be uniformly embedded at community level.

The programme employs innovative approaches to capacity building not only of the ASHAs but also of other cadres in the public health system.

The nucleus of the programme nests within a mental health institution – RMHN becomes a support system, a fallback mechanism.

The programme has a major addition of human resources at various levels.

Community health care is connected to institutional reform to create opportunities for employment and rehabilitation.

Extending Our Reach

Prison Outreach Programme

The outreach programme in Central Jail, Nagpur, which used to be run by the staff of RMHN, has recently been taken over by Udaan-DMHP.

The Udaan-DMHP psychiatrist visits the prison once a week, when he sees as many as 25 to 30 individuals with mental illness. To begin with, the focus has been on providing medication; with a population of over two thousand prisoners, a single psychiatrist is unable to address the psychosocial aspects of treatment. Even so, this intervention has resulted in marked improvement in those individuals with problems of depression, anxiety, psychoses, and epilepsy.

School Awareness Programmes

Mental health awareness programmes have taken place in a hundred schools in three blocks – Kalmeshwar, Hingna and Mouda. It is an hour-long programme for high school students conducted in Hindi or Marathi by a professional psychologist, who introduces the concept of mental health and mental illness. The focus is on aspects that relate to student life – stress, depression, anxiety, fear of failure, peer pressure. The students are also encouraged to tell their people at home about the introduction of a high quality psychiatric OPD clinic in their block.

One of the future plans is to design a special programme for the youth that looks at mental health from the perspective of wellness rather than illness. Such a programme will talk about mental health through arts, crafts, songs, and even drama. Such a programme can also empower the youth to develop leadership and life skills.

One Year of Udaan-DMHP

Looking Back, Looking Forward

The first year of the Udaan-DMHP partnership simply flew by. There was so much to initiate and implement; so much to experience and learn.

One of the biggest learnings was about the power of collaboration: that such a comprehensive programme cannot be designed and implemented solely by the government or solely by a non-government entity like Tata Trusts. While the Trusts can call upon a wide spectrum of expertise from their various departments and also from the many Tata companies, it still needs not only the clout of the government but also its wide infrastructure to reach scale: at mile zero, the only presence is that of the government and of no other agency. So the only way forward is collaboration.

Another learning was that different elements of the public health system fall under the purview of different departments/officials. For example, the DMHP traditionally sits with the Civil Surgeon while the ASHAs are managed by the District Health Officer. These elements had to be brought together, so that the programme could use the resources of the health system and also collaborate with it effectively. The programme also learnt that only a government official with a high level of authority can bring these elements together.

Year One: Udaan-DMHP Achievements

Number of blocks activated 3

SCREENING

Number of **households** screened
41,018

Number of **individuals** screened (K10)
1,25,883

Number of **individuals screened positive for SMD**
10,444

Number of **individuals screened positive for CMD**
11,596

PSYCHIATRIC OPD CLINICS

Total number of service users **undergoing treatment in the three blocks**
826

Number of first time individuals coming to the clinics
622

Number of follow-up service users in the clinics
204

TRAINING

Total number of **staff trained**
598

Number of **ASHAs trained**
495

Number of **paramedical staff trained**
62

Number of **medical officers trained**
41

OUTREACH PROGRAMMES

Number of schools reached
100

Number of students reached through the school programme
17,045

Number of individuals under treatment through the prison outreach programme
224

Despite the achievements, it was important that the programme take stock of and reflect on all that had transpired in the first year. Many of the design elements of the programme were the first of their kind and so there were no precedents to serve as guideposts. The programme, however, has eminent advisors from the government and non-government sectors. They are stalwarts in various aspects related to mental health and community work, and the programme needed to hear from them.

The first Advisory Board meeting of Udaan-DMHP was convened on 10 January 2019 at the VC hall, located inside the Regional Mental Hospital, Nagpur. The objective was to discuss the path of the programme, its design, challenges, and achievements, and, most importantly, to get inputs from the distinguished group as regards course corrections.

The meeting was co-chaired by Dr Mohan Isaac, Professor at UWA Medical School, and Dr Vikram Patel, Professor, Department of Global Health and Population, Harvard TH Chan School of Public Health, and Founder, Sangath. The Board members included technical experts such as Dr Sanjeev Jain and Dr Pratima Murthy from NIMHANS, as well as representatives from NGOs such as SCARF and SAA, that have made a name for themselves in the mental health sector.

The Deputy Director of Mental Health, Karnataka, and the State Nodal Officer for Mental Health, Kerala, were also present as honorary Board members. Tata Trusts was also represented in good measure by department heads of communications, finance, and human resources. The Taluka Medical Officer, a service user, as well as some ASHAs also participated.




The major takeaway from the meeting was the validation of the work done so far by Udaan-DMHP, with some specific pointers for streamlining the protocol. The direction for fine-tuning was reiterated by Dr Mohan Isaac in his concluding remarks:

> *I would think that my personal take on this is, even if nothing occurs to persons with minor mental disorders, if at the end of four or five years, all people with severe mental disorders: if they could be identified, brought into a register, managed, rehabilitated, followed up – I think you would have achieved a great lot . . . To me, if persons – those with severe psychosis, epilepsy, mental retardation with problems – are provided care, that would be an excellent outcome. . . . I am really excited, not at all unhappy about the various problems that you have raised, and on a personal level I am very happy because for the past thirty years or so people have criticized and said that the District Mental Health Programme just doesn't work, etc. Nobody has come out with any alternative. . . . I think this is the first time someone is looking into various aspects and I am really looking forward to this . . .*

One point that came out strongly from the meeting was that, while in theory scaling up – from one block to 13 blocks using a non-specialist driven task sharing approach – was a grand idea, and one that had been talked about for a long time, the challenge for Udaan-DMHP was to prove that this model actually works on the ground and shows quantifiable results.

The second year of Udaan-DMHP will see many more frontline workers trained, many more blocks and many more clinics activated as per the complex timeline that has been worked out.

There will be even more emphasis on capacity building, especially of the ASHAs and other frontline workers. They will be trained to conduct psycho-education sessions with families and community groups using a variety of communications support materials that will be specially designed for this purpose.

Udaan-DMHP recognizes the enormous value of this cadre and is working out a remuneration package for the ASHAs, which will cover every aspect of the work that they will do on the programme. Currently the ASHAs are being remunerated for screening at household level and for every training programme that they attend. However, remuneration track points have also been identified for home visits or any other work that they undertake as part of case management, such as accompanying the person who is diagnosed with a disorder to the OPD clinic in case s/he is unable to make it alone to the facility. In addition they will also be remunerated for their work in the community at large, such as holding stakeholder group meetings.

The frontline workers as well as other personnel such as block co-ordinators will also be trained to work with specific stakeholder groups in the community who can help further the mental health agenda. This work is especially challenging. For example, how can faith healers be co-opted? What sort of communication strategies would have to be employed so as to dialogue with this group in a non-threatening and sensitive manner?

All this will be a continuation of the work set out in the first year. However, the challenge is to create new projects that can be layered on to Udaan-DMHP: projects that meet the specific and urgent needs of various groups in the community.

Here are some such projects:

- Programme for the youth – that looks at mental health from the lens of wellness

- Programme for the ageing population – that addresses the variety of psychological and emotional needs of the elderly

- A mental health programme that is relevant to women of all age groups but at the same time pays special attention to post-partum disorders such as post-partum blues, depression, and psychoses

Can Udaan-DMHP enlarge its operations and take on such complex projects while at the same time achieving its set goals and targets?

Yes, it can! The first year has shown that the capacities of motivated individuals are boundless; and that a programme built on the will and work of such individuals can continuously reinvent itself to become even more meaningful to the community at large.

SECTION 2

UDAAN

AT

THE REGIONAL MENTAL HOSPITAL, NAGPUR

The Reform Process Continues

The process of institutional reform at the Regional Mental Hospital, Nagpur (RMHN) – which is where the Udaan project was initiated – continued during the year. While building on and moving ahead in all aspects of structural and process reform, capacity building, and development of individual care services, the focus this year was on strengthening clinical processes. Another significant area of activity was the design of a model for financial inclusion of service users; alongside this, new employment pathways were also created.

Reform of Clinical Processes

Reform of the clinical processes at RMHN has been one of the key objectives and key challenges of Udaan, given the scale of operations of a public hospital like RMHN as well as the nature of the clinical tasks involved. This year saw some significant progress in Udaan's efforts in this regard.

Dissemination of Clinical Audit Report

One of the important activities undertaken last year was the commissioning of an external agency (SCARF) to do a comprehensive clinical audit covering clinical processes in the OPD and the IPD. Based on detailed observations and inspection, and interviews with different stakeholders, SCARF had submitted a detailed report in April 2018.

The findings of the report, along with the key recommendations for strengthening of clinical processes, were disseminated to the RMHN staff on 23 August 2018. Representatives of each department participated in the dissemination workshop. Seven areas had been highlighted; based on this, four protocols have been developed; four more protocols and two training modules for ward attendants and nurses are also currently under preparation.

Changes in the Pharmacy

A small change makes a big difference!

During process observation in the OPD, the Udaan team had noted that while handing over the drugs prescribed to service users or caregivers in the pharmacy, the pharmacist would inform them orally of the dosage, the time at which each drug had to be taken, and the duration of use. The instructions were not always understood; and many users found it difficult to remember the instructions even when they understood them.

The Udaan team devised a simple but effective method to address this problem. Every day, a team member would sit in the pharmacy, get the medicines from the pharmacist, put each drug into an envelope (instead of just handing them over), and explain the dosage and duration. The instructions were also clearly written on each envelope, and questions and clarifications of users addressed.

With the Udaan team doing this hand-holding from September 2018, the OPD pharmacist is now able to manage the activity independently.

This 'innovation' has received appreciation not just from the users but also from the psychiatrists and pharmacy staff, who are no longer approached repeatedly by users for clarification.

Like any innovation, there were some issues that had to be ironed out before the system began to function smoothly. For one thing, arrangements had to be made to procure a sufficient number of envelopes and pens, and also to get the pharmacy staff to accept the new procedure. The Udaan team, however, managed to convince the hospital authorities of the benefits of introducing a new system; accordingly, the MS issued an office order making the use of envelopes compulsory in the pharmacy. An order was also issued to get the Occupational Therapy department to provide a regular supply of envelopes to the pharmacy for the purpose of medicine distribution.

Another issue was the limited amount of time specified for distribution of medicines at the pharmacy – the time taken per service user in the new system is much longer. This was also one reason why there was some resistance from the pharmacy staff initially. This problem was resolved by the Udaan team members providing support in the form of additional manpower and taking on the responsibility of writing and explaining the instructions.

There were also difficulties related to the structure of the pharmacy, with the small window between the pharmacist and users making communication difficult. Besides, the waiting area in the OPD and the queue for the pharmacy were close to each other and seating for all those in queue was a problem. This was a bigger challenge, but with a lot of effort the Udaan team managed to get approval for government funding to enable the construction of a new, wide window and better seating facilities. The team coordinated with the PWD for construction of this improved facility, which is expected to be put to use in the near future.

Drug stock updates

The shortage of anti-psychotic drugs in the OPD has been a matter of concern for some time, and has also been highlighted in the media. The Udaan team had raised the issue with the hospital authorities, and the then MS had formed a committee of three members, comprising the deputy MS, an anaesthetist from the hospital, and a senior consultant from Udaan, to provide regular updates on drug stocks. The OPD pharmacist also joined the committee later.

This system has now been operationalized. Initially, reports on drug stocks were submitted every fortnight. Currently a monthly drug stock update is done by Udaan with the help of the Pharmacy Officer to ensure that a regular supply of drugs is available at the RMHN pharmacy for the OPD and in the IPD. The Udaan team has also taken up, with the government health authorities, the issue of non-availability of drugs in some cases due to imposition of a quarantine period. The team also monitors the drug stocks and follows up with the authorities to ensure that sufficient stocks are always available.

In addition, it is now possible to make indents directly from the OPD pharmacy to the central repository on a daily basis for immediate replenishment of drug stocks, instead of OPD and IPD requirements being clubbed together (as was the practice earlier). It is hoped that the hospital, which is currently reviewing the process, will adopt this more efficient system.

Automation

Maintaining records of each service user is a huge task, given the very large number of users, including many that come from villages and towns nearby. Udaan's observation of hospital processes had revealed that retrieving a case file could take as much as 20 minutes per user. Besides, keeping the records updated and ensuring proper follow-up was also a major problem.

The solution was obvious – automation of all records. A standardized case history module was developed, and now registration of all new service users is done directly on the computer, using the new software. Records of old service users have also been computerized. Apart from significantly reducing the time taken for registration and retrieval of case records – the exact amount of reduction in time is still being measured – the system also allows the psychiatrist to update the records and make a note of the drugs prescribed. The updated prescriptions are available online in the pharmacy, which in turn helps in better dispensing and management of drug stocks.

As in any other systemic change, the process was not without its difficulties, but with the Udaan team doing some hand-holding, the hospital staff are gradually becoming more comfortable with the software. The Udaan team maintains a record of the occasions when it is called upon for troubleshooting – and the good news is that these occasions have been steadily decreasing in number.

Other Clinical Processes

Suicide risk assessment and management is a critical task in a mental health institution. Udaan has developed a detailed protocol on this theme, on the basis of Tata Trusts' earlier work in mental health programmes across the country. This has been verified by the experts at SCARF, and will now be translated into a training module for RMHN staff, including psychiatrists, medical social workers, and occupational therapists.

As recommended by the clinical audit team, a change has been introduced in the mealtimes of service users due to receive ECT in the morning. As per the new practice, service users have a late tea and a late dinner on the previous evening, so that the gap between meals (before and after ECT) is not excessive.

SCARF has also submitted a draft of SOPs related to ECT administration and management of adverse events. The Udaan team has requested the hospital authorities to provide the necessary equipment for this purpose.

Structural and Process Reform

Ward Reform

Meal distribution system

In keeping with its commitment to ensure individual dignity and autonomy, Udaan had piloted a scheme last year – in one men's ward and one women's ward – to replace preset meal trays with a buffet system. This scheme was extended to two more wards this year.

The benefits of this new system are clearly evident, especially in the women's wards. For one thing, service users are no longer forced to limit themselves to the preset quantities – they are happy to take second helpings and choose the food items that they like. There is less wastage, since everyone is free to take only as much food as they want. Udaan has facilitated the purchase of utensils for storage of leftovers, which are used if someone is hungry between meals. Since wastage is less, cleaning is easier, and sanitation workers are burdened less than they were previously. Service users are also more involved in serving meals, and often begin laying out the plates and so on even before the staff arrive. Even service users with physical impairments make an effort to sit at the table.

There are, however, some challenges that remain. Not everyone is able to serve themselves. In wards 16 and 21, which are geriatric wards, service users have problems of mobility, and so the old system of preset meal trays continues. There is also some dissatisfaction among the staff, since the buffet system takes longer and is less ‘organized’. The Udaan team has tried to deal with this by ensuring that case managers are present at mealtimes; ward attendants’ shifts have been changed, and a few dissatisfied staff members have been transferred.

Crowd management is also a real issue. Although service users have now been divided into two batches, queue management not only takes some time and effort but those at the end of the queue are restless and impatient until they get their turn. These issues are being addressed with the help of the hospital staff; we also hope that service users will, over time, learn the advantages of waiting in queue with the confidence that everyone will get enough to eat. A minor problem is that since the new plates provided do not have ‘partitions’ the different food items get mixed on the plate. This problem will also be addressed soon, by ensuring that plates of a more appropriate design are purchased.

Mirror, mirror on the wall

The idea of having a mirror in each ward came to one of the Udaan team members after a visit to The Banyan in Chennai, where women seemed to enjoy using the mirrors installed in the rooms.

When the hospital authorities were approached with a request to provide full-length mirrors in all the wards, however, there was strong opposition from the staff as well as the authorities. Why did service users need a mirror? Who would ensure that mirrors were not broken? What if service users hurt themselves with broken mirrors? The Udaan team responded by pointing out that the few small mirrors that were provided in some parts of the hospital remained unbroken; there was also a suggestion to have plastic mirrors initially instead of glass ones.

After a survey of the market, a plastic sheet was procured and converted to a mirror; one of the hospital attendants donated four such plastic mirrors. Soon it was clear that the service users enjoyed using the mirrors; and the members of staff were convinced that the idea of having mirrors was a good one, after all.

In the stable wards, large glass mirrors – 6 ft. x 2.5 ft – have been installed, and there has not been a single accident or breakage so far. What's more, it is not only the service users who use these mirrors – the nurses and attendants do so, too!

Refurbishment and renovation

Construction of four new wards – the Step-down ward, the Acute ward, the Recovery ward, and the Family ward – was completed this year. Three old wards (two in the men's section and one in the women's section) have been converted to step-down wards to house service users transitioning to the world outside. The four new family units – each housing two families – make it possible for family members of service users to stay with their loved ones undergoing treatment, just as they would in any other hospital.

Construction and renovation involved working closely with the PWD officials, who were not just cooperative but very willing to execute the ideas that the Udaan team came up with. For example, they readily agreed to Udaan's request that the wards be painted in a different colour, something that would distinguish them from the uniform cream/yellow of the other hospital wards and create a feeling of 'home'. Other similar requests were also acceded to – whether it was installing tiles in the bathroom or building a proper verandah and a garden.

Several other small but impactful infrastructural improvements were made this year. A few of these are highlighted here.

Construction of new dinner sheds in both the male and female inpatient sections

Construction of seating platforms (stone benches)

Installation of mosquito nets

Fencing of farm

Construction of four new pits for composting of organic wastes

Whitewashing of the campus

Sanitation and Hygiene

The effort to improve hygienic practices of service users continued this year. The temporary solution found last year – of recycling old, unused hospital equipment – was no longer needed, with the construction of new handwashing platforms.

The challenges related to the creation of a proper sewage line – identified as a critical need early on – continued this year. As a temporary measure, however, open drains were covered and sewage tanks constructed in both male and female inpatient sections.

As part of Udaan's continuing emphasis on ensuring the dignity, autonomy, and individuality of service users, a hair salon and a beauty parlour had been set up last year on the hospital premises. These facilities continue to be popular with service users, with the number of users steadily increasing. While the men's hair salon saw 15,166 footfalls during the year, women used the services of the beauty parlour, which started functioning much later than the men's salon, 5846 times.

Another significant step in promoting user dignity was the stopping of unnecessary tonsuring of service users.

Many of the service users at RMHN have a history of homelessness. When they are brought to the hospital, it is often after a period of having no access to proper sanitation facilities, and they are tonsured as a hygienic measure. However, this practice continues even when there are no such issues of health or hygiene. This can have an adverse impact on the self-image of these individuals – especially women – in a culture where a lot of emphasis is placed on hair as a significant marker of personal attractiveness. Besides, the fact that tonsuring is done routinely also takes away the right of the service user to assert any choice over his or her appearance. The Mental Healthcare Act, 2017 also prohibits forced tonsuring.

The Udaan team took up this issue with the hospital authorities and convinced them to change the established practice, and to find other ways of dealing with problems such as lice. Thanks to their efforts, service users are no longer tonsured, except when medically recommended.

OPD Reform

The Outpatients Department was given a facelift this year. Apart from being freshly painted, the OPD also saw the refurbishment of the porch, new flooring, and installation of new signage and information boards, making the area more user-friendly.

The OPD pharmacy was completely redesigned to facilitate easier communication between pharmacist and service users, and CCTV cameras were upgraded.

These changes, along with changes in processes brought about by automation, have contributed to an overall enhancement of service user experience.

Automation and Data Management

The efforts towards automation, initiated last year, were given a fillip this year with the initiation of a system of paperless entries – that is, the registration of new service users is now done directly on the system. This also makes it possible for real-time data to be available to the doctor/counsellor, and for a significant improvement in maintaining records of service users. The module for generating MIS reports of the data collected was integrated into the software.

10 to 15 new service users are registered every day in the OPD, with 5549 new service users being registered so far.

The new process of service delivery, based on standard protocols, has now increased the turnaround time in some aspects – especially the time spent with psychiatrists, with proper case records now being maintained.

Baseline Turn Around Time (TAT) Calculation

Department	Turn Around Time (TAT)	
	New Patient	Follow-up Patient
Patient Registration Desk (OPD)	8 minutes	7 minutes
Psychiatric Social Worker Department (OPD)	9 minutes	NA
Suicide Risk Prevention Clinic (OPD)	4 minutes	4 minutes
Psychiatrist Chamber (OPD)	13 minutes	3 minutes
Laboratory (OPD)	60 minutes	
Pharmacy (OPD)	2 minutes	

Automation Turn Around Time (TAT) Calculation

Department	Turn Around Time (TAT)	
	New Patient	Follow-up Patient
Patient Registration Desk (OPD)	3 minutes	2 minutes
Psychiatric Social Worker Department (OPD)	14 minutes	NA
Suicide Risk Prevention Clinic (OPD)	8 minutes	8 minutes
Psychiatrist Chamber (OPD)	10 minutes	Software being developed
Laboratory (OPD)	60 minutes	
Pharmacy (OPD)	3 minutes	

Testing of the IPD software module has also been completed along with the initiation of real-time entries for demonstration purposes.

Capacity Building

Building capacities and skills of the staff in different positions at the hospital is essential for ensuring that the reforms are sustained. Capacity building has therefore been an ongoing part of Udaan's activities.

Three major training programmes were conducted during the year.

- The introduction of individual case management is a key element of the Udaan reform process at RMHN. Pre-measurement (and post-measurement at a later stage) of service users is necessary in order to measure the impact and efficacy of this innovation. This pre-measurement is to be done by people who are themselves not case managers, in order to ensure a blind study.

  Six members of staff – not part of the Udaan-RMHN team – were trained this year on the pre-measurement of service users for individual case management. Pre-measurement activities have now begun.

- Training of staff on the Mental Healthcare Act, 2017 by Mr Akhileshwar Sahay, member, drafting committee of MHCA, 2017.

- Training of hospital staff in the newly developed protocols for ECT administration, sentinel events, family wards, and clinical prescription. A total of 22 staff members were trained by SCARF.

Individual Care Services

Engagement of Service Users

The construction of a library and a meditation hall was envisaged as part of Udaan's effort to engage service users in activities that are both relaxing and educative.

The Udaan team realized the need to plan the location of these facilities carefully, so as to make it easy for service users to come regularly. As in the case of the hair salon and beauty parlour, the team identified four open cells that were not being used, and that could be converted for this purpose.

The creation of the two new facilities demonstrated, yet again, the collaborative spirit of the Udaan project, with different agencies participating at every step. First of all, permission was needed from the hospital authorities for the library and the meditation hall. In each case, the MS readily granted permission to create two separate facilities, one each for male and female service users. The PWD then helped to renovate the structures. With no funds available for painting, Udaan approached TAL Solutions, and the new rooms were freshly painted, thanks to their generous help. TAL also provided two cupboards – one each for the men's and women's libraries.
The Ward Sister in ward number 23 and the male OT department provided a few floor mats and doormats, while a music system and speakers for the meditation hall were provided by the hospital authorities.

Getting the books for the library also saw the involvement of the larger city community. Apart from seeking individual donations, the Udaan team visited 10 to 15 libraries in Nagpur, and four of them donated nearly a hundred books. Interestingly, several librarians were initially surprised by the request, and wondered whether service users would actually be able to read; this was an opportunity for the team to create awareness about Udan's work, and a few librarians even expressed an interest in visiting the Udaan library – two libraries had people who had relatives in RMHN.

In addition to these donations, Udaan has also purchased books from the market. The books have been chosen carefully, and are intended specially for people with intellectual disability and cognitive difficulties.

The library now has a collection of 570 books. There is also a plan to work out a system with a few interested libraries to borrow books regularly from their collection, and the team hopes to take this up in the coming year. There are also back issues of magazines, and a staff nurse has managed to get people to donate journals that are also of interest to the staff.

The books have been indexed and numbered, and divided among the male and female facilities. A daily register of users is also maintained. Currently, service users are not permitted to take the books outside the library.

The MS has issued an office order to the wards to send service users to the library and the meditation hall. The response has been quite enthusiastic, and an average of 20 women and 10 men visit every day. They usually spend about two hours in the library, and about an hour in the meditation hall.

Service users seem to enjoy the colourful pictures on the walls of the library, and all the users – including those who are unable to read – enjoy going through the picture books and magazines. So much so, that they are sometimes reluctant to leave! They talk to the staff about the books they have read; a few service users have suggested that newspapers, paper, and pens be provided, and the team in now working on this.

Unfortunately, the library does not yet have an electric connection, and is therefore an uncomfortable place to be in, especially in summer. The paperwork for the connection has been completed but the work is yet to be done by the PWD. Due to constraints imposed by rules related to elections, a permanent electric connection cannot be provided by the hospital until after the general elections in April-May 2019. At the MS's suggestion, the library timing (initially planned for the afternoon, post-lunch) was shifted to the mornings, when it is relatively cooler; efforts are on to get at least a temporary connection and also provide drinking water. Staff services are also a constraint, since two case managers are needed – one each in the library and the meditation hall – for the library and meditation sessions.

Case managers motivate service users to attend the sessions in the meditation hall regularly. Relaxing instrumental music is played, and service users learn techniques of breathing and meditation from instructors or through instructional audios. Not everyone is able to follow the instructions, but even those who don't, enjoy the sessions and feel relaxed. And listening to music is, of course, therapeutic.

Creating Employment Pathways

One of the most significant objectives of Udaan is to create employment pathways that will ensure financial independence for service users even while keeping them engaged in productive activities. This year saw some important steps in this direction.

Agriculture

Farming remains the most important activity for employment generation. Cultivation of the land cleared in the previous year continued this year, with a good yield of bananas, papaya, and vegetables. While 6.5 acres are being farmed currently, an additional 3 acres have also been identified for clearing and cultivation in the near future.

In the period August 2018 to March 2019, 14,736 kilograms (839 bunches) of green bananas (*kachcha* bananas) were sold to a vendor chosen from a tender floated by the hospital. This generated a revenue of ₹1,21,569/-.

A total of 57 service users were employed in agricultural activities during the year. A significant step this year was the identification of six women service users for agricultural work; the Udaan team hopes to involve them in farming activities very soon.

Bakery

During hospital rounds, the Udaan team observed that as per the diet chart, *pav* was served for breakfast four times a week to service users in the IPD. Enquiries revealed that the bread came from Nagpur Jail, and ₹ 70,000 per month was being spent on this. This set the team thinking . . . why not set up a bakery that could not only supply bread to the hospital but also serve as a means of employment to service users?

After some discussion and getting the necessary permissions from the hospital authorities, a suitable space was identified within the hospital premises – an unused passage in the male Occupational Therapy department. Many vendors were consulted, and a feasible business model drawn up. The task of remodelling the shed to create a suitable baking unit was begun during the year. With the help of the PWD, the required infrastructure is now ready, and the plan is to secure government funding or use CSR funds to buy the remaining equipment.

Professional staff will be recruited and trained to do the main tasks. Once the bakery is functional – within the next few months – service users will be trained by staff from the government catering college in packaging the products. So the employment pathway would involve suitable packing of products such as bread and cookies.

The baked goods will also be made available for sale in the OPD and in the mobile cafeteria. The hope is that at a later date the model can be scaled up to supply these products to other outlets in the city and generate revenue.

Mobile cafeteria

RMHN sees more than 50,000 footfalls a year in the OPD alone. But there is no affordable eatery nearby, especially for people coming from outside the city; even the hospital staff do not have such a convenience. This prompted the idea of setting up a cafeteria that would fulfil this need and simultaneously work as an employment pathway for service users at the hospital. A suitable space was identified and plans began to be made.

Soon, however, the Udaan team realized that building a cafeteria would involve a lot of investment, not only financially but also in terms of time and co-ordination with the PWD. This is when the team came up with the idea of a mobile cafeteria, one that would serve the purpose at a much lower cost.

This idea was shared with the Skills team at Tata Trusts when they visited the hospital. The Skills team helped arrange for a food truck. Tata Motors willingly provided the truck at a subsidized rate through Zaika Motors, a Nagpur-based dealer.

This was, however, only the beginning of the story. The truck had to be remodelled and refurbished, and given a name. It had to be painted and made visually attractive.

The interiors were redesigned, as were the exteriors, with great care. After considering several options, the truck was named *Chai Nashta*. The tagline – *Khao Piyo, Khush Raho* – expresses its purpose perfectly!

The food truck is meant to be happy, attractive and inviting. The visual design therefore had to be bright and cheerful, depicting a sense of joyful eating. The initial idea was to use colourful illustrations created by service users themselves; however, despite the efforts of the Udaan team who organized an art workshop with the service users, appropriate illustrations could not be developed, and the task was finally carried out by a professional artist-designer.

The colours and figures on the food truck are graphic and contemporary while being culturally recognizable. The design has also been kept light-hearted through the addition of animals. Finally, a colourful geometric pattern has been chosen to bind the elements together. This pattern is repeated on all sides and covers the roof of the truck, making it instantly identifiable even from above.

The food truck is now ready. The Udaan team plans to recruit cooks and other staff very soon, and invite people from the local college of hotel management to train service users on how best to serve customers. All cooking equipment, cutlery, and so on will also be purchased. With this, the mobile cafeteria will be ready to function within a few months.

Tailoring unit

With the ban on plastic bags, it was evident that bags made of cloth or other materials were going to be in great demand, especially by shopkeepers. This generated some excitement in Udaan, with members wondering whether service users could be trained to make cloth bags.

Earlier, in response to a request from TAL for a list of requirements, the Udaan team had already asked for sewing machines, with the idea of using them in the day care centre. 10 sewing machines soon reached RMHN, five each to be used in the male and female wards.

Now, with the idea of using these machines for bag-making, the Udaan team identified service users who could be trained in the activity. A few service users already had some experience in tailoring, and some more were interested. An Udaan team member conducted an elaborate market survey to find out about materials and sizes for the bags. He sourced blue sturdy net material from a wholesale supplier and followed one lead after another to locate a master bag-maker who could train the women. One such master was finally identified, and after much persuasion, he agreed to come to the hospital for two hours per day for ten days to provide training.

The bag-maker did come; but only for two days. In those two days, he had made up his mind that those with mental illness could not learn anything, let alone learn to use the sewing machine. Little did he know that in those two days of training, two of the women had picked up the technique. With the help of a case manager who had also attended the training, they practised on the machines and in no time they were able to teach the entire process of bag-making to some more service users. In a few days, five women and three men had been trained enough to make six to ten bags a day.

Training the service users was one important aspect. An equally important need was to procure orders from shopkeeper-clients who would understand what this bag-making enterprise was all about and who would thus be willing to pay a little more for the Udaan bags than the mass produced ones that were readily and cheaply available.

A shop owner that sold agricultural produce came forward to place the first order for 200 bags. This may be a small order but it is a big victory for the team. Work is underway to complete the order. According to the case manager in charge of this enterprise, the service users look forward to their time on the sewing machines; they help each other, and marvel at their ability to turn a piece of net fabric into a bag complete with handles.

There are still many hurdles to be overcome, chief among them being to find a way to sell the bags at a competitive price. Right now, the operation is so small that the cost of production is high. The Udaan team hopes to increase the number of work hours (currently only two hours a day are spent on this activity) and involve more service users. Quality control is an ongoing issue, and the team is working on improving the finishing, and offering better customization.

The fact remains, however, that the tailoring unit has made it possible for at least a small number of service users to build some skills; equally important, they are happily engaged for a few hours every day. In fact some service users who are due to go home on leave of absence have enquired whether it would be possible for them to continue the tailoring work. The Udaan team hopes to make that possible.

Arun's story

If you ever visit the Udaan office at RMHN, one of the first people you are likely to meet is Arun. You might see him filing papers or running a mop across the office floor. Soon he will offer you a glass of water or a cup of tea. Like the rest of the Udaan team, he will probably be busy with his assigned tasks.

What is so special about him, you ask? Well, Arun is a service user at RMHN.

The Arun you will meet is a different person from the one who was brought to the hospital by the police more than five years ago. He had been taken into custody for violent behaviour, after he was seen attacking two-wheelers with a trident and injuring pedestrians. The police had first taken him to the Bhandara government hospital, where he was diagnosed with symptoms of psychosis; he had poor self-care, would wander about, and was abusive and violent. And that is why he was brought to the mental hospital.

At RMHN, the young man was treated by psychiatrists, along with appropriate interventions by the psychiatric social worker and the occupational therapist. They noticed that he had a speech impairment in addition to his mental illness; his hearing was also impaired. This made it difficult to find out anything about his family; no one even knew his name. So even though his symptoms became manageable over time, and he was well on the road to recovery, he continued to stay on at RMHN, helping the staff nurses and other ward staff in their activities.

Creating employment pathways and empowering service users is a key aspect of the Udaan reform process. That is why, when the team was looking for a person to help around the Udaan office, they decided to recruit a service user for the task, thus demonstrating by example that community reintegration for recovered service users is indeed possible. The hospital authorities suggested Arun – the name was chosen by the young man himself – and he joined the Udaan office on 1 November 2018.

Like any other Udaan employee, Arun shows up at the office every morning; he then starts on his tasks for the day, such as keeping the office clean and taking care of papers and stationery items. His skills have improved, and he is able to select and buy supplies for the office. He is generally well-groomed and cheerful. He has learnt to communicate through signs and gestures, and even through drawings.

Arun receives a salary for his work. He has been depositing it in his bank account, and is looking forward to buying new clothes and a mobile phone in the near future.

Financial Inclusion

Financial inclusion is a key aspect of active citizenship. Access to useful financial services in general, and for marginalized communities in particular, has also been a policy objective of the government in recent times. Service users in mental health institutions are among the most disadvantaged social and economic groups, but their needs in this respect have not been addressed so far.

An important objective of Udaan has therefore been to work towards financial inclusion of people with mental illness. As part of its effort towards achieving this objective, this year Udaan has initiated an internal banking system at RMHN.

One difficulty in opening bank accounts for all service users was their status as 'patients' in a mental hospital. This meant that individual bank accounts could not be opened. After discussion with the hospital authorities and much deliberation, a method was devised to overcome this challenge.

As part of the internal banking system, each service user who is employed (in agricultural activities, for example) has been provided with a passbook. Remuneration due to the service user is noted in the passbook. The total amount due to the employees is deposited in an external bank.

Udaan has opened a savings account in the name of Prayas Banking at a private bank in Nagpur, to be operated jointly by a committee comprising an attendant, the Administrative Officer, and the Deputy Superintendent of RMHN. While Udaan facilitated the formation of this committee, it has deliberately chosen not to be a member of it.

Anyone wanting to access their savings can approach the Udaan team to help them withdraw the required amount.

As more employment pathways become operational, we envisage that service users will have more opportunities to save and use their earnings.

SECTION 3

INDICATORS OF IMPACT

The Udaan project is the first of its kind – a partnership between a state government and a private philanthropy in the mental health sector. In such a case, how is the success or failure of the project to be measured? How do we assess the impact of the project? How do we know we are on the right track?

These are critical questions – questions that the Udaan team has grappled with right from the inception of the project. When the project took birth, the Udaan team had – on the basis of the earlier work done by Tata Trusts in the field of mental health – an ambitious vision of what mental health reform needs to achieve in our country. But the task of translating this vision into a systematic framework with an achievable goal, and further breaking down that goal into specific, measurable objectives within a limited time period, was an onerous one, as was the setting out of the activities that would help achieve these objectives.

Using a Logical Framework Approach, the Udaan team does a monthly review to monitor all activities related to critical aspects of reform. The process of log frame setting was, however, not easy, especially for the RMHN programme. It took a long time, and several iterations, for Udaan to develop a set of indicators that would measure the impact of the reforms undertaken. Many experts in the mental health sector contributed to this development.

Since Udaan has developed this as a model, this sets the benchmark, a blueprint which similar projects in future can use to create their own reform objectives and activities, and assess the impact of reform at any mental health institution.

RMHN Indicators						
Sl. No.	Indicator	Indicator type	Cumulative target (Project duration)	Target (as per reporting frequency)	Reporting frequency	Achieved as on March 2019 (Cumulative)
1	No. of structures refurbished/developed	Input	245	35	Half-yearly	193
2	Percentage of unique protocols developed as against 16	Activity	100%	2	Half-yearly	56% (9)
3	No. of service users employed through the programme (100)	Activity	100	25	Annual	1
4	Percentage of service users completing 300 hours of employment	Output	More than 30%	More than 30%	Half-yearly	In process
5	Percentage of service users employed outside the programme	Output	20%	20%	Annual	To be initiated
6	Number of clinical protocol professional training days completed (1787)	Output	1787	76	Quarterly	76
7	Percentage of staff trained in MHCA as against the target of 243	Output	100%	6% (15)	Quarterly	9% (22)
8	Percentage of staff trained in human rights as against the target of 243	Output	100%	6% (15)	Quarterly	89% (218)
9	Percentage of processes automated as against the target of 22	Output	100%	18% (4)	Quarterly	27% (6)
10	Percentage change in turnaround time in OPD (New patients)	Outcome	50%	50%	Half-yearly	Change in TAT is being analyzed as against the baseline TAT
11	Percentage change in turnaround time in OPD (Follow-up patients)	Outcome	50%	50%	Half-yearly	Change in TAT is being analyzed as against the baseline TAT
12	Percentage change in turnaround time in the admission process (IPD)	Outcome	50%	50%	Half-yearly	Yet to be initiated
13	Percentage change in turnaround time in the discharge process (IPD)	Outcome	50%	50%	Half-yearly	Yet to be initiated

DMHP Indicators					
Sl. No.	Indicator	Indicator type	Reporting frequency	Cumulative target (from Jan 2018 to March 2019)	Achieved as on March 2019 (as against target)
1	Number of blocks activated (13)	Activity	Quarterly	4	3
2	Number of ASHAs trained in the screening module as against the target of 1724	Activity	Quarterly	512	189
3	Number of (12) module based trainings completed for public healthcare professionals (ASHAs, MO, Paramedical) as against the target of 21,634	Activity	Quarterly	668	296
4	Number of households screened per month	Activity	Monthly	43609 HH	12754
5	Percentage of ASHAs completing 100 households per month	Activity	Monthly	NA	15%
6	Number of people screened for CMD in the project location	Output	Monthly	134134	38484
7	Percentage of people screened positive for SMD in the project location *(Prevalence rate as per the NMHS Report 15-16: 0.8%)	Output	Cumulative	NA	NA
8	Percentage of people screened positive for CMD *(Prevalence rate as per the NMHS Report 15-16: 10.6%)	Output	Cumulative	NA	NA
9	Percentage of cases coming for diagnosis from those screened positive on SMD	Output	Monthly	>40%	Referral system will be in place from May 2019
10	Percentage of cases coming for diagnosis out of those screened positive CMD (K10 30+)	Output	Monthly	>40%	Referral system will be in place from May 2019
11	Percentage of cases diagnosed positive SMD offered detailed psychological intervention	Outcome	Quarterly	>40%	Yet to be initiated
12	Percentage of cases screened positive CMD (K10 25-30) offered brief psychological intervention	Outcome	Monthly	>80%	0%
13	Percentage of cases diagnosed positive CMD (K10 30+) offered detailed psychological intervention	Outcome	Quarterly	>40%	Yet to be initiated

4 SECTION

THE POWER OF PARTNERSHIP

This year Udaan was once again witness to the power of partnership. The collaborative spirit has grown stronger in the Regional Mental Hospital, Nagpur; it has also empowered the newly launched District Mental Health Programme to achieve a great deal in a relatively short time.

The willingness of very different people and entities to work together revs up the engine of collaboration. Then comes the getting-to-know-each-other period: a time for learning about each other and from each other; followed by the push and pull of adjustment, of give and take. Somewhere along the line, trust adds its power to the engine and this makes it move faster, not only along straight and narrow paths but also on roads less known. Many well-wishers get on board, some alight after a mile or two; others stay the course, offering various kinds of help and that too ever so quietly and graciously.

Udaan has gone through all these stages with the public health system.

From the outside, the government looks like an impersonal system, and oft-times it is that. However, working closely with the system has revealed its human side. After all, the system comprises people, and it is the human element that creates system readiness and willingness; Udaan has seen firsthand how one official can make such a big difference.

There is also the recognition that even though the collaboration is formally with the public health system, Udaan-DMHP can engage with the whole spectrum of government. And this did happen: the Chief Executive Officer of the Zilla Parishad, Mr Sanjay Yadav, for example, got on board; he offered his whole machinery to help with the screening process.

It was the Deputy Director, Health Services (DDHS), Nagpur Circle, Dr Sanjay Jaiswal, who brought the different elements of the public health system together so that Udaan-DMHP could effectively use the resources of the health system. He convened several meetings in his office; he got the different department heads of the health system to commit what they could do to facilitate Udaan-DMHP. The way the programme could be rolled out; which blocks could be selected; the choice of Kalmeshwar as the first block for activation – all these aspects evolved through continuous dialogue with various government officials at these joint meetings. In the early days of designing the programme, the DDHS also took the Udaan-DMHP core team to Ramtek, which is one of the furthest blocks and one that has a significant tribal population. He wanted the team to experience the scale of operations and to know that the journey ahead was going test the mettle of each and every Udaan-DMHP team member.

The Civil Surgeon (CS) became the programme's mentor and guide. It was the CS, Dr Devendra Paturkar, who inaugurated the very first psychiatric OPD clinic in Kalmeshwar. In fact, every time a new block is activated, he makes it a point to attend the inaugural function, regardless of the other demands on his time. He also takes a close personal interest in the functioning of Udaan-DMHP. His willingness to use his authority to mitigate blocks and delays, solve problems, and make the system deliver has been invaluable in enabling the programme to forge ahead.

The CS has, for example, minutely tracked the budget and taught the team how to get budget sanctions for various activities. As he put it, '*. . . if you want to spend certain amount of money in the government sector, you are bound by the guidelines provided by the department for that money; we have to work within the framework; even if an activity is outside the framework, we have to somehow find a way of bringing it into the framework and make it work.*'

Even those departments that had initially been tough to work with have become allies, more or less, and lent their power to the collaborative engine.

How has this change come about? Members of the Udaan team explain:

> *At first we could not tell the PWD, for example, what we wanted done; they would say, get letter, get permission from Medical Superintendent of RMHN. Even after getting permission, they would say, this work can happen only after one year, or they would say our budgets are restricted; they would point out so many formalities that we used to think that the work would happen only after two years . . .*
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> *We took a year to study how the PWD functions and . . . made a proper protocol in consultation with PWD officials, the core committee at RMHN, and the MS. We made SOPs – so that we know how to direct our proposals. PWD was happy that we took the trouble to understand their way of functioning. Now, let me tell you, we have good co-ordination . . .*
>
> *The speed has come from connecting with the people; building rapport . . . slowly, slowly, the PWD themselves have started taking interest . . . So much infrastructure work has not happened in any other mental hospital!*

It is not just the question of MoU between Tata Trusts and the public health system of Maharashtra. Tata Trusts do not need any introduction in this country or anywhere else. There are no two opinions about the efficiency, proficiency or capacity of this entity. This is a given. This (collaboration) is what the approach should be for every health problem, not just while working on mental health. This project should work as a guideline for tackling and solving other important health issues as well.

– Dr Devendra Paturkar, Civil Surgeon, Nagpur District

Mr Jayant Zoting (extreme left) with colleagues from TAL

Such manifestations of the collaborative spirit have come not only from the government but also from the private sector. Last year, Udaan watched with fascination the ripple effect of giving set off by one person, Mr Jayant Zoting, Deputy General Manager, TAL Manufacturing Solutions Ltd., Nagpur.

Mr Zoting tells the story of TAL's involvement:

> *We were thinking of a CSR activity for the last three to four years; but where to do it was a big question mark for us. One sudden day, we got an email from Tata Motors, which had come to them from Tata Sons, asking whether TAL can support TataTrusts at Nagpur.*
>
> *I got in touch with Tata Motors; they said Tata Trusts, Nagpur requires a JCB; we are in the construction mode so we had all the equipment; so we sent the JCB there. A lot of good work was done during that period and we were suddenly surprised when we saw bananas coming out of that land. I showed the photos to our Board members; they were also really surprised. They said, you are doing CSR for a mental hospital and suddenly they have started growing bananas there!*
>
> *Then we got in touch with Udaan and told them that the Board has decided to go in for full-fledged CSR activity with Tata Trusts and that is how the partnership started. We asked what support Udaan wants from us. They gave us a list and we got that sanctioned from the Board and it is really worth seeing.*
>
> *We had a visit to the hospital. We were really surprised to see what all Tata Trusts is doing there and that is how it started and in future also we would like to support . . . I briefed the new management also; they too are happy that we are supporting CSR activity in Nagpur. . . .*

We had a group – Ashish, myself, my HR team – we all belong to Nagpur; we remember that in our childhood how scared we used to be if someone said, I am taking you to mental hospital, and now an organization that we know of is working for reform of the mental hospital! We all felt that yes, we should do something; we belong to this city; it was an emotional connection and it was an opportunity to give back; we were looking for a CSR in Nagpur, so this was the right opportunity to do so and that is how we partnered.

Mr Ashish Adhau talks about how he broadened the circle of giving: *'. . . all the suppliers whom we contacted to meet Tata Trusts requirements have given their best price; we tell them why we want such and such material; they also participate by giving us the product at cost price.'*

And this is how the ripple effect of giving is still being felt. Mr Zoting has roped in not just his TAL colleagues but also his personal friends. In his words: *'One of my friends who is in Nashik has a friend who has a Xerox machine dealership in Nagpur. My Nashik friend spoke to his friend and told him, you don't take your profit, just transfer the asset; this is for the mental hospital in my home town*.'

The team that works on reform at the Regional Mental Hospital, Nagpur and the Udaan-DMHP team are daily strengthened by such goodwill.

They believe that quiet gestures, kind words, and thoughtful actions make a big difference.

Their hope is for more people and more organizations to get on board and make a commitment, however small, to the larger good.

This is the faith and this is the hope. Wish the programme well.

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