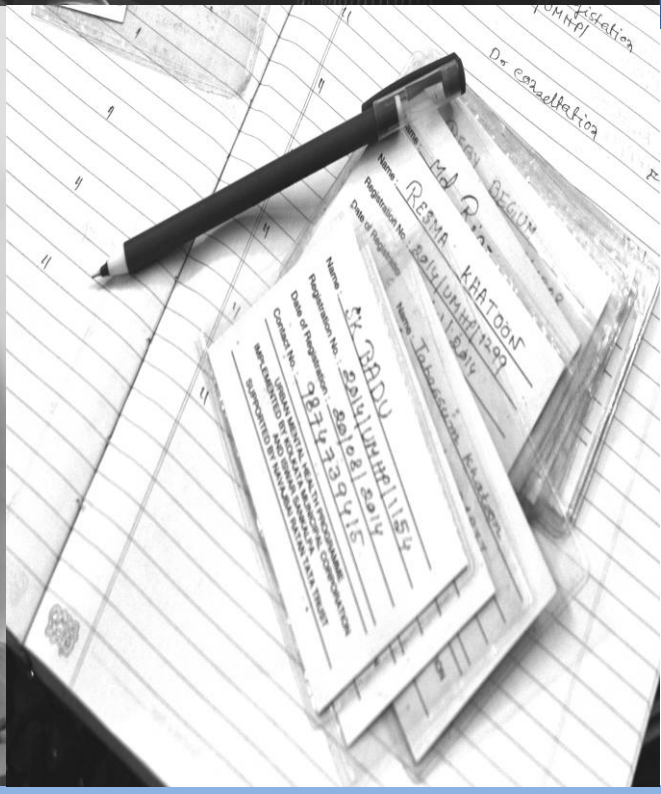

EXPERIENCES OF THE URBAN MENTAL HEALTH PROGRAMME (2012 – 2015) IN TWO LOW-INCOME WARDS IN KOLKATA, WEST BENGAL

A partnership between Iswar Sankalpa and the Kolkata Municipal Corporation

Funded by The Navajbai Ratan Tata Trust

THE COMMUNITY IN THE TWO LOW-INCOME WARDS

URBAN MENTAL HEALTH PROGRAMME (2012 – 2015) IN TWO LOW-INCOME WARDS IN KOLKATA, WEST BENGAL

A PARTNERSHIP BETWEEN ISWAR SANKALPA AND THE KOLKATA MUNICIPAL CORPORATION

FUNDED BY THE NAVAJBAI RATAN TATA TRUST

The Urban Mental Health Programme (UMHP), implemented over the period April 2012 to March 2015, is a partnership between Iswar Sankalpa (IS), a Kolkata based NGO, and the Kolkata Municipal Corporation (KMC), the city's civic administrative body.

Funded by the Navajbai Ratan Tata Trust (NRTT), the UMHP is a pilot initiative that has attempted the integration of mental health services in primary health care settings in two municipal wards in Kolkata. Iswar Sankalpa's vision is that the mental health services provided in these wards will serve as models for providing integrated mental health care in urban primary care settings, and will be replicated in all wards of the city.

This document describes the experiences and learnings of the first two years and 9 months of UMHP's implementation.

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"NO HEALTH WITHOUT MENTAL HEALTH"

~ WORLD HEALTH ORGANIZATION

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EXECUTIVE HEALTH OFFICER OF BOROUGH IX, DR P.K.ROY. CHOWDHURY

ALL THE DOCTORS AND HEALTH WORKERS OF WARDS 78 AND 82

ALL THE DOCTORS AND HEALTH WORKERS OF BOROUGH IX

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INTRODUCTION

Mental Health Treatment Gap in India

According to the Census (2011), India's population is estimated at 1.2 billion, accounting for 17.5% of the world's population. Neuropsychiatric disorders in India are estimated to contribute to 11.6% of the global burden of disease (WHO 2008). As the following tables show, the prevalence of mental illness far outstrips the country's mental health service provision.

Since national level data on the prevalence of mental disorders in India are not available, the findings of several epidemiological studies summarized for all ages and both sexes have been presented below:

- Major mental and behavioural disorders estimated as 65/1000 population based on the average value of two pooled studies (Reddy and Chandrashekhar 1998; and Ganguli 2000) (57/1000 and 73/1000, respectively).
- The prevalence of schizophrenia has been considered as 3/1000
- Prevalence of mood disorders have been pegged at 16/1000
- For depression, a conservative estimate of 2% has been used based on the meta-analysis study of Reddy and Chandrashekhar (1998) and WHO estimates.
- Substance and drug addiction: Alcohol users— 60/1000; cannabis—8/1000 and opiates; — 2/1000 population.
- Child and adolescent mental health problems are estimated at 128/1000 child population (1–16 years) based on a WHO study, or 43/1000 population of all ages.
- Geriatric mental health problems are assumed to be present among 31/1000 population above 60 years based on a meta-analysis study or 2.48/1000 population of all ages. Specific rates of dementia are 19/1000 in the 65+ years age group or 1.52/1000 population of all ages.
- Epilepsy has been conservatively estimated at 9/1000

(Gururaj, Girish, & Isaac, 2005)

TABLE 1: PREVALENCE OF MENTAL ILLNESSES, INDIA (2005)

India has no mental health policy, and the National Mental Health Programme (NMHP) 1982 functions as a de facto policy. The Central budget for the NHMP is only 0.06% of the country's health budget.

Availability of mental health facilities are as follows: (population 1.2 billion (UNO, 2009)

- Mental health outpatient facilities number at 4,000 (Rate of 0.329/ 1,00,000 population)
- Psychiatric beds in general hospitals number at 10,000 (Rate of 0.823 / 1,00,000 population)
- Mental hospitals number at 43 (0.004/ 1,00,000 population)
- Beds in mental hospitals = 17,835 (1.469 / 1,00,000 population).
- There are no figures available for day treatment centre or community residential facilities in the country

Long term care in mental hospitals : Less than 1 year: 62% / More than 1 and less than 5 years: 24% / More than 5 years = 14%

Human resources in the formal sector are as follows:

- Psychiatrists = 0.301 / 1,00,000
- Nurses = 0.166 /1,00,000
- Psychologists = 0.47 / 1,00,000
- Social workers = 0.033 /1,00,000

There are no figures for number of occupational therapists or other health workers

The majority of primary health care doctors and nurses have not received official in-service training on mental health within the last five years.

(Mental Health Atlas, 2011)

TABLE 2: MENTAL HEALTH INDICATORS, INDIA (2011)

The gross disparity between the number of persons with psychosocial disabilities and the available treatment facilities and trained professionals is reflected in the findings of the World Health Survey, which, in India, covered the states of Assam, Karnataka, Rajasthan, Uttar Pradesh and West Bengal. The following table illustrates the percentage of persons diagnosed and treated in the 6 states:

	Psychosis		Depression	
State	**Need %**	**Covered %**	**Need %**	**Covered %**
Assam	1.0	39.1	3.2	32.3
Karnataka	0.7	85.2	9.2	13.0
Maharashtra	2.2	48.7	27.3	9.6
Rajasthan	3.6	36.2	7.3	29.7
Uttar Pradesh	2.7	45.5	7.4	8.2
West Bengal	1.8	66.5	11.7	17.8

TABLE 3: PREVALENCE AND COVERAGE OF MENTAL DISORDERS (WHS, 2003)

West Bengal has a population of 91 million (Census 2011), making it the fourth most populous state in India. Yet, the only mental health services in the state, as per official figures (Annual Administrative Report 2009-10) are as follows:

- Six (6) Govt. run psychiatric hospitals, Psychiatric units of eleven (11) Govt. medical colleges and hospitals, psychiatric departments of 16 district hospitals, 7 Sub-Divisional Hospitals, 1 Block Primary Health Centre and 3 Rural Hospitals under the DMHP. There are also NGO-run psychiatric OPD under joint venture schemes in 5 Hospitals.
- Drug addiction centres are available at 4 Govt. run Mental Hospital, 3 Govt. Medical College and Hospitals and 7 Registered nursing homes for persons with psychosocial disability.

Going by WHO's estimated prevalence of mental illness in a given population at 10 – 12%, at its current population, West Bengal would have at least 9.1 million persons with psychosocial disability. Ideally, each one of these would need at least one out-patient (OPD) visit, however official figures for the years 2006-07 show that only 0.63 million have accessed government OPD services. Based on the WHO estimated prevalence of 5% for severe mental illnesses, at least 4.5 million persons would need In-patient care. However, official figures show that, in 2006-07, indoor admissions in psychiatric facilities in West Bengal number about 1500.

As the UMHP project proposal notes, health care service in West Bengal are negatively impacted by a lack of attention by the political class and policy makers, compounded by poor consumer awareness. Mental health care, being the low priority area, remains the pariah of the pariahs. The state has no emergency psychiatric facilities, and psychiatric facilities available provide almost no general health services. The facilities available are over-burdened, under-staffed and follow a top-heavy approach -- where physicians/psychiatrists are the only window of service delivery, and there are no clinical psychologists, psychiatric nurses or rehabilitation services. There is no stipulated policy for recruitment and training of ward staff and the supply of basic needs in the hospitals, like food, bed-linen, clothes and hygienic measures are uniformly poor. There are a number of private consultants and clinic, with fee structure such that such services are only accessible by the rich or middle class. Health insurance does not cover mental illnesses.

Public health services in the city of Kolkata, with its 4.4 million citizens, are provided by the city's municipal authorities, and the State's Department of Health and Family Welfare.

Given that about 30% of the city's households are slum households (Census Commissioners Report on Slums, 2011), the KMC's primary health care centres with their free services located in each administrative ward are the most accessible medical facilities for the city's poor. Yet, not one provides mental health services.

Iswar Sankalpa's experiences in Kolkata, West Bengal

Iswar Sankalpa was established in Kolkata in 2007 by mental health professionals with considerable years of experience in private practice, in community mental health and in the development sector. The organization was formed with the express purpose of bringing mental health services to socio-economically disadvantaged communities and marginalized persons in the city, and doing so in a humane and dignified manner. No population could be more marginalized than homeless persons with psychosocial disabilities, and Iswar Sankalpa's first programme, **Naya Daur Outreach (2007 to date)** was designed to provide acutely needed assistance and medical services to such persons living on the streets of Kolkata.

Iswar Sankalpa's programmes and significant indicators (2007 – December 2014)								
	2007 -09	**2009 -10**	**2010 -11**	**2011 -12**	**2012 -13**	**2013 -14**	**April – Dec 14**	**Total**
NAYA DAUR OUTREACH: Community-based support and treatment for homeless persons with psychosocial disabilities								
New persons provided medical treatment and psychosocial support	120	212	183	101	60	45	29	750
No. of times persons provided nutrition, clothes and hygiene care	605	715	718	648	586	585	465	-
AROGYA - Emergency Care for homeless persons with psychosocial disabilities								
New persons rescued and cared for by IS or other NGOs	-	5	39	36	50	43	26	199
New persons hospitalized	-	2	15	6	6	2	1	32
New persons restored to families by IS	-	-	19	15	12	4	4	54
Police Stations participating in process	-	4	22	21	27	31	21	-
Drop-in-Rehabilitation Centre for homeless persons with psychosocial disabilities								
Persons using the centre	-	-	26	23	17	23	24	55
Persons provided health care services	-	-	26	19	16	22	22	-
Persons provided rehabilitation services	-	-	1	1	3	3	2	-
Sarbari: Shelter for homeless women with psychosocial disabilities								
Total women residents	-	-	74	64	72	59	42	311
Nos. receiving vocational training	-	-	14	23	25	84	87	-
Nos. receiving supportive employment	-	-	-	2	4	5	7	18
Average Duration of Stay	**<3 months** 151		**3 – 6 months** 55	**6 – 12 months** 42		**12 – 36 months** 68	**>36 months** 17	
Of the approximate 2000 homeless persons with psychosocial disabilities whose lives and health that Iswar Sankalpa has intervened in, 215 have been restored to their families.								

TABLE 4: ISWAR SANKALPA'S PROGRAMMES AND KEY INDICATORS (2007 - 2014)

Apart from providing a range of services (See Table 4) to over 2,000 homeless persons, Naya Daur had two significant outcomes. One, its community-based service delivery model afforded a much needed visibility to the issue of mental health, and compelled communities in the city – both privileged and disadvantaged – to learn about, to speak of, and to participate in addressing the lack of treatment and the absence of dignity and support for those suffering from psychological disorders.

The Outreach programme's other significant outcome was advocating for, and receiving varying degrees of participation from governmental agencies in Kolkata. These include the Kolkata Police, the Kolkata Municipal Corporation, the West Bengal Department of Health and Family and the Department of Social Welfare, all duty bearers who are constitutionally mandated to provide public health, shelter, protection, rehabilitation and other supportive services to the city's residents.

Iswar Sankalpa's partnership with the Kolkata Police resulted in two services. First saw the establishment of a **Drop-in-Centre (2009 to date)** for homeless persons with psychosocial disabilities at Hastings Police Station. A second partnership saw the establishment of **an Emergency Response Unit** (2010– to date) was established through which Iswar Sankalpa and Kolkata Police jointly respond to persons on the street who, because of their acute psychosocial disability and distress, are highly agitated, hostile, often causing a disturbance in the neighbourhood, and in the absence of immediate medical and psychological intervention, are a danger to themselves and to others.

The KMC has been Sankalpa's key partner since the Outreach programme's first activity, a baseline study of the city's wards, was executed in 2007. Since April 2010, the KMC and Iswar Sankalpa have been running a joint venture called **Sarbari,** for which KMC has provided a building and Iswar Sankalpa the services for a shelter for homeless women with psychosocial disabilities, the first of its kind in Kolkata. The Urban Mental Health Programme is the second joint initiative between Iswar Sankalpa and the KMC.

Iswar Sankalpa's interventions are guided by the organization's vision – that of ensuring the dignity and holistic well-being of persons with psychosocial disabilities, especially those from underprivileged backgrounds. Acutely aware of the gross human rights violations of persons with psychosocial disabilities, the organization spent the first five years of its existence bringing much needed care to homeless persons with mental illnesses on the streets of Kolkata. As their work progressed, a significant learning emerged: a number of persons were homeless not because they were indigent or had no families or home, they were on the streets because their disorders had caused cognitive dysfunctions, including memory loss, and they tended to wander away from home and be unable to find their way back. They thus remained on the streets alone and untended, wandering further and further away from home, with their physical and mental condition progressively deteriorating. With psychiatric treatment and other support provided by the Outreach and Shelter project, over 215 of the 2000 persons Iswar Sankalpa has worked with since 2007 have been restored home.

State	Nos.
Andhra Pradesh	6
Assam	9
Bihar	13
Chattisgarh	1
Jharkhand	4
Madhya Pradesh	9
Maharashtra	4
Orissa	6
Tamil Nadu	1
Tripura	1
Uttar Pradesh	9
West Bengal	141
Punjab	1
Others	10
Total	215

TABLE 5: DESTINATIONS OF 215 PERSONS RESTORED TO THEIR FAMILIES (ISWAR SANKALPA 2007-DECEMBER 2014)

Most families of restored persons, all from less affluent homes and mostly from rural and non-metro areas of the country, had the same story to tell: their only access to health care was through their local primary health centres, none of which had facilities to treat mental disorders. For most, travelling to urban

areas, or to the few psychiatric hospitals available in larger towns in the districts, was economically unfeasible, or could only be undertaken sporadically; the result being that their family member with mental illness would gradually become increasingly disabled and difficult to look after. The lack of access to mental health care, in fact, lack of awareness of anything to do with mental health, was also evident in the communities where Iswar Sankalpa provided intervention to most of their homeless clients. In areas such as Rajabazar, in and around Sealdah station, Entally and Chetla, localities where there are large numbers of slums and street dwellers, it became evident that the concept of mental health, or even the recognition of mental illness, was alarmingly absent. At mental health camps that were organized in these communities by Iswar Sankalpa, people slowly began to bring their family members, some suffering from psychosis, some from depression, and others from anxiety disorders. Although the psychiatrists attending the camp would prescribe medicines, there were very few places in the vicinity of their homes where such persons could be referred to for continued treatment.

It is in this disabling context that Iswar Sankalpa implemented the Urban Mental Health Programme.

PROJECT DESIGN AND RATIONALE

Rationale for integrated Mental Health Services in primary care settings

The National Mental Health Programme (NMHP) was formulated in 1982 in India as a country-wide initiative for providing mental healthcare based on the community psychiatry approach, with the District Mental Health Programme (DMHP) as its delivery mechanism. The primary approaches advocated by the NMHP were a diffusion of mental health skills to the periphery of the health service system and integration of basic mental healthcare into general health services and linkage to community development and mental healthcare (Srinivasa Murthy, 2011).

Pilot initiatives during the period 1975 – 1981, notably the NIMHANS supported initiative in Bellary, and the WHO / PGIMER project in Chandigarh, served as testing ground for providing integrated mental health services through primary health care centres, and these have since served as models for the DMHP services at the community level.

Although the District Mental Health Programme has, over the last three decades, made some attempt to provide integrated mental health services through primary health care systems, supported by structures at secondary and tertiary levels, the programme has only reached 123 of India's 675 districts, has several design and implementation flaws, and there is little evidence to show that mental health services are available at the primary level even in the districts where the DMHP has functioned with reasonable efficiency.

Moreover, the DMHP has been conspicuous by its absence in urban areas, making outpatient psychiatric services available at overcrowded government hospitals being the only mental health facilities available to the urban poor. A study conducted in 2004 in major urban settings shows a mental health services gap as follows: Chennai – 96%, Delhi – 92% and Lucknow – 82%. Significantly, while the private sector bears the major service load at primary level for general health care (Chennai 47.2% , Delhi 60.2% and Lucknow 46.2%), service load on specialist mental health care services are the highest in the government sector (Chennai 64%, Delhi 67% and Lucknow 46.3%). (Desai, et al., 2004).

Iswar Sankalpa's understanding is that the NHMP and DMHP failed not because they were ill conceived or lacked vision, they failed mainly because of a lack of long-term political, administrative and technical support and funding at national and state levels. However, as Srinivasa Murthy (2011) notes, the greatest contribution of the DMHP has been to establish that the concept of providing integrated mental and general health services through primary care centres is inherently sound, and is in fact, the only means of delivering basic mental health services through the public health delivery system, provided that such services are supported by a vertical and parallel framework of referral and support services, technical, administrative and programmatic support and of course, adequate funding.

Given that urban health care delivery models do not necessarily follow the structure of the public health system in rural areas, and that urban areas have special and complex needs due to relative high proportion of immigrant population, homelessness and the presence of slums, Iswar Sankalpa has implemented the UMHP as a pilot initiative that will inform a working model of integrated mental health services in primary urban health care settings in India.

Project Partners

The Kolkata Municipal Corporation

The Kolkata Municipal Corporation (formerly Calcutta Municipal Corporation), established in 1876, is responsible for the civic infrastructure and administration of the city of Kolkata. The KMC administers an area of 185 sq. km, and its actions are governed by the Calcutta Municipal Corporation Act, 1980. The city is divided into 141 administrative wards, these wards in turn grouped into 15 boroughs, with a population of over 4.4 million (Census 2011). The population density is estimated to be 24,252 persons per sq. km.

Providing preventive and curative public health services are one of the civic duties of the body. KMC's Ward Health Units serve as the primary health care units for the city.

The Navajbai Ratan Tata Trust

Established in 1919, the Sir Ratan Tata Trust (SRTT) is one of the oldest philanthropic institutions in India, and has played a pioneering role in changing traditional ideas of charity. In 2012 – 2013, the SRTT and its associate trust, the Navajbai Ratan Tata Trust (NRTT) formed in 1974, disbursed grants of over Rs. 2.15 billion (Annual Report 2012-2013). In 2012 – 2013, with disbursals of Rs. 674.5 million, Health Care comprised 39% of the two trusts total programmatic disbursals of Rs. 1733.96 million, other thematic areas being Rural Livelihoods and Communities, Education, Enhancing Civil Society and Governance and Art and Culture.

In 2011, the Trusts initiated their Mental Health Initiative with the mandate to improve provision of Mental Health services and quality care and treatment in underserved regions. In 2012-2013, MHI has reached out to 9,250 people out of which 8,721 are covered under Community Mental Health Programmes in various regions. The NRTT's association with Iswar Sankalpa began with a small grant in 2011 to document the latter's Naya Daur programme, an initiative that works for the homeless persons with mental illness. The partnership has deepened with the trust pledging Rs. 16,337,000 for project Sambandhan over the period 2012 – 2015.

Contractual understanding between Iswar Sankalpa and KMC

The partnership between IS and KMC was formalized under a Memorandum of Understanding between the two parties on 30th July, 2012. Under the MOU, the two parties were committed to a three-year joint pilot initiative to integrate mental health services within the existing primary health delivery systems (Ward Health Units) of the KMC in two wards, Ward 78 and Ward 82.

This initiative was launched in Ward 78 (Ekbalpore) in the first year of the pilot (2012-2013), and in Ward 82 (Chetla) in the second year (2013-2014). At the end of the implementation period (2015), the two parties were to consider using the experiences and learning from the pilot to replicate the programme in other wards in the city.

Ward 78 (Ekbalpore and surrounding areas), bounded on the north by Md Iqbal Road, on the east by Diamond Harbour Road and on the south by Hussain Shah Road has an estimated population of 58,444, of which 58% (33, 638) live in two slums, Mominpur and Mayurbhanj. The majority of the population is Muslim. There are 19 primary schools and 11 upper primary schools, and despite the existence of secondary schools in the area, there are a large number of school dropouts. The people living in Mayurbhanj are slightly better off than those in Mominpur, as they have more regular jobs.

Ward no 82 (Chetla and surrounding areas) is bounded by Tolly's Nullah on the west and Alipur Road on the east. The eastern –Budge Budge line runs along the south of this ward, and Judges Court Road bounds it on the north. This area covers an estimated no. of 2488 households which includes one-third population living in slums. Bengali speaking Hindus are a majority in this ward. Most are daily wagers (rickshaw pullers, labourers) or in low paying jobs (many women are employed as domestic help). A red-light area in this ward influences alcohol addiction and drug-abuse.

Purpose and objectives of the UMHP

The goal of the UMHP is "Increasing the quality, accessibility and acceptability of mental health care services in 2 urban wards in Kolkata". To achieve this goal, the project set three objectives:

1. Increasing the quality and accessibility of mental health care services in urban communities by integrating mental health into the existing health service delivery systems in KMC Ward Health Units.
2. Improving mental health awareness in the community thereby creating an informed demand and increased acceptability of such services.
3. Creating Ward Health Committees in each ward to function as a local level monitoring and grievance mechanism

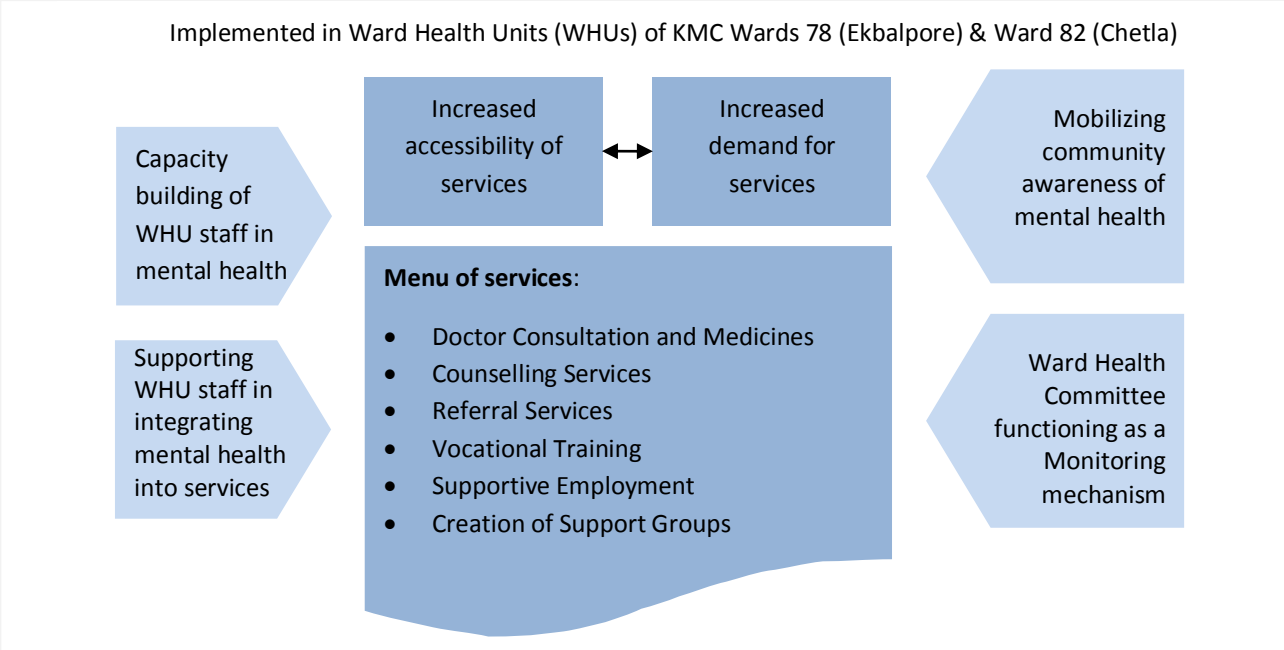


FIGURE 1: URBAN MENTAL HEALTH PROGRAMME: CONCEPTUAL FRAMEWORK

UMHP Service Delivery Model

The UMHP follows a bio-psycho-social model of care, which posits that mental health problems are not just limited to the biological (medical) domain of human experience, but may be influenced by psychological, social and spiritual factors, and similarly can be treated with medicine, counselling and psychotherapy and various forms of social and other support.

Mental health service delivery under the UMHP therefore entails a menu of services, with each patient being provided a treatment plan depending on his or her needs. While psychiatric diagnosis, medical care and counselling form the core of the services delivered, the UMHP model addresses the need for social and economic rehabilitation has tried to provide these through vocational therapy, economic rehabilitation efforts, formation of patient support groups and providing referral services.

Division of Responsibilities between agencies

Iswar Sankalpa

Capacity building

- Make arrangements for the trainers, training materials, training manual and refreshments for all training of KMC personnel over 3 years.

Deployment of Human Resources

- Provide all the required professional staff throughout the project period. These will include 1 Program manager, 2 Social Workers, 1 Counsellor and 1 Rehabilitation Specialist.
- Assign a visiting Psychiatrist once a week in the first year, once a fortnight in the second year and once a month in the third year to assist the Medical Officer in their discharge of duties towards mental patients.
- Organize awareness camps and conducting ward mental health committee meetings.
- Coordinate self help groups for the economic empowerment of those with mental health conditions.

Incentive payments to Ward Health Workers

- Pay an allowance to the health workers based on the number of people identified and referred.

Reporting

- Submit a quarterly report to the CMOH of Kolkata Municipal Corporation marking a copy to MMIC (Health), Commissioner of KMC and Medical Officer of Ward Health Centre.

Kolkata Municipal Corporation

Space and facilities at Ward Health Unit

- Provide space in the Ward Health Centres with adequate table space and storage facility for the mental health personnel in the IS team, including the Program Manager, Visiting Psychiatrist and Counsellor.
- Provide space for the Rehabilitation Specialist and Social Workers to work with groups after clinic hours.
- Provide medicines to all the patients with mental illness who attend the clinic.

Capacity building

- Select and send personnel for training and arrange for the training venue during the 3 days of the training at the start of the program and for 2 days every 6 months over three years for refresher courses.

Deployment of Human Resources

- Assign their Health Workers for identification and referral of people suffering from mental illness in the respective wards.
- Assign Medical Officers to assess and prescribe medication to people suffering from mental illness.
- Depute its staff to attend awareness programs and joining the mental health committee.

FIGURE 2: DIVISION OF RESPONSIBILITIES BETWEEN KMC AND ISWAR SANKALPA

The UMHP's Larger Programmatic Context

Iswar Sankalpa is currently implementing Project Sambandhan (2012 – 2015). The three-year project, funded by the Navajbai Ratan Tata Trust, has two broad areas of service delivery:

- **Outreach (Naya Daur)** and **Shelter** (**Sarbari)** continue Iswar Sankalpa's previous work on interventions for homeless persons with psychosocial disabilities in Kolkata
- The **Urban Mental Health Programme,** the subject of this paper, focuses on providing integrated mental health service delivery for communities from disadvantaged socio-economic backgrounds through primary health care centres in two wards in the city.

The schematic below describes the framework of project Sambandhan and its components:

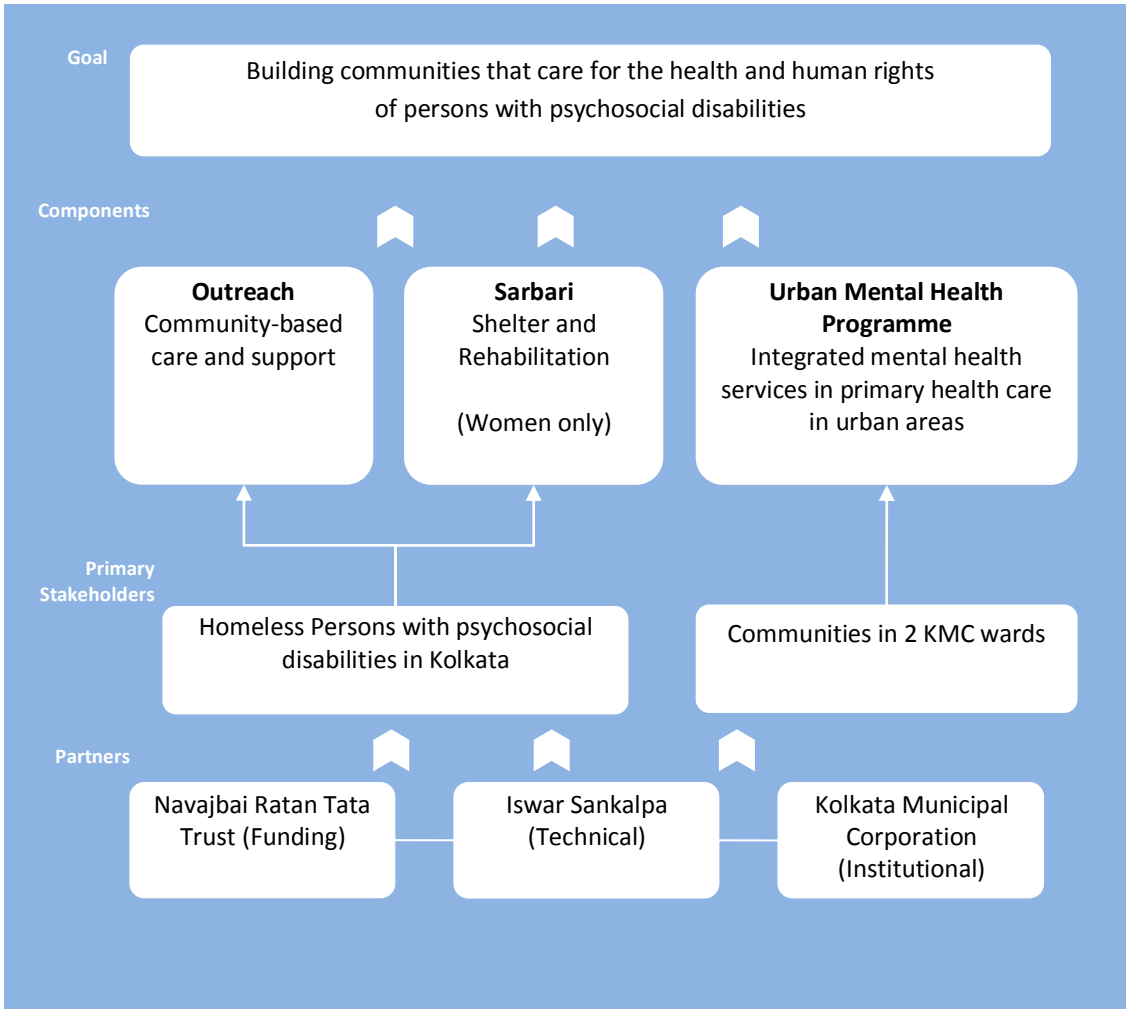


FIGURE 3: SAMBANDHAN (2012 - 2015) - CONCEPTUAL FRAMEWORK

CAPACITY BUILDING OF WHU STAFF IN MENTAL HEALTH

Training design and intent

KMC Ward Health Units are headed by Medical Officers (MOs), M.B.B. S - qualified doctors whose medical training provides only a cursory overview of psychiatry. A situation analysis study conducted in 2012 in 5 KMC wards in Kolkata (including Ward 78 and 82) revealed that while MOs of WHUs have a basic knowledge of mental health issues, including recognizing signs and symptoms of mental illnesses and broad classifications of disorders, they could not state what the prevalence of mental illnesses was in their communities, and said that since their medical training was not enough to qualify them to diagnose mental disorders or prescribe psychotropic medicines when persons with psychosocial problems came to them, they would refer them to the psychiatric departments of government hospitals elsewhere in Kolkata.

The MOs also felt that given the existing over-load of patients who visited the WHU, and the need to spend greater amount of time in diagnosis when dealing with mental illness, integrating mental health services into their own schedules would not be feasible. They all agreed however, that mental health services were greatly needed by the communities they served, and that the hold that faith-healers and quacks had on the patients and families needed to be countered.

Apart from the MO, each WHU also has a pharmacist, and other ancillary staff who man the unit. In addition, each WHU has two groups of field workers – referred to as Ward Health Workers (WHW). While one group are mainly engaged in dealing with vector borne diseases in the ward, the second group are outreach workers who go from door-to-door focusing on mother-and-child health and nutrition.

The situational analysis study showed that by and large, WHWs had a very poor understanding of mental health issues. According to them, signs of mental illnesses were '*people roaming aimlessly*', '*self talking*', '*people who are unable to take care of themselves*', '*people who lack self-hygiene*', '*no social interaction*', '*distorted social interaction*'. They attributed the occurrence of mental illnesses to heredity, head injuries, familial disturbances and tensions. Some went so far as to say that '*mental diseases are caused by insects in the brain*, and in response to a question on the meaning of disability, a worker in Ward 78 mentioned that '*a disability means that a person lacks in intelligence*'.

However, when prompted with cues, the door-to-door outreach workers observed that many of the families they visited on their daily rounds had members who showed signs of depression, anxiety, psychosis and other signs of psychosocial disabilities, though they could not name the disorders, and expressed hesitation in engaging with such people. Kabir Islam, a 43 year old WHW even said "*Can mental illness be treated at all? I don't think so.*"

Under the UMHP, the MOs and the door-to-door WHW of Wards 78 and 82 would be provided appropriate training in mental health and supported in providing mental health services in their respective wards.

For MOs, there would be intensive training sessions at the start of the project, to be followed by 2 days refresher training every six months for the duration of the project. It was expected that the training provided to MOs would enable them to provide basic mental health services and appropriate referrals for patients who visited the WHU, and that their work would be supervised by consultant psychiatrist who would make weekly visits to the Ward Health Unit.

Similarly, WHWs would be provided orientation training at the start of the project, to be followed by 2 days refresher trainings every six months. Their major task would be identifying persons with psychosocial disabilities during their outreach activities and conducting follow-up of patients. They would also be supported by the project team in their outreach activities. Each WHW would be paid an allowance from the project funds as an incentive for referring clients at the following rates: Rs 50/- for each new patient referral, Rs 20/- for the patient's first follow up visit to clinic, and Rs 15/each- for the patients next two consecutive follow up-visits to the clinic in a year. Separate training curriculums were designed for

medical officers and health workers by the following persons: Sarbani Das Roy (Programme Director, Sambandhan), Gunjan Chandak Khemka (Project Manager, UMHP), Laboni Roy, Psychotherapist, Dr. Kishore Kumar Kengeri Venkatesh, Psychiatrist and Dr. Debasis Chatterjee, Psychiatrist. The training curriculum broadly follows the principles of training in mental health for non-psychiatric doctors and social workers followed by NIMHANS and other published practices and is described below:

Medical Officers Training Curriculum	Ward Health Workers Training Curriculum
Purpose of training	
To impart basic clinical skills necessary to diagnose and treat mental health disorders in primary health care settings, and provide appropriate referrals, if necessary	To impart skills necessary to identify and refer persons with mental health disorders to the ward health clinic
Training Content	
• Importance of integration of mental health in primary care • History taking and Mental State Examination • Understanding major disorders and pharmacological treatment • Basics of counselling	• Understanding mental health • Signs and symptoms of disorders: • Recognizing family dynamics and significance of family support • Drug compliance and side-effects of drugs • Case documentation identification of clients, follow-up and referrals
Methodology	
Role Plays / Audio-Visual Presentations / Case Studies / Lectures	Role Plays / Audio-Visual Presentations / Case Studies / Lectures
Takeaway material	
Mental Health Care in Primary Care for medical officers (Workbook), NIMHANS, 2008	Health Workers Manual developed by NIMHANS (Bengali Translation)
On-site supervision	
Once a week by visiting psychiatrist	Daily supervision by IS team

TABLE 6: TRAINING CURRICULUM (MEDICAL OFFICERS AND WARD HEALTH WORKERS)

Delays and Deviations from planned design

A series of delays and the reluctance of KMC personnel to add their new duties to their existing workload posed major challenges at the beginning of the project. The MOU which was scheduled to be signed by April 2012 was finally signed in July 2012, leading to significant delays in beginning medical interventions at Ward 78 (Ekbalpore), the first ward selected for intervention. The Iswar Sankalpa team therefore began working on awareness building and networking in the community, and in order to keep up momentum generated by these activities, started providing mental health services in September, 2012 with psychiatric services being provided by the visiting psychiatrist.

Although the first orientation trainings was held in September 2012, and received good participation and feedback from the ward health personnel of Borough IX (the administrative cluster that both Ward 78 and 82 come under), more intensive trainings were postponed to December 2012, because the Ward Health Unit's time and efforts were diverted to dealing with the seasonal dengue emergency which affected Kolkata during the late monsoon and post-monsoon period. By this time, the practice of sending patients with psychosocial disabilities to the visiting psychiatrist had already been established in Ward 78 (Ekbalpore), and the MO, although appreciative and supportive of the mental health interventions being provided by the Sankalpa team, pleaded inability to see patients needing psychiatric care because of his existing workload.

Post the trainings held in September and December 2012, a number of meetings were held with the WHWs of Ward 78 to ensure their involvement in identifying and referring patients to the clinic, and in ensuring follow-up of the patients. Although they were cooperative, their involvement was limited to identifying clients in the community, and referring them to the team. They showed great reluctance to maintain any kind of documentation, involvement in the patient's treatment plan and follow-up activities. A similar situation occurred when the UMHP team started work in Ward 82 (Chetla) in June 2013.

After efforts at inducting the MOs and WHWs did not show appreciable results, Iswar Sankalpa, with the concurrence of NRTT, made the following changes to the staffing structures in each ward:

- In place of the MO, the visiting psychiatrist who was originally to provide only supervisory support, continued to provide full-fledged psychiatrist services, twice a week in Ward 78 (Ekbalpore) and once a week in Ward 82 (Chetla)
- One more Counsellor was added to the team so that each ward health unit was manned by one Counsellor exclusively
- Additionally, two part-time community social workers was added to each team to assist in field activities

The MO at Ward 78 (Chetla) did however, over the course of the project, refer several patients to the UMHP, and had prescribed sedatives to some of his own patients. WHWs of the ward have intermittently referred patients, and have also taken part in awareness generation activities.

However, as the level of integration as envisaged by the project design has not been achieved, refresher trainings of MOs were halted in August 2013 and for the WHW in December 2014 and have not been taken up again, yet. The following table provides an overview of the training schedule and attendance over the first two years, nine months of the project:

Medical Officers:					
Month	Duration	Trainer	Total attendance Borough IX	From WHU 78	From WHU 82
Sept 2012	6 hours	Dr. Kishore, Psychiatrist (NIMHANS)	11	Yes	Yes
Dec 2012	15 hours	Dr. D. Chatterjee Psychiatrist,	10	Yes	Yes
Aug 2013	3.5 hours		12	Yes	Yes
Ward Health Workers					
Sept 2012	6 hours	Dr. Kishore, Psychiatrist (NIMHANS)	43	Yes	-
Dec 2012	7 hours		51	Yes	-
May 2013	6 hours	Dr. Abhiruchi Chatterjee, Psychiatrist	39	Yes	-
June 2013	3 hours		20	-	Yes
Dec 2014	**3 hours**	Laboni Roy, Psychotherapist	27	Yes	-

TABLE 7: TRAININGS ACHIEVED (2012 - 2014)

COMMUNITY MOBILIZATION AND AWARENESS GENERATION

"Sometimes marriage works as a medicine for the mentally ill people" (Ajujul Raja, 50 years old)

"After marriage when the responsibilities come, men become bound to lead a systematic social life and consequently mental problems go off" (Ahmed Ali, 35 years, factory worker)

Communication strategy design and implementation

Iswar Sankalpa's 2012 situation analysis study found that living as they did in overcrowded, cramped homes, often without electricity and sanitation, surrounded by open garbage dumps and uncovered drains, and working mostly in hazardous, low-paying jobs, slum-dwellers had a poor health and hygiene awareness, and their poverty and illiteracy negatively impacted their health seeking behaviour.

Physical health problems were recognized and better understood because these have overt symptoms, and the first line of approach was usually the local ward health unit (where treatment is free), a neighbourhood doctor, or the local dispensary.

India has plurality of medical health systems, and people also approached homeopaths and other alternate healing providers, sometimes because the treatment was cheaper. For serious physical problems, they went to the larger government hospitals in other parts of the city where free or subsidized treatment is available.

Signs of mental disorders however, were little understood. Mental illnesses were attributed to black magic, or as punishment for past sins. Respondents to the study used the pejoratives 'mental' and 'pagol' to describe persons suffering from hallucinations, delusions and OCD behavior. Families either cloistered their suffering member at home, some locked in all day while the rest went to work, or even chained to beds so that they would not wander. Neighbours looked on families with such members with pity or disgust, and avoided them.

By and large, the first line of treatment would be faith healers and quacks. It was only when they found that the informal sector has no cures to offer, or the disability had become so debilitating and they could not cope, that they turned to medical help, first accessing the ward health unit, only to be referred to the out-patient psychiatric departments of government hospitals. Finally, by the time the person received proper medical care, the illness would be far advanced, and major disabilities would set in.

A lack of understanding of the length and modalities of treatment of mental disorders, the inability of poor families to take time off to accompany the patient for follow-up treatment, and the absence of social and economic support in the community would result in treatment dropouts, and patients would become increasingly dysfunctional, lose their jobs, and be viewed on as burdens by families and community alike.

"Although there are Government Hospitals for the treatment of the mental illness, most people are deterred by the thought of waiting in long queues there for hours.

They prefer to visit the local health units, but these don't have psychiatric facilities.

Many of them don't even opt for treatment as they don't realize that they or their family member is suffering from a mental illness".

(Shyamal Das, Health Worker, Baseline)

The UMHP communication strategy therefore consisted of two key messages:

- Mental illness is a medical condition, and those suffering from psychosocial disabilities can, and should receive medical attention and other forms of support
- Free mental health services are available at the Ward Health Unit

The UMHP awareness dissemination strategy consisted of four major pathways:

1. Door-to-door awareness campaigns, which gave them the opportunity to have individual interactions with families, providing psycho-education and identifying persons with psychosocial disorders

2. Mass awareness campaigns through distribution of leaflets through newspapers, putting up posters in strategic places, running auto-campaigns (Fitting auto-rickshaws with posters and a loudspeaker announcing awareness messages), street theatre and holding street corner meetings were used to draw public attention to mental health services available in the community.

3. Targeted awareness programmes through local CBOs, schools and other organizations gave them an opportunity to address local interest groups, and provided platforms for discussions on mental health, recognizing mental illnesses and as sources of referrals to the clinic.

   These discussions also helped the team build relationships with local people; get a better insight into the community's needs and behaviour and to build support for their activities. Intensive psycho-education would be provided to de-mystify the causes of mental disorders and to reduce the fear and stigma against people with psychosocial problems.

4. Advocacy and linkages with key influencers in the community: political activists, community leaders – especially maulvis in Ward 78 (Ekbalpore), faith healers and alternate medicine providers and general physicians.

   Rather than reject the community's practices of alternate healing and thereby antagonize the strong network of traditional healers and quacks, the UMHP team also propagated the message of "Dava bhi hai, aur dua bhi" which roughly translates to "Prayer and medical help can both bring about healing".

   In fact very early into the project, the UMHP team introduced themselves to religious leaders and traditional healers to ensure that the latter did not feel threatened by the UMHP, and put forward the idea that if they felt that any of their followers needed medical help – it was available at the Ward Health Unit.

> "Mental health services are now available from 10 am to 1 pm, from Monday to Friday at your Ward Health Unit.
>
> Our mental health is just as important as our physical health. If the mind is not happy and well, then the body will also not be well. Mental health issues can be treated through medication and other services like counselling. They are not caused due to black magic or evil spirits and it cannot be cured by marriage. People with mental health conditions need the love, support and care of their family and friends.
>
> So if you know of anyone in your neighbourhood who needs help, please get them to the clinic at the earliest possible."

FIGURE 4: MESSAGE USED IN AUTO-CAMPAIGNS AND DOOR-TO-DOOR VISITS

	Ward 78 (Ekbalpore)		Ward 82 (Chetla)	
	No. of events	# of people participated	No. of events	# of people participated
1. Door-to-door awareness and outreach by WHW and IS social workers	-	20835	-	14177
2. Networking with key community influencers	-	4	-	2
3. Leaflets distributed/Posters put up		Approximately 1,50,000		
4. Interactive events				
Local Clubs and CBOS	15	238	8	169
Schools (Teachers/Students)	10	170	4	197
Awareness desks near mosques on Friday afternoon prayers/Near parks/Bus Stands	13	2196	4	345
Street theatre	3	212	-	-
5. Mass campaigns				
Auto campaign (displaying posters on auto-rickshaws plying the area around the wards)	3	600	3	600
Distribution of leaflets through news papers	1	3000	1	1400
Announcements by Imams	5	500	1	100
Health Camps in Conjunction with Schools/Local Government Bodies/CBOs	4	2810	1	400
Loudspeaker announcements	2	200	-	-
Audio-Visual Methods/	5	177	1	12
Displaying posters during Pujas and Independence Day and distributing leaflets	-	-	2	600

TABLE 8: NETWORKING AND AWARENESS CAMPAIGNS HELD BETWEEN APRIL 2012 – DECEMBER 2014

IEC material	Usage
Posters designed by an IIM student	Displayed in public spaces and behind Auto-rickshaws plying in the routes near where UMHP clinics are
Leaflets on several mental disorders (psychosis, depression, epilepsy, anger, stress and anxiety)	Distributed at awareness events
Messages broadcast in Bengali and Hindi	Over loud-speakers during auto campaigns and other events. Also used during door-to-door awareness
6 sets of flash cards – hand drawings depicting mental illnesses	Used at small interactive events to elicit recognition of signs and symptoms of mental illness
Videos on schizophrenia, depression and epilepsy prepared by pharmaceutical companies	Displayed in WHU and at interactive sessions

TABLE 9: IEC MATERIALS USED


चिंता
अवसाद
तनाव
मानसिक स्वास्थ्य है
सबसे ज़रूरी !
अधिक जानकारी के लिए 78 के हेल्थ यूनिट , इकबालपुर मैटरनिटी अस्पताल आईये
(इकबालपुर नर्सिंग होम के सामने)
Urban Mental Health Programme, Implemented by: The Kolkata Municipal Corporation and Iswar Sankalpa
SUPPORTED BY: NAVAJBAI RATAN TATA TRUST
LPG
RJ
35
WB 04
D 5379

Demand for mental health services

Although the UMHP's awareness programmes and community outreach efforts have addressed just the tip of the iceberg when it comes to changing community attitudes and practices, the communication strategy combined with appreciation of the services has been instrumental in ensuring a growing number of referrals to the services offered by the programme.

In Ward 78 (Ekbalpore), over a period of 28 months September 2012 – December 2014), 1004 clients utilized the UMHP services. In Ward 82 (Chetla), between June 2013 and December 2014, a period of 19 months, 465 clients have utilized UMHP services.

Door-to-door outreach resulted in the highest number of referrals (40.1%) and clients themselves, and their families, were the second highest source of referrals (20.63%). Door to door outreach was particularly effective because the method gave the social workers time to build rapport with families, to describe symptoms of mental illnesses at length, and to counter fears and myths about psychiatric disorders. It also gave the families an opportunity to discuss their problems in private.

That there is a need for mental health services is also evident from the amount of time taken and the distances covered by clients in accessing the WHU. Although the majority of clients were from the two wards covered under the programme, a number of clients from other wards also accessed the services of Wards 78 and 82. One of UMHP clients' was a Kolkata resident who formally travelled periodically to Ranchi for treatment at a major psychiatric centre there, and now comes to the WHU for treatment. Another client travelled periodically from Bihar to the WHU for treatment. Interestingly, apart from referring clients from the persons who come to them at the WHU, WHWs have been referring their own families to both the ward's mental health unit.

In Ward 78 (Ekbalpore), one of the strategies adopted by the team in this primarily Muslim locality was to set up awareness desks outside mosques on several Fridays. Although many people avoided eye-contact and walked away, at each event, the team did get a few enquiries, and have used the occasion to distribute leaflets and initiate one-on-one discussions with community people.

Several community members have suggested that leaflets and posters should be written and Urdu, and that there should be an emphasis on announcements and using of visuals, since a large number of the wards population are illiterate or semi-literate.

Building relationships with the imams in the area has been a necessary and productive exercise. One imam was particularly helpful: he used one of his Friday meetings to discuss mental health and announced the availability of UMHP services. At a recent interview, he felt that such services should include the treatment of addiction and the widespread awareness of its ill impact.

As such, individuals and organizations such as schools, clubs, small business etc have been approachable, and some have been helpful in providing insights into the local communities, referring clients to the clinics, and suggesting ways and means of generating awareness.

At a recent group discussion between family members of clients, one person admonished another for using the word '*pagol*' in conversation.

Although one could not say that stigma against mental illnesses have reduced, one could assert that those who have come in contact with the UMHP are more aware and sensitive about persons with psychosocial disabilities, and that focused awareness campaigns and public support by key influencers in the community will go a long way in countering negative perceptions of persons suffering from psychosocial disabilities

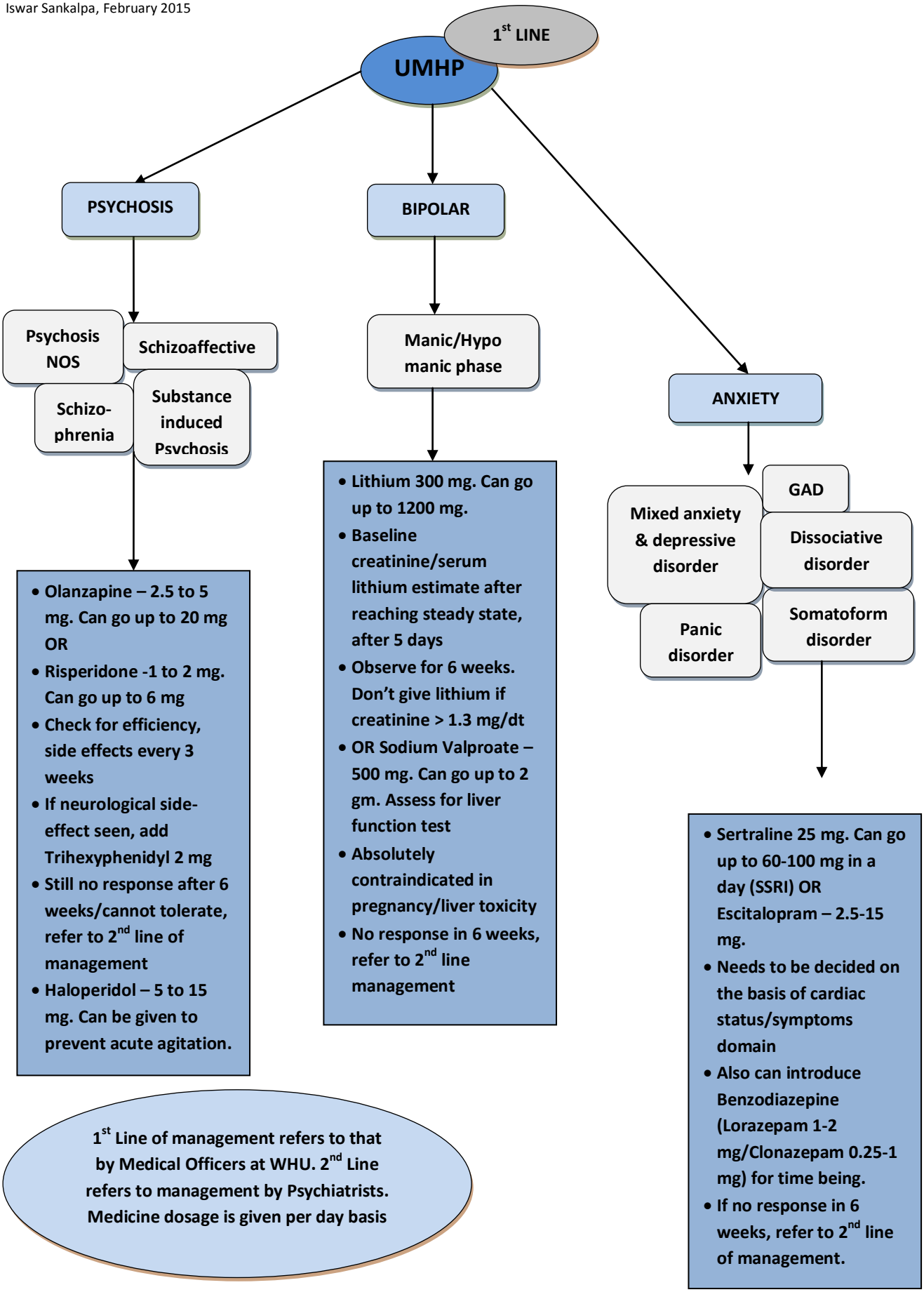


FIGURE 5: PHARMACOLOGICAL MANAGEMENT: 1ST LINE

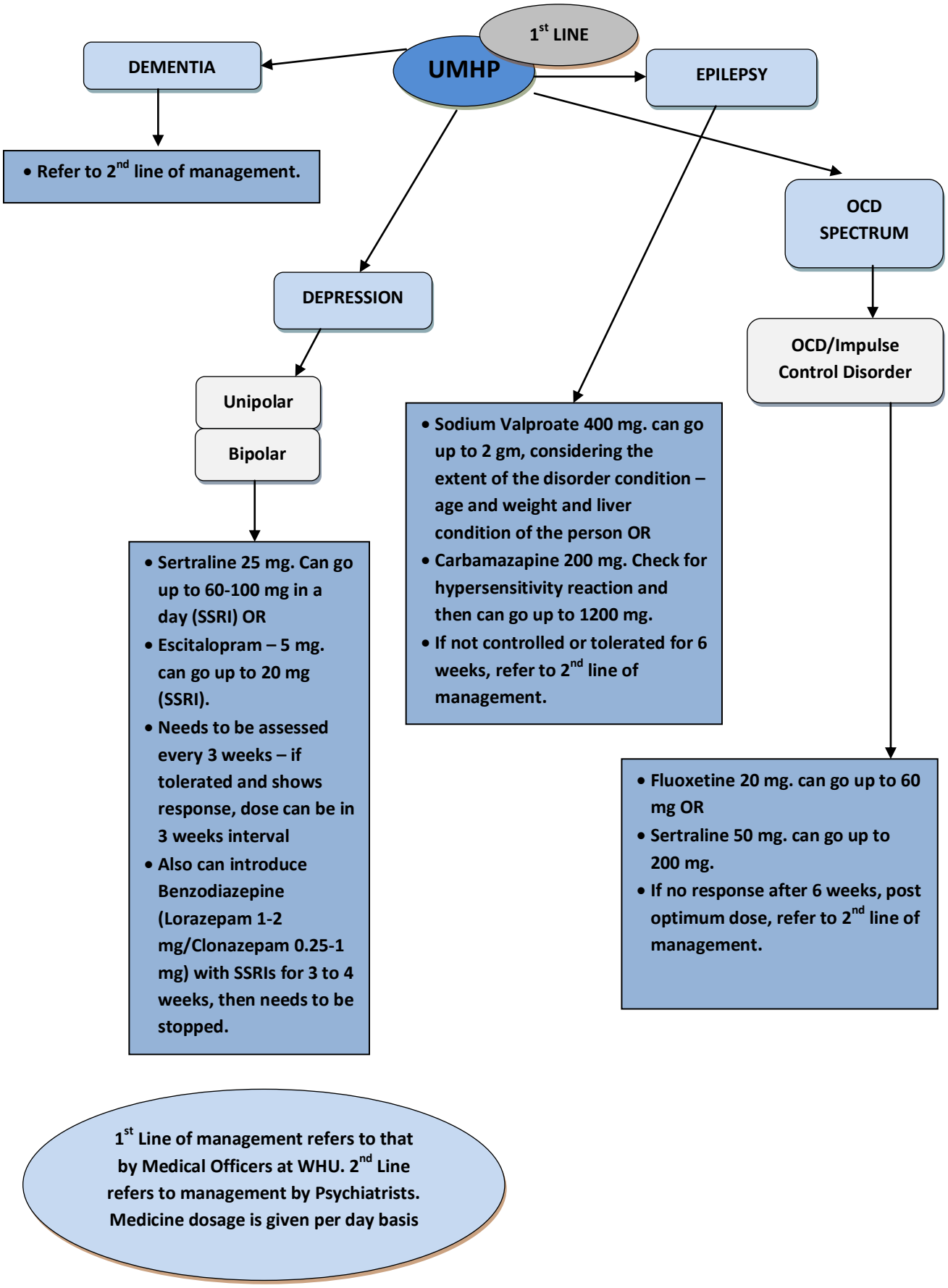


FIGURE 5a: PHARMACOLOGICAL MANAGEMENT: 1ST LINE

DELIVERY OF MENTAL HEALTH SERVICES

Free mental health services are provided at each Ward Health Unit from Mondays to Fridays. (Services at Ward 78 (Ekbalpore) began in September, 2012, and in Ward 82 (Chetla) in June, 2013).

Although the official KMC hours are 8 am to 1 pm, the mental health services section often remain open till 5 pm or so, depending on the patient load. The UMHP provides services to people over the age of 15, and caters mainly to Common Mental Disorders, Severe Mental Disorders and Epilepsy.

The composition of the Mental Health Services team in each ward is as follows:

- A counsellor and a social worker screen new clients and provide counselling, follow-up and other services to existing clients. A rehabilitation officer looks into productive engagement of client in both wards
- Outreach work is conducted mainly by the social worker, supported by two part-time community members

The part-time psychiatrist attends Ward 78 (Ekbalpore) twice a week (Mondays and Wednesdays), and Ward 82 (Chetla) once a week (Tuesdays). Both units are provided hands-on supervision by a project manager. Additional support is often provided by other IS counsellors and volunteers

Psychiatric treatment, counselling and referrals

In-clinic services

People on their first visit were met by the counsellor or social worker, who conducted detailed screening using facets of the mental state examination and spoke to both, the person and caregiver.

The first interview could take up to 45 minutes or more, at the end of which the client was given a follow-up date, either for counselling or for a psychiatric consultation. If necessary, the team advised diagnostic tests to rule out physical causes of problems. The most commonly recommended were thyroid tests. In several cases, IQ assessments or even CT scans have been recommended. The team built up a referral network of diagnostic centres, where UMHP patients with a monthly income of less than Rs. 10,000/- could have tests conducted at discounts ranging from 10-30%.

The team used the Clinical Global Impression Scale (CGI) as a tool to assess efficacy of medicinal interventions. Clients were given a severity of illness score when they were prescribed medicines, following which global improvement and medicine efficacy index scores were given in 3-4 weeks time. Post three months, these two scales are administered again to understand whether client's status was the same, improved or deteriorating, and these scales informed regular follow ups and medication.

The team also used the Global Assessment of Functioning (GAF) to measure the social, psychological and social functioning of clients, the Indian Disability Evaluation and Assessment Scale (IDEAS) to measure the individual's overall disability levels due to the mental health condition and the Family Burden Scale to assess the socio-economic and psychological burden on the family of the individual. These scales were administered at the time of the person's registration into the programme, and then every 6 months.

For each client, the team maintained a detailed file describing the client's name, contact no and other profile information, case notes from every counselling visit, scales administered, copies of each prescription and the treatment plan. Each client's case was discussed in the team, and a treatment plan drawn up and regularly monitored. Even if the team felt that a client needed only counselling and other psycho-social support, he/she was given at least one psychiatric consultation in order to ensure a medical opinion.

Every person was given a registration card, on which follow-up dates were written. After psychiatric consultations, clients cued up at the ward health unit's pharmacy to collect their medications at no cost.

(Note: although people suffering from dementia are enrolled in the UMHP, they have to purchase their medicines from outside, as these are not covered under the project MOU with the KMC)

KMC medical supplies have at times been irregular, and at those times, the IS team provides clients with a few doctor's samples, and advises them to buy the rest. Clients coming to the clinic however, expected free medication, and several discontinued treatment when they did not receive the requisite amount from the pharmacy. The team has also noted that despite being provided discounted referrals for diagnostic tests, many clients pleaded the inability to pay any amount, and wanted completely free treatment.

Experiences and learnings

At the initial stages of the project, clients and their families would be distinctly dismayed when being attended to by the counsellor or the social worker, and would keep asking to see a doctor. There was also no understanding of the concept of counselling, and clients would grow impatient at what they felt were protracted discussions when they were expecting to receive medication. Moreover, clients and their families had no understanding of the relatively lengthy and often chronic course of mental illness and had unrealistic expectations of the efficacy of medicines. They felt that once the medication was given, the client would completely recover, as one would expect after a course of medication given to someone with a fever or a physical disease.

Subsequently, in each client's first visit, the team placed great emphasis on providing clients and their families with information about the role of counselling and psycho-social support in mental health problems, as well as what one could reasonably expect in terms of improvement in functioning. Although cognitive therapy tools such as thought-diaries, thought stopping and other techniques were taught to many clients, and some did report trying to use these, the ability of clients, given their socio-economic background and literacy levels to spend time in self-reflection was very limited, and counselling sessions were mostly restricted to allowing clients to express their frustrations, and in providing supportive guidance. For many clients, especially women, the counselling sessions were the first time they were able to discuss their personal lives and frustrations without censure, and expressed that they feel 'lighter, less burdened' after sharing their problems. Such sessions were particularly appreciated by the female Muslim clientele of Ward 78 (Ekbalpore), who live extremely cloistered lives, with little exposure to the outside world. Clients in Ward 82 (Chetla) however, were not as appreciative of counselling services, as they reported that frequent changes in counsellors at the ward hampered the process.

Similarly for families of clients, counselling provided a much-needed space where they feel that their problems were heard and understood, where they received ideas on how to deal with the symptoms of psycho-social problems, and learned coping strategies. Their experiences with government services elsewhere, were restricted to encounters of 5 to 10 minutes, with often dismissive and discriminating attitudes, and little concern for their feelings or opinions, and the very fact that members of the team, including the psychiatrist, speaks to them with concern and regard, and spends anything between twenty to forty-five minutes with them in each session, has been much appreciated.

Despite the team's best efforts to explain the length of the treatment and the need for medicine management, the treatment compliance was low. Psychotropic drugs take at least two to three weeks to show any change in a patient, and caregivers and clients often stopped medication after a few weeks saying that it does not work. Another factor that affected treatment compliance was the irregular supply of psychotropic drugs by KMC.

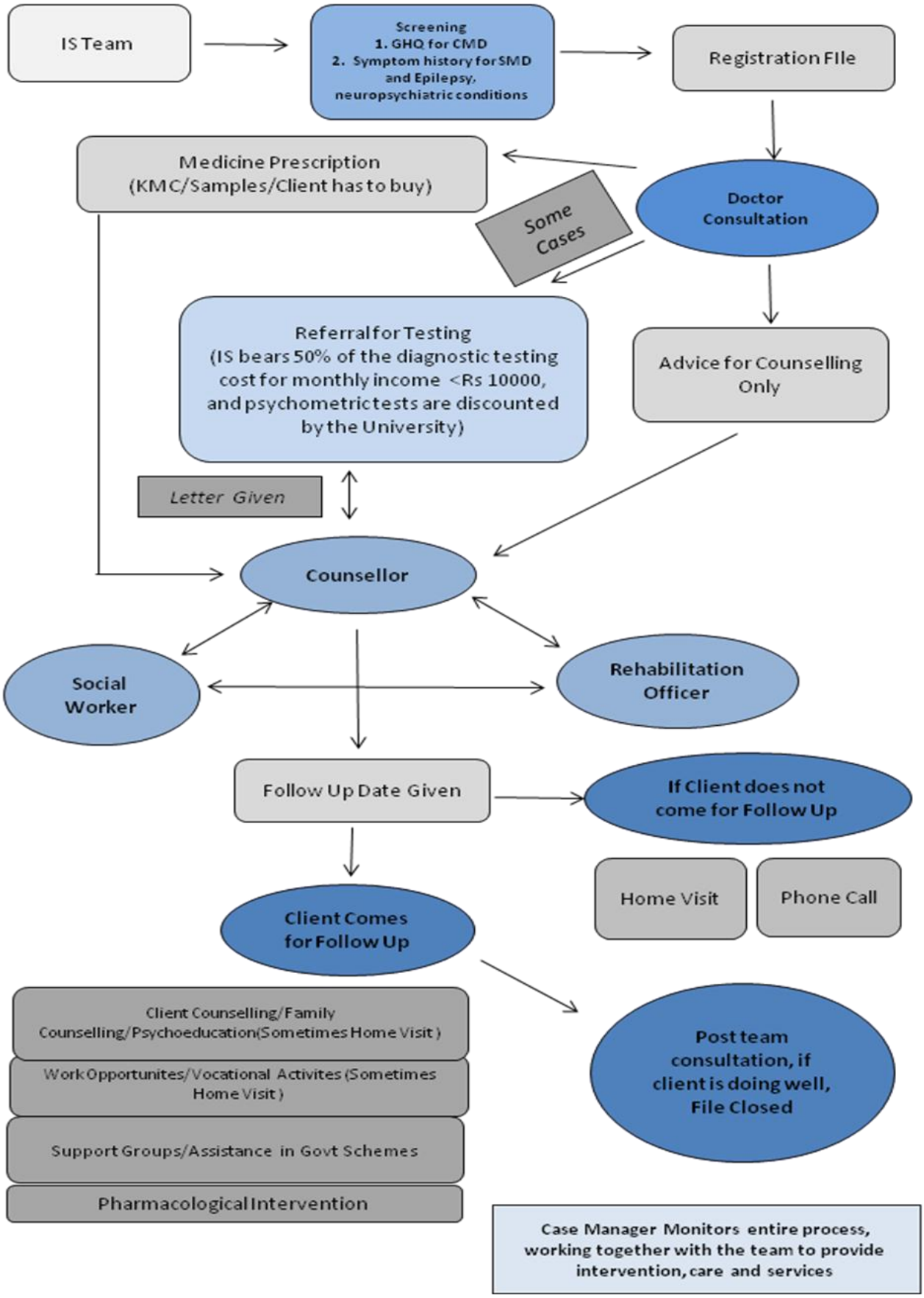


FIGURE 6: TREATMENT PROTOCOL - CHART 1

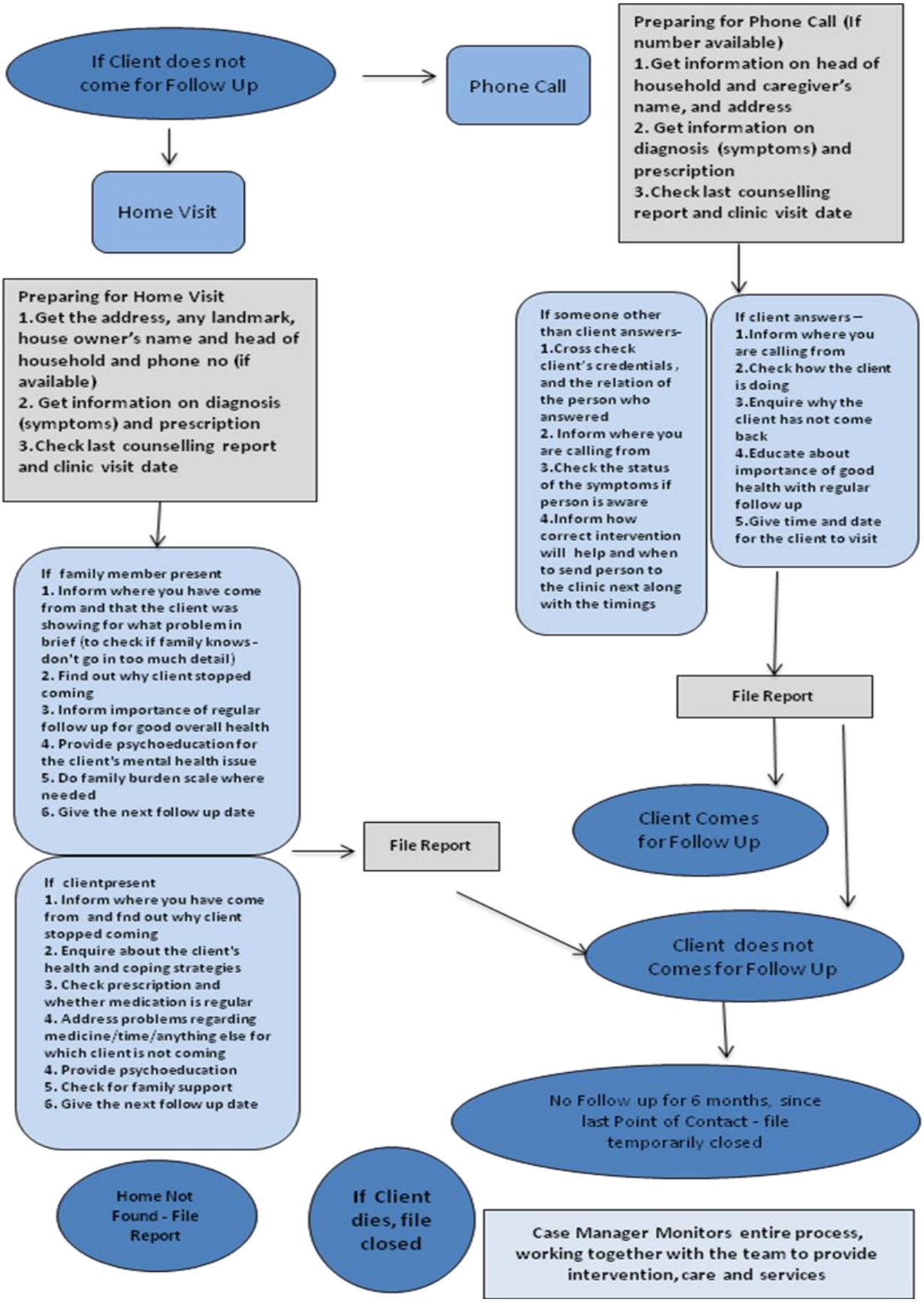


FIGURE 7: TREATMENT PROTOCOL - CHART 1

Follow-up Home-visits

Home visits have been the key to ensuring treatment compliance and continued visits to the clinic. In the first year of the project, home visits were undertaken by the IS team and the health workers in cases when family support was poor and psycho-education and counselling was required, as well as for clients who had stopped coming for follow up visits. In certain cases visits were conducted to verify the home situation when clients cited the inability to pay for diagnostic tests and asked for further reductions.

Subsequently, the team devised a more structured way to conduct home visits, a move that has helped them cover more patients in an efficient manner. While the counsellor focused on those houses where the client requires family support counselling, the rehabilitation officer focused on those houses where the need is to engage them in vocational activities/community living skills/supportive employment and also where help was needed in order to get disability cards for the client. Social workers focused on those clients who had not been coming for follow up visits to the clinic. Another point of contact undertaken by the team was to call clients up when they missed their follow up dates for a long period in order to keep them under the clinic intervention.

Temporary closure of dormant files

Given the increasing patient load, and drop-outs, the team devised a protocol for temporary closure of dormant cases: Files would be temporarily closed after the following steps were taken: 2 home visits/2 phone calls or 1 phone call and 1 home visit with no follow-up visit by the client to the clinic in over 6 months.

Referrals

For technical reasons, as well as reasons of capacity, UMHP does not provide services to children and adolescents, nor does it provide rehabilitation services to persons addicted to alcohol or substances, although it does treat them for co-morbid psychiatric conditions.

The team however, has built up a database of organizations that provide such services, and provides referrals to these when necessary. A number of persons have sought treatment for children with disabilities – they have been referred to appropriate services, including subsidized IQ testing services at Rajabazar College. Adults with disabilities have been referred to the Government Hospitals, for disability certificates.

However, the team has found that most people who have received such referrals have not gone on to use them, again perhaps because of their socio-economic limitations.

Vocational Therapy, Supportive Employment and Formation of Self Help groups

In order to provide comprehensive mental health care services, UMHP was intended to provide vocational therapy, assist in economic rehabilitation, and facilitate the formation of self-help groups for their patients.

In an ideal setting, vocational therapy is used in combination with a structured rehabilitation program and is designed to enable the disabled individual to resume productive employment. Individuals who have experienced changes in their mental or physical function due to illness or injury may require vocational therapy to allow them to return to work. For a period of eleven months, the UMHP team provided a group of 2 to 12 female clients with classes in sewing every Tuesday at the WHU in Ward 78 (Ekbalpore). However, linking clients with training institutes is a better utilization of resources, and currently, 13 clients are enrolled in stitching classes in Ward 78 (Ekbalpore), and one in Ward 82 (Chetla). Because of Ward 78's primarily Muslim conservative clientele, the team has necessarily had to find vocational training institutes within the ward area itself, as families are very reluctant to allow their female members to spend much time outdoors.

Another focus area was encouraging clients to be involved in supportive employment avenues and also re-engage in community living skills in order to help them increase their functionality and at the same time, become more independent in their daily lives. This also helps the family members to change the family's perception of the client as a burden to being another helping hand in the family unit. The team has been able to encourage 49 people to become involved

in some employment opportunity in the neighbourhood. This process however, has not been easy. Although several clients and their families have, in clinic sessions and also on follow-up visits, emphasized their desire to work, when suggested avenues for employment, have been reluctant to take the suggestions up. Often people take up a job for a short time, and then leave it. A great deal of hand-holding and encouragement has gone into the process of linking people to supportive employment.

Self-help groups where patients in a mutually supportive environment are an effective part of mental health healing strategies. Although the team made several attempts to bring clients together in a group, their attempts failed, partly because their clients could not appreciate the value of forming such a group, and partly because their daily lives were so stressed and over-burdened, it was difficult to get them to sit together at a particular time.

Currently instead, the team has formed a support group of clients and caregivers in Ward 78 (Ekbalpore), and this seems to be relatively successful. Apart from providing mutual support, the team members are proving to be a community advocacy group.

Deployment of Human Resource

In each ward, the social workers, counsellor and rehabilitation specialist, supervised by the Project Manager, spend the first half in manning the clinic, and providing screening and counselling services.

Given that each counselling session takes a minimum of 30-45 minutes, the counsellor cannot see more than 5-6 persons per day. On the days earmarked for psychiatric visits, no counselling sessions are held; instead the team focuses on providing the psychiatrist with client updates and documentation support. In case of the psychiatrist visit days, about 30 clients visit the WHU on an average, and clinic timings have to be extended to 3 or 4 pm, till as such time all clients have been attended to and their documentation completed.

Post-clinic hours are used to create treatment plans for clients and update the project's documentation. Afternoons are also utilized to conduct follow-ups through home-visits and phone calls, and for door-to-door visits to identify new patients

The social workers field work includes but is not exclusive to doing door to door identification and follow-up visits and facilitating the activities of the caregiver support group. They also conduct awareness meetings and make multiple networking visits to schools, clubs, CBOs, other organizations, general physicians in the neighbourhood, and government officials. Apart from supervising stitching sessions for vocational therapy every Tuesday in Ward 78, the rehabilitation specialist makes home visits to motivate clients to engage in jobs or vocational activities and develops linkages with potential employers.

Their specific duties apart, all team members contribute to documentation and field activities, including manning awareness campaign events, networking, generating referrals and conducting home visits. All team members accompany each other as and when required – rehabilitation officer may need male social worker to visit certain employment avenues. Male social worker may need the female social worker/counsellor to visit certain homes as men are not allowed in. In terms of need, every team member fills in for the other.

With a target of 20-25 home visits every month – the team can cover between 240-300 houses in a year at the most. Sometimes, there have to be multiple visits to one house and sometimes a lot of time is spent in locating homes which leads to lesser homes being covered.

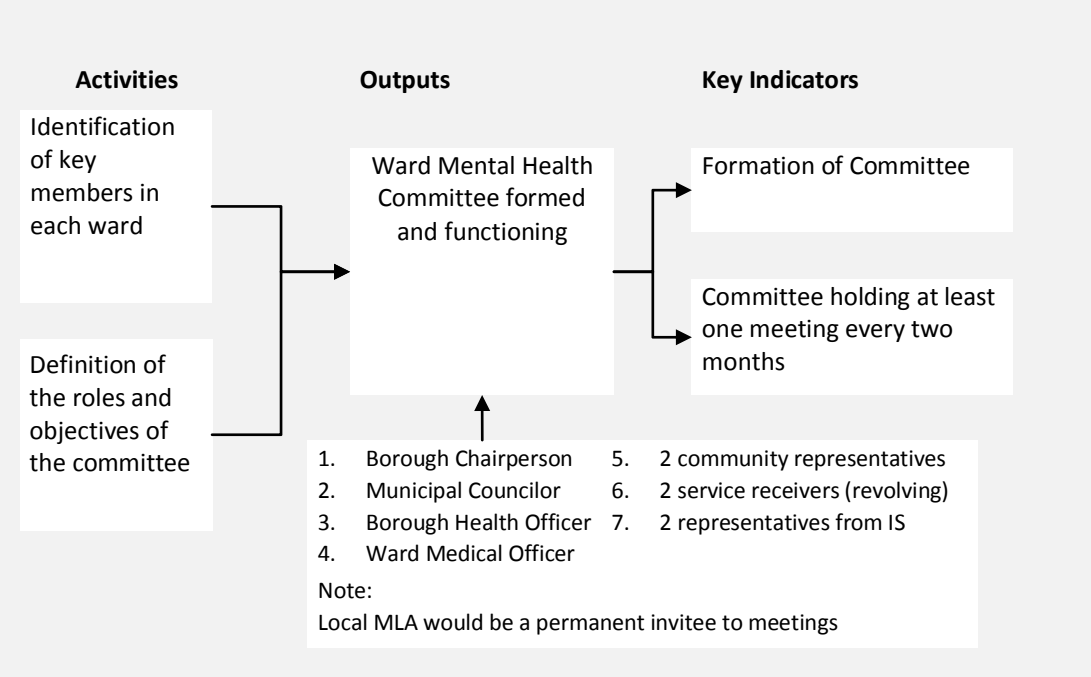


FIGURE 8: WARD MENTAL HEALTH COMMITTEE- CONCEPTUAL FRAMEWORK

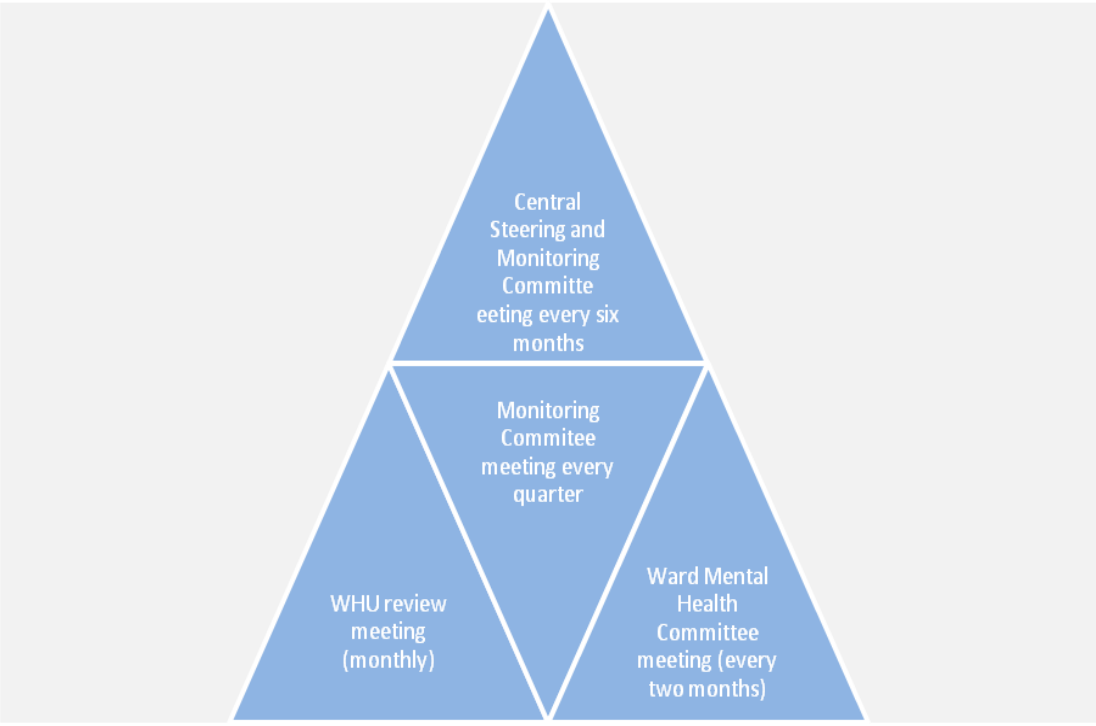


FIGURE 9: UMHP FOUR-TIER MONITORING & EVALUATION FRAMEWORK

RECORD-KEEPING, REVIEW AND MONITORING MECHANISMS

Record-keeping

Apart from the individual client files, the UMHP team maintains comprehensive records, both in paper-form and in an e-MIS system. These are used as a reference to analyze patient status and needs, prioritize work, and prepare regular reports for funders and KMC.

1. Awareness generation activities
    a. Networking visits and relationships built with persons and organizations
    b. Reports on all awareness meetings, trainings and other meetings
    c. Record of door to door awareness visits
    d. IEC material distributed
2. Identification of clients
    a. Identification by WHWs
    b. Identification of clients by social workers
3. Medicine supply
    a. Medicines being supplied by the KMC
    b. Medicines being procured through samples
4. Referral registers
5. Client Management
    a. Daily client register
    b. All client files and corresponding e-MIS
    c. Review of status of clients through GAF, IDEAS, Family Burden scale and CGI
    d. Home visits conducted and phone calls made
6. Rehabilitation related work – number of clients engaging in supportive employment/vocational activities/community living skills –on going status
7. Group session reports
8. Point of Contact sheet for each client to track client interactions in the clinic and field, and record of follow-up attempts

Monitoring and evaluation

The project design envisaged a four-tier review and monitoring mechanism which is described below:

1. Ward Health Unit Level: A monthly joint review meeting would be held at each WHU, attended by the Medical Officer, Psychiatrist, Program Manager, Social Workers, Counsellor, Rehabilitation Specialist and Health Workers.

2. Ward Mental Health Committee (WMHC) at the Ward level: The project envisaged the formation of a Ward Mental Health Committee in each ward, comprising of key stakeholders from the Kolkata Municipal Corporation, the Ward Health Unit, IS and community representatives.

   Although the project design document stated that the committees were to function as ward-level monitoring and grievance mechanisms and were to meet once every two months, it did not specify the roles and responsibilities of the members, intending that such definitions should emerge from the committee members themselves. In the long-term, it was intended that Ward Mental Health Committee would function under guidelines issued by the KMC.

3. A Monitoring Committee comprising Joint Municipal Commissioner, Chief Municipal Health Officer, Chief Municipal Auditor, Representatives of Iswar Sankalpa were to hold quarterly assessment and review meetings.

4. Central Steering Committee at the municipality level: A central steering committee chaired by the Member Mayor in Council (Health) and the Municipal Commissioner along with suitable representation from all stake holders was to be formed. This Central Steering Committee was to meet at least once in six months to review the work done under the UMHP at the Ward Health Centres, to suggest suitable improvements and midcourse corrections, and resolve the difficulties

faced by the field officers in implementation of the program.

In addition, Iswar Sankalpa and the projects funders, NRTT, were to conduct regular internal evaluations, slated for the end of the first and second year.

Although the Ward Health Unit in Ward 78 was expected to begin operations in April, 2012, patients began attending only in September, 2012. In March 2013, at the end of the first reporting year, the project team noted that in view of the weak involvement of the functionaries of the WHU, formation of the WMHC was postponed to the next year (2013-2014).

By the middle of 2013 – 2014, because of appointments being continually deferred by key government officials, the team decided to cancel the formation of such a committee during the pilot phase. Instead they decided to focus their energies on the formation of an 'interest group' formed with caregivers and concerned others in 2014-2015.

However, annual reports have been provided to the KMC CMOH and MMIC after every financial year. Since a few months, June 2014, the MO at WHU 78 has been taking a weekly report of people coming to receive mental health services.

Iswar Sankalpa and NRTT conducted three internal evaluations, one at the end of year one, in December 2012, then October 2013, and one in October 2014.

The major observations of the evaluations are listed below:

1. UMHP needs to consider ways in which WHU medical officers and WHW can be motivated to participate in the pilot initiative.
2. Given that the environmental stressors of the clients are very high, the psychosocial and economic rehabilitation of clients needs to be strengthened
3. While awareness generation activities are progressing well, strategies need to take into account greater involvement and support of the community, especially in the form of support groups
4. Given the high percentage of clients with common mental disorders, the programme needs to focus on identifying and treating more clients with severe mental disorders.
5. The team needs to design more structured psychosocial interventions for clients with common mental disorders.

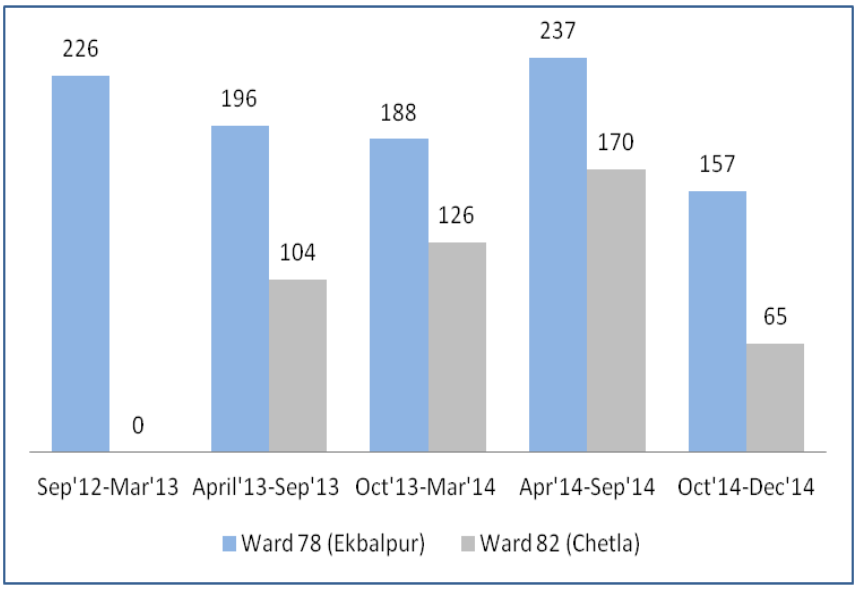
FACTSHEETS

Total Number of Clients

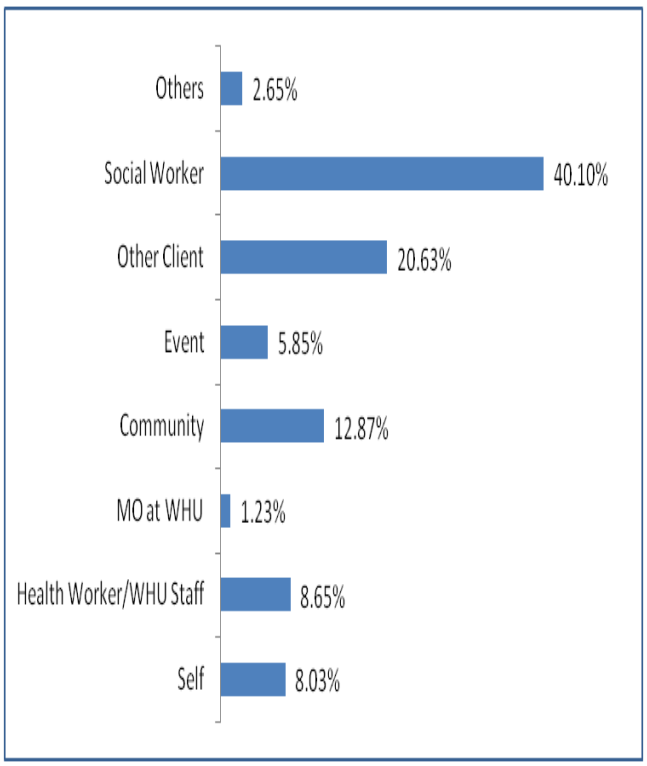
(September 2012 – December 2014)

1469

No. of persons accessing UMHP services (September 2012 – December 2014)



Source of Referrals



Time taken to reach WHU

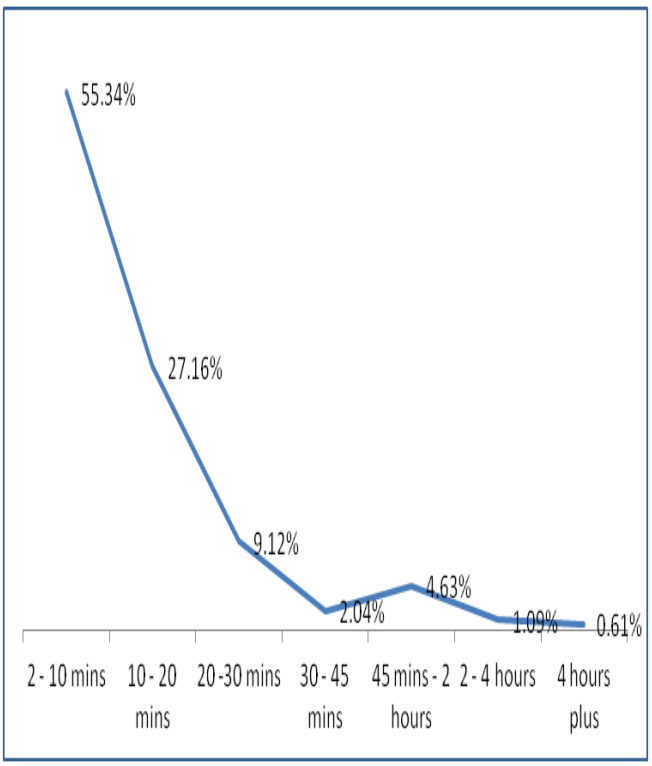
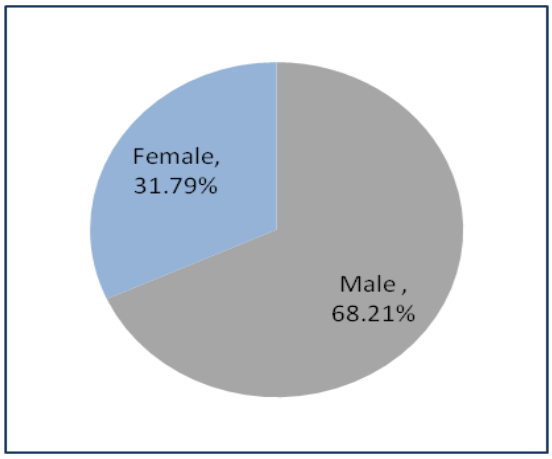
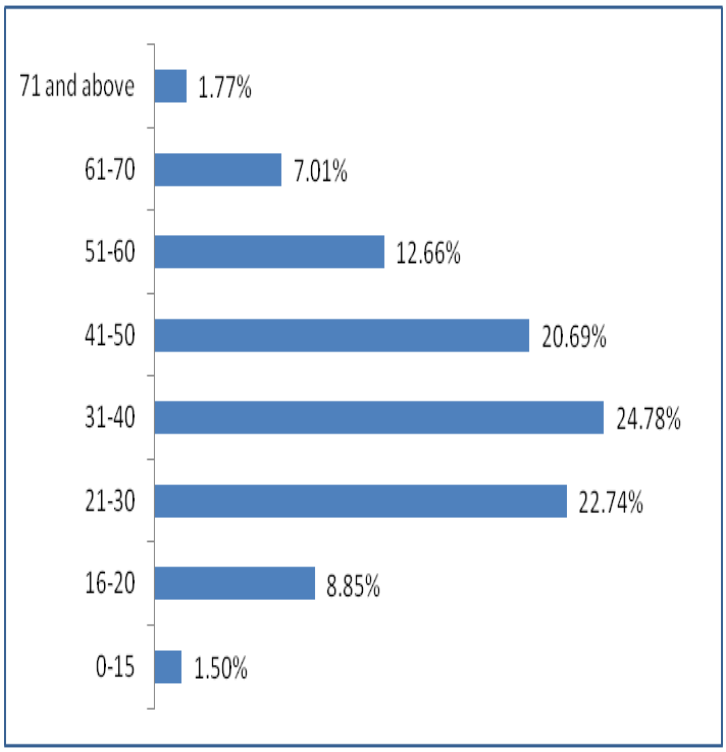


FIGURE 10: ACCESS TO SERVICES

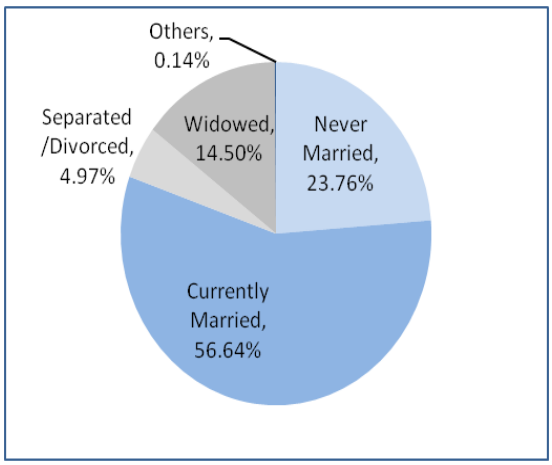
Gender-wise



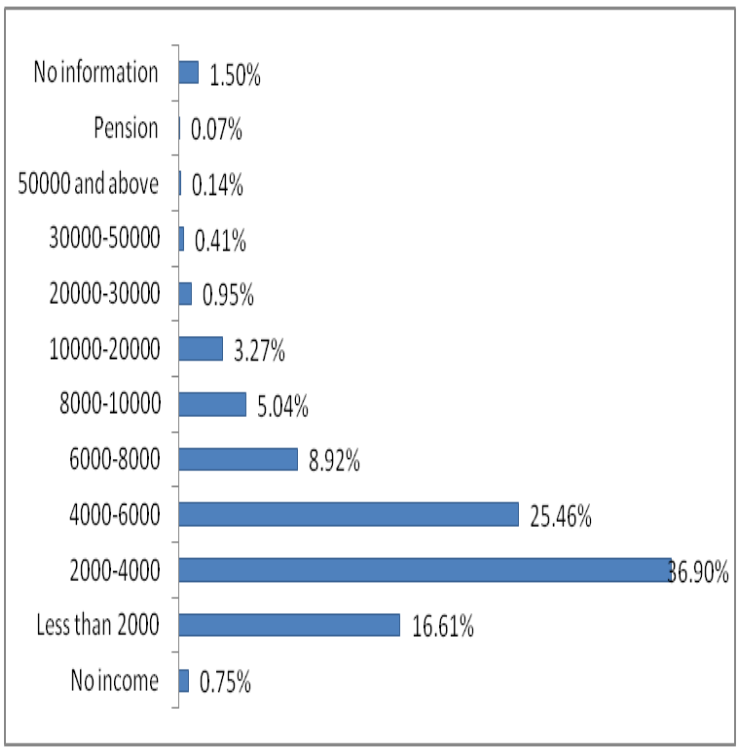
Age-wise



Marital Status



Income levels



Literacy levels

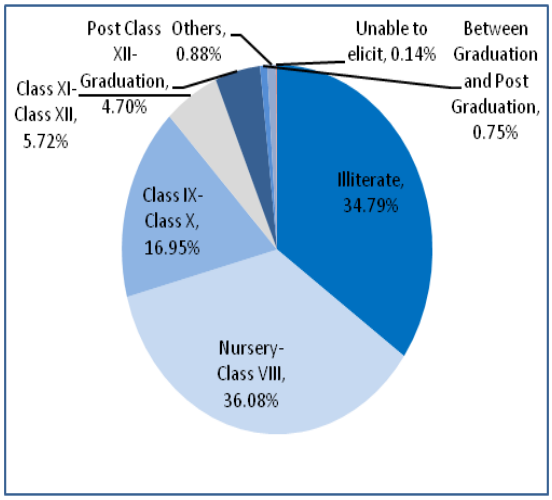
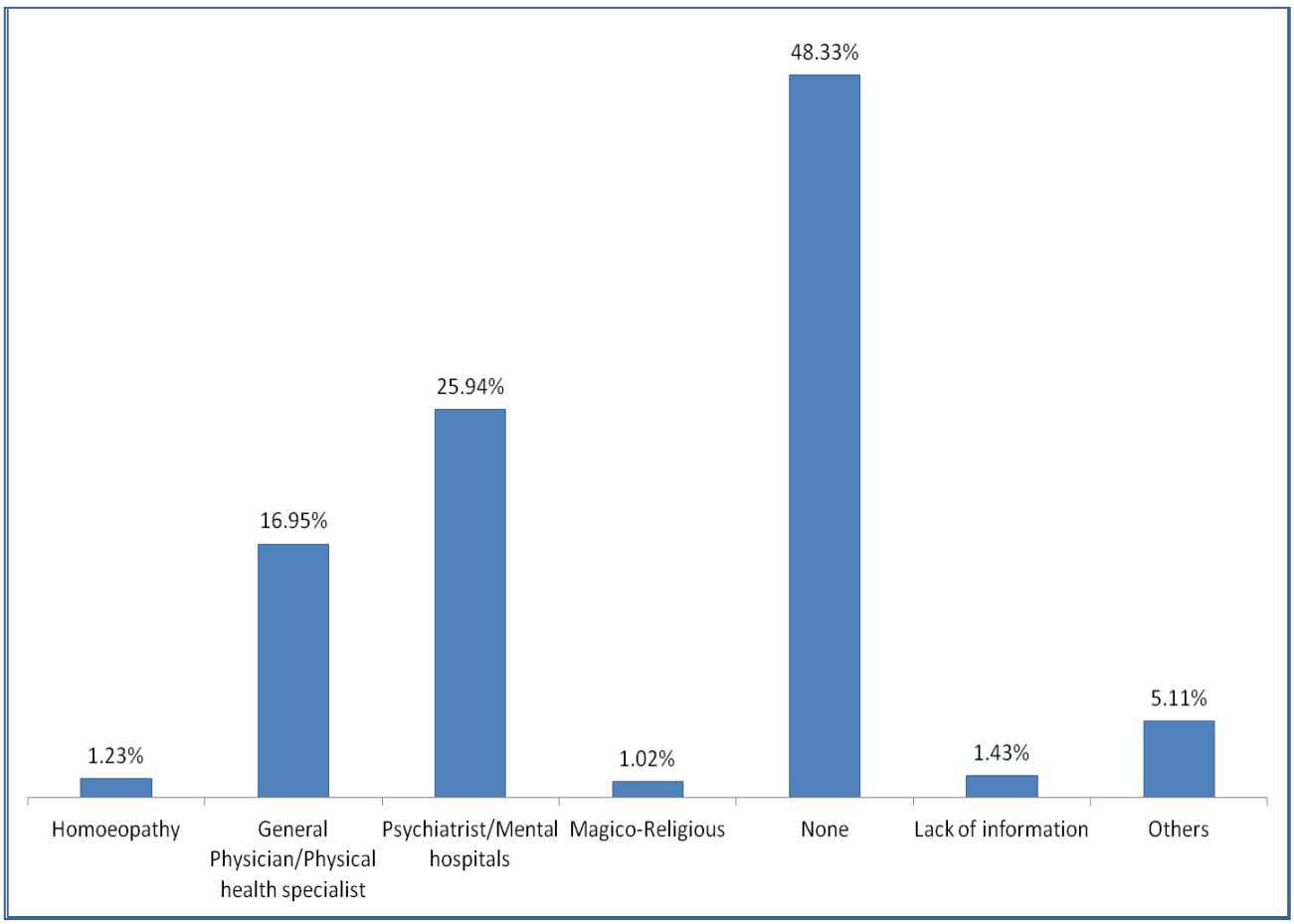


FIGURE 5: DEMOGRAPHIC PROFILE OF CLIENTS

Previous Treatment History



Duration of Illness

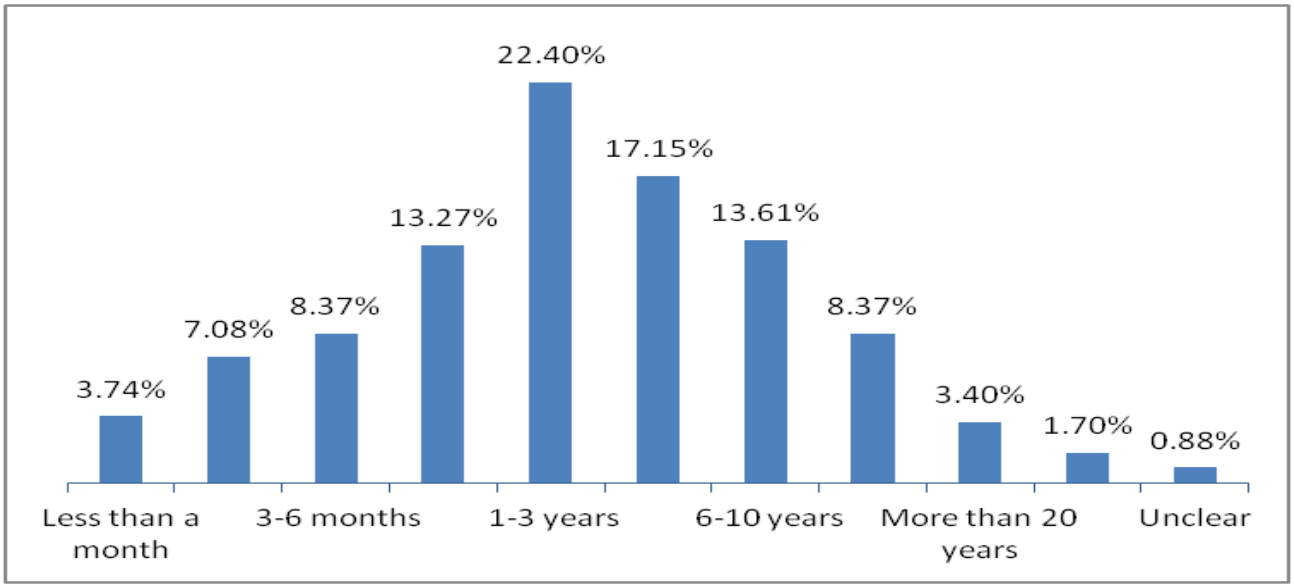
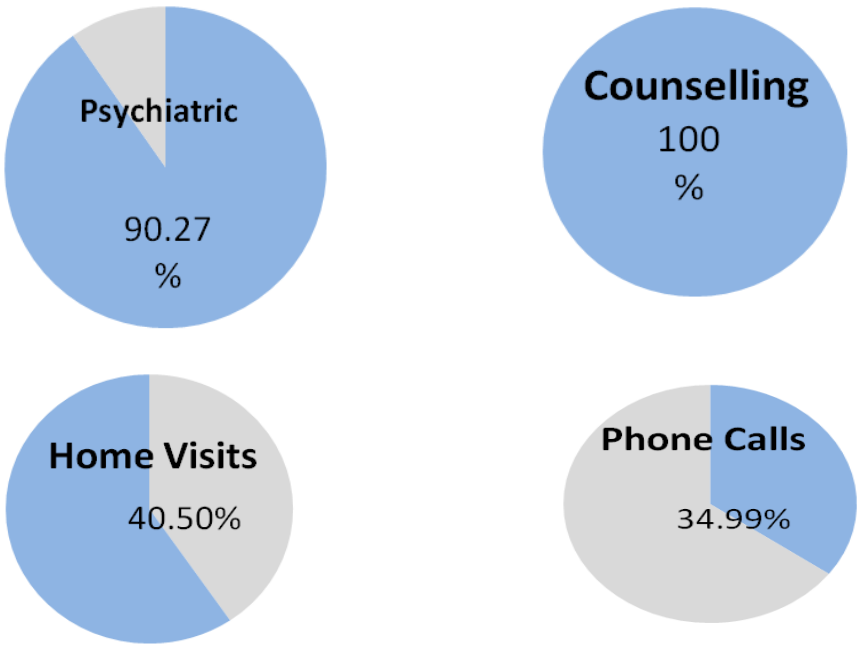


FIGURE 6: ILLNESS HISTORY

Clients receiving at least one of the following:



1016 of the 1469 clients i.e. 69.2% have come for a 2nd visit to the clinic

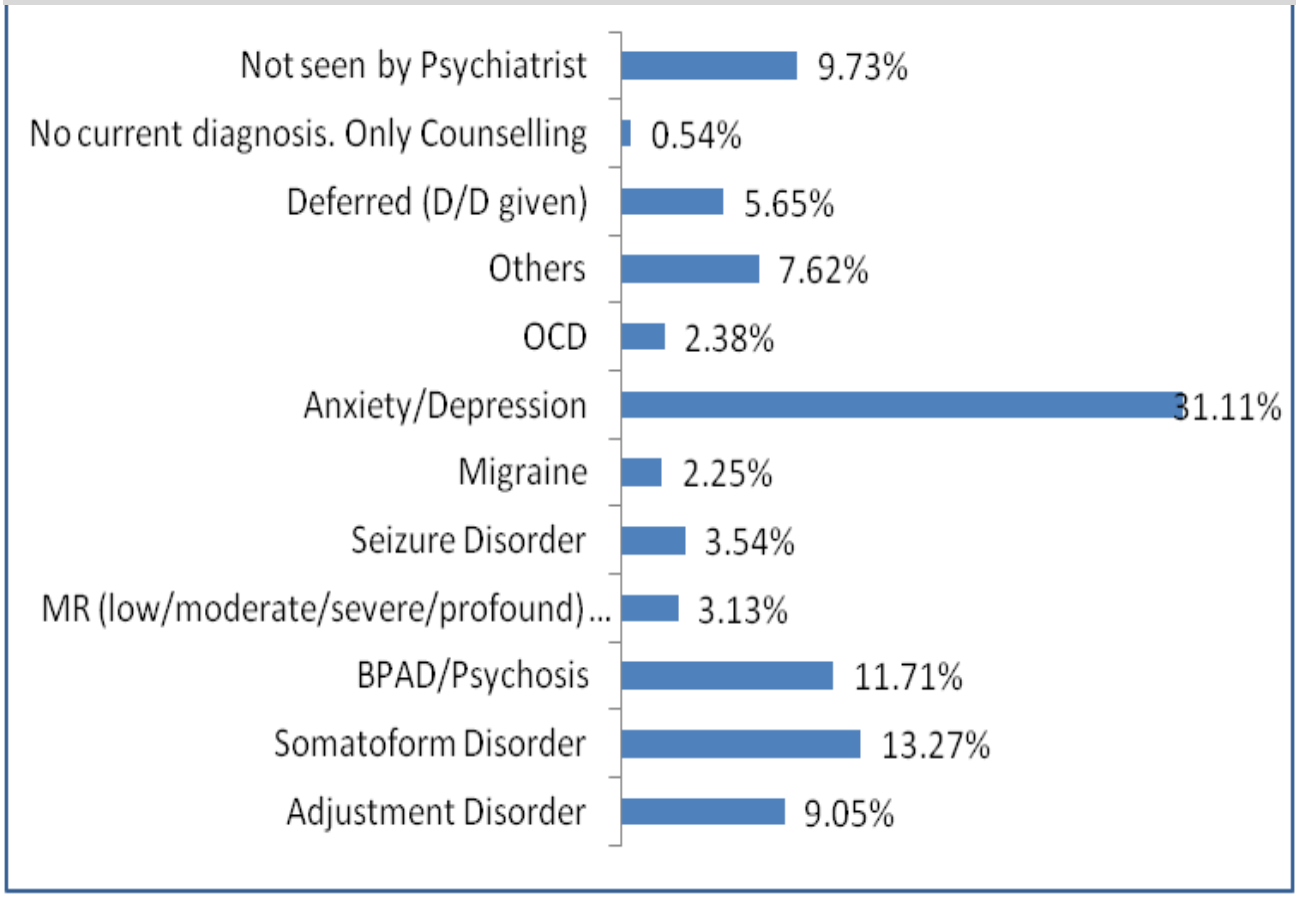


FIGURE 7: DIAGNOSTIC PROFILE

CASE STUDIES

Case 1

Alam, age 24 years old came to the clinic on 26th December 2012. He lives in a family of 8 members and was unemployed. He studied till primary level. The family income is very meagre and his primary caregiver, his mother, is old and ailing with no knowledge of mental health conditions

Diagnosis - Paranoid Schizophrenia, and differential diagnosis BPAD current episode mania and psychotic symptoms. Co-morbid condition – Poliomyelitis

Intervention Course – The focus was on psycho-education of the family in order to build a supportive recovery environment. Regular medication was ensured along with regular visits to the clinic for doctor consultation and counselling sessions. Counselling focus was on increasing functionality and encouraging an activity schedule.

Symptoms of auditory hallucinations and delusions of persecution and grandeur have reduced significantly. Regular interaction with family ensures some support from them. He has started engaging in some household work and is contributing, albeit minimally to the family in a productive manner

Case 2

Noor, age 52 years old, lives with her husband and daughter. She was registered in the programme on 14th March 2013. She has studied till Middle school. Her husband is an addict and there is a history of physical and mental abuse towards her. She had been working earlier as a tailor but was currently unemployed.

Diagnosis – Moderate depression and somatic symptoms with a differential diagnosis of Adjustment disorder.

Intervention Course - Regular medication and counseling was provided. She was part of group counselling sessions too; working on her assertiveness and self-worth. Her home was also visited to speak to her husband. For a small time period, she was also engaged as a hired volunteer in the programme itself to impart stitching skills to other woman clients. This led her to become motivated to start her own tailoring work again.

Case 3

Champa, age 45 years old came to the clinic on 20th March 2013. She lives with her husband and children, is illiterate and hails from a poor socio-economic background. When she visited the WHU, she was suffering from lack of sleep, extensive fear and restlessness on seeing any dead body covered in white and would repeatedly wash herself and her clothes. She had a poor appetite and would end up not eating anything at all. She had no eye contact and if she was asked anything, she would start crying and remain quiet.

Diagnosis – She was diagnosed as having Specific Phobia and a differential diagnosis of panic disorder, obsessive compulsive disorder and moderate depression with obsessive compulsive symptoms.

Intervention Course - She started taking medicines regularly and came for counselling sessions. These sessions focused on family psycho-education and relaxation exercises were used with her source of phobia and fear in order to systematically de-sensitize her. Some of her negative thoughts were also explored, to understand her core beliefs. She was also encouraged to engage in daily house hold work and looking after her children by trying to create a step by step activity calendar.

Today, she is a cheerful woman, engaging in her household responsibilities and continuing to come regularly for follow-up visits to the clinic.

Case 4

Purnima, 18 years old, lives with her parents and was studying in Class X when she visited the clinic on 30th July, 2013. Her mother was the informant - She said that since the last 2 months, she was not sleeping properly and had lost her appetite. She complained of someone always talking to her privately – and there was a lot of self muttering and laughing. There was a feeling of loneliness, and she had lost all interest in her studies. It was also noticed that her mother was often very critical of her.

Diagnosis - She has been diagnosed preliminarily with 1st Episode Psychosis or Acute Psychosis with the differential diagnosis of schizophrenia or bipolar affective disorder with current episode depression with somatic syndromes.

Intervention Course – Along with regular medication, she came for a few counselling sessions. She was counselled with focus on time management, self care, daily engaged living, sleep hygiene and social skills training. After few sessions of doctor consultation and counselling session, there was noticeable improvement. Her mother and father were called in for separate counselling sessions too.

Currently, she has not reported any auditory hallucinations and has managed to give all her papers for her Class X final examinations. She has also joined a stitching class in her community to learn a skill for future use.

Case 5

Sheikh, age 40 years, lives with his mother and brother and was the only earning member of his family till his mental health condition started interfering with his work. He was registered on 17th April, 2014 and the family's economic condition is very poor.

Diagnosis – He was diagnosed as having Undifferentiated Schizophrenia.

Intervention Course – He had previously sought treatment at a government hospital but post his symptoms reducing, he had discontinued it. His brother had started working post his illness becoming very disabling for him. The family was regularly counselled about his mental illness, and the importance of regular and supportive care.

His counselling focused on increasing functionality and motivation to work again. His self care and social interaction skills have improved tremendously, and he is currently working at a shoe shop on a daily wage.

Case 6

Jogmaya, age 50 years old was registered on 1st July, 2014. She lives with her husband and mother-in law and is illiterate. She has recently had a tumour related operation, post which she reported disturbed and decreased sleep and appetite, worrying, weakness, pain in different body parts and low mood. Her behavioural manifestation of symptoms were lack of confidence, wish to be left alone, anxiety and negative thoughts about her illness.

Diagnosis – She was diagnosed with Mixed Anxiety and Depressive disorder, with a differential diagnosis of change in cervical vertebrae.

Intervention Course – She was started on medicines and started coming for counselling sessions two weeks later.

She was counselled with a focus on self care and management of repetitive thoughts. Her reasons for anxiety were explored, along with enhancing assertiveness and self confidence. Her feelings of panic and being withdrawn were addressed through this, and slowly she started opening up. Cognitive Behavioural therapy techniques were used, in addition to family visits and psycho-education about her problems.

All her presenting symptoms have reduced, and some have stopped altogether. She is motivated enough to visit the clinic for regular follow up.

THE WAY FORWARD

The Urban Mental Health Programme has demonstrated that providing a bio-social model of care, which places as much emphasis on pharmacological intervention as it does on psycho-social interventions is feasible and essential by small multi-disciplinary teams in primary health care settings, without compromising on quality of care.

With political will extended to support the programme, the Urban Mental Health Programme has with the help of senior officers at the Kolkata Municipal Corporation succeeded in making both mental and physical health care available under the same roof in the primary urban health care setting. The recent launch of the National Urban Health Mission in the city has also prepared the ground for the KMC to plan upscaling this mental health programme in the overall health service delivery for the urban poor.

There are however, several challenges in replicating and scaling up the programme. In this pilot phase, the programme has been able to elicit limited interest and participation from KMC personnel at the health unit level, resulting in only a restricted ownership of the programme by the municipal authority. However, through the provision of infrastructural support, medicine, and pharmacist, the KMC has extended cooperation to its maximum extent, especially in the area of a relatively small pilot project. Under the circumstances, the laudable goal of integrating mental health into primary care is only feasible in the near term, with certain changes in the approach.

To build on the outcomes of this programme, the implementers need to:

1. Extend their services to other wards of the city to derive a greater baseline of experience
2. Develop a stronger model of referrals from the Ward MO, in addition to evolving their basic involvement in the case of follow-up consultations for people with common mental health conditions
3. Find more innovative ways to involve Ward Health Workers in community outreach and support of clients, with a focus on their own self-growth and stress management, making the relationship between IS and the WHW a mutually beneficial one
4. Engage intensively with ground level community organizations in support of clients in order to involve the community in the pathway of care
5. Develop more non-pharmacological intervention strategies for the support of client to enhance overall mental well-being
6. Develop a team of lay mental health counsellors at the community level and from the community in order to prepare grounds for sustainability of mental health awareness initiatives
7. Increase focus on rehabilitative methods in order to help overall productivity of the client
8. Build a referral mechanism to secondary and tertiary care systems in the wards they work in

Overall, despite earlier challenges, it cannot be denied that support has been extended to IS for the implementation and running of the Urban Mental Health Programme from all the quarters of the Kolkata Municipal Corporation, at different points of time. It is recommended that moving forward, in case of an expansion plan, continuous engagement with both the top-level as well as the direct field functionaries will only result in a more enriched primary health care set-up.

ANNEXURE

THE KOLKATA MUNICIPAL CORPORATION
Health Department
5, S.N.Banerjee Road, Kolkata- 700 013
Phone no. 2286-1238

To
The Secretary
Iswar Sankalpa
138,S P Mukherjee Road,
Kolkata – 700 026

Madam,

Please find enclosed a copy of MOU signed between the Kolkata Municipal Corporation and Iswar Sankalpa of 24A, Iswar Ganguli Street, Kolkata – 700 026 in connection with Urban Mental Health Project – Sambandhan on a pilot basis in wards 78 and 82.

Thanking you,

Yours sincerely,

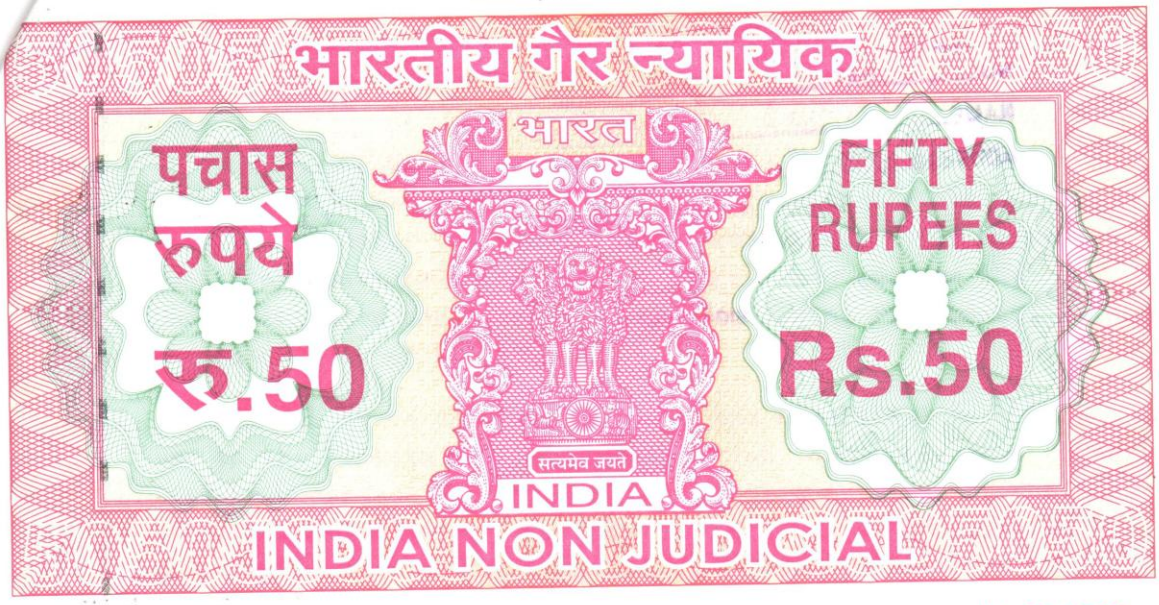
7/8/12

07.08.12

Chief Municipal Health Officer

Chief Municipal Health Officer
Health Department (H.Q.)
Kolkata Municipal Corporation

532
30.06.12



पश्चिमबङ्ग पश्चिम बंगाल WEST BENGAL K 874597

MEMORANDUM OF UNDERSTANDING

THIS MEMORANDUM OF UNDERSTANDING made at Kolkata this 30.th DAY OF July, 2012 BETWEEN THE KOLKATA MUNICIPAL CORPORATION, a statutory body constituted under the Kolkata Municipal Corporation Act, 1980 having its head office at 5, S.N. Banerjee Road, Kolkata - 700 013 and representated by its authorised representativ Shri Arnob Roy, Municipal Commissioner, hereinafter referred to as the "FIRST PARTY" (which expression shall unless excluded by or repugnant to the subject or context be deemed to mean and include its successors and assigns) of the ONE PART AND ISWAR SANKALPA, a Non Government Organization having its registered office at 24A, Iswar Ganguly Street, Kolkata - 700 026, and represented by its Secretary, Sarbani Das Roy hereinafter referred to as the "SECOND PARTY" (which expression shall unless excluded byor repugnant to the subject or context be deemed to mean and include its successors and assigns) of the OTHER PART.

WHEREAS Kolkata Municipal Corporation is a Corporation formed under the Calcutta Municipal !Consolidation Act, 1876, discharging functions of policy-making, directive and rule-making with respect to the civic infrastructure and administration of the city of Kolkata under the amended Calcutta Municipal Act, 1051;

contd...P/2

389 16/07/12
NO. DATE RS 527/-
NAME Iswar Sankalpa
ADDRESS 24-A, Iswar Gangully Street.
141-26
ALIPORE JUDGES' COURT
A. K. SAMAJPATI
SIGNATURE

WHEREAS Iswar Sankalpa is a society formed on the 6th day of March, 2007 under the Society Registration Act, 1961 by mental health professionals that brings support and care to the underprivileged and homeless People suffering from mental illness on the streets of Kolkata.

AND WHEREAS it is considered useful and beneficial to citizens and to the Kolkata Municipal Corporation and Government authorities to undertake a joint pilot initiative in the introduction of mental health service within the existing health service delivery system of the Corporation in Ward 78 and Ward 82;

AND WHEREAS the said proposal of the Second Party was placed before the MMIC (Health) for consideration.

AND WHEREAS the parties hereto are accordingly desirous of entering into this Memorandum of Understanding to record the terms on which they may work together.

NOW THIS MEMORANDUM OF UNDERSTANDING WITNESSETH AS UNDER :

1. Sambandhan - Urban Mental Health Programme will be launched in the Ward 78 of Kolkata Muncipal Corporation in the first/ *the second year of the program with an objective of increasing the quality, accessibility and acceptability of mental health care services in the 2 wardd of Kolkata.

/year and in Ward 82 of Kolkata Municipal Corporation in the**

2. The Program will run for a period of three years at the end of which it may be considered for upscale in other wards of Kolkata by the Kolkata Municipal Corporation.

3. The Program will entail the following components ;

   a. Training of Kolkata Municipal Corporation Medical Officers and Health Workers.

   b. Expansion of existing health services by Kolkata Municipal Corporation to include the care and treatment of mental illness within the existing structure of Ward health Units/Dispensaries.

   c. Counselling, Rehabilitation initiatives, Formation of self help groups and economic empowerment of persons with mental illness.

d. Awareness generation on issues of Mental Health to increase early detection and promotion of positive mental health.

e. Advocacy to enable the upholding of human rights of persons with disabilities.

Responsibilities of the First Party :

1. The FIRST PARTY (Kolkata Municipal Corporation) will select and send the personnel for training and arrange for the training venue during the 3 (three) days of the training at the start of the program and for 2 days every 6 months over three years for refresher courses.

2. The FIRST PARTY will be responsible for providing space in the Ward Health Centres with adequate table space and storage facility for the mental health personnel in the team. This will include the Program Manager, Visiting Psychiatrist and Psychologist. There will be provision of space for the Rehabilitation Specialist and Social Workers to work with groups after clinic hours. The concerned officials of the Kolkata Municipal Corporation, including the Counceillors of the Kolkata Municipal Corporation shall have the right to enter the said allotted space as and when necessary for inspection.

3. The FIRST PARTY will be responsible for providing medicines to all the patients with mental illness who attend the clinic.

4. The FIRST PARTY will be responsible for assigning their Health Workers for identification and referral of people suffering from mental illness in the respective wards.

5. The FIRST PARTY will assign the Medical officers to assess and prescribe medication to people suffering from mental illness.

6. The FIRST PARTY will be responsible for deputing its staff to attend awareness programs and joining the mental health committee.

Responsibilities of the Second Party :

1. The SECOND PARTY (Iswar Sankalpa) will make arrangements for the trainers, training materials, training manual and refreshments for all training sessions over 3 years.

2. The SECOND PARTY will provide all the required professional staff throughout the project period. These will include 1 programm manager, 2 social workers, 1 psychologist and 1 Rehabilitation Specialist.

3. The SECOND PARTY will assign a Visiting Psychiatrist once a week in the first year, once a fortnight in the second year and once a month in the third year to assist the Medical Officer in their discharge of duties towards mental patients.

4. The SECOND PARTY will be responsible for paying an allowance to the health workers based on the number of people identified and referred. The payment will be at the ~~xxxx~~ rate of Rs. 50/- for each New patient referral, Rs. 20/- for first follow up visit to Clinic, Rs. 15/- each for next two consecutive follow up visits to the clinic inayear.

5. The SECOND PARTY will be responsible for organizing awareness camps and conducting Ward mental health committee meetings.

6. The SECOND PARTY will coordinate self help groups for the economic empowerment of mentally unwell.

7. The SECOND PARTY will submit a quarterly report to the CMHO of Kolkata Municipal Corporation marking a copy to MMIC (Health), Commissioner of KMC and Medical Officer of Ward Health Centre.

8. The SECOND PARTY will arrange to send the Utilization Certificate, duly verified, at the end of the financial year to Iswar Sankalpa and KMC for audit purpose.

Review and Monitoring Structure :

1. A monthly joint review meeting would be held and the same would be attended by the Medical Officer, Psychiatrist, Program Manager, Social Workers, Counsellor, Rehabilitation Specialist and Health Workers.

2. A ward mental health committee will be formed in both wards comprising of the Borough Chairperson, Municipal Councillor, the Borough Health Officer, Ward Medical officer, 2 representatives from the community, 2 service receivers (revolving) and 2 representatives from Iswar Sankalpa. The local MLA will be a permanent Special invitee to the meetings of the Committee.

3. The Ward Mental health Management Committee would meet at least once in every two months and will be responsible for guiding/monitoring the project as per guidelines issued by Kolkata Municipal Corporation. It will address local issues and problem as are normally expected from such a Committee.

4. A central steering committee chaired by the Member Mayor in Council (Health) and the Municipal Commissioner along with suitable representation from all stake holders will be formed. This Central Steering Committee will meet at least once, every 6 (six) months. It will review the work done at the Ward health Centre with respect to the pilot project, suggest suitable improvement and midcourse corrections, and resolve the difficulties faced by the field officers in implementation of the program.

Contd..p/6.

5. The Kolkata Municipal Corporation would evaluate the success of the project in providing improved health services to the people. Evaluation will also facilitate identification of intervention areas for removal of difficulties. At the end of 3 years external evaluation will be done by an independent agency and the reports shared with all shareholders. Iswar Sankalpa will also be responsible to undertake periodic internal and external evaluation at the end of the project period.

6. The Urban Mental Health Pfoject performance in the Kolkata Municipal Corporation shall be assessed and reviewed by a monitoring committee on a quarterly basis. The monitoring committee is composed under :

a. Joint Municipal Commissioner
b. Chief Municipal Health Officer
c. Chief Municipal Auditor
d. Representatives of Iswar Sankalpa

ARBITRATION

Disputes and differences arising out of or in connection with or relating to the interpretation or implementation or termination of this Memorandum of Understanding which cannot be settled by mutual negotiation within 60 (sixty) days, shall be referred to the sole arbitration of the Hon'ble Mayor of the Kolkata Municipal Corporation and if he deelines, to his nominee. Such arbitration shall be held according to the provisions of the Arbitration and Counciliation Act, 1996 and any modification or re-enactment thereto. The venue of the arbitration proceedings shall be at Kolkata and language of the arbitration shall be English. The arbitration award shall be final and binding upon the parties and the parties agree to be bound thereby and to act accordingly. When any dispute has been referred to arbitration, except for the matters in dispute, the parties shall continue to exercise their remaining respective rights and fulfil their remaining respective obligations, under these presents, to the extent practicable. For the purpose of this MoU the jurisdiction will be of local courts and local laws as applicable in the State of West Bengal".

Contd... p/7

The SECOND PARTY, by executing and signing this Agreement, declares that no case (civil and criminal) is pending against them or their representatives regarding violation of Human Rights. The SECOND PARTY further undertakes that in the event it is found that any criminal and civil case for violation of Human Rights is pending against the SECOND PARTY in any court of India, then the FIRST PARTY reserves it's right to cancel this Agreement without any further notice.

IN WITNESS WHEREOF the parties to these presents have hereunto set and subscribed their respective hands the day month and year first above written.

Municipal Secretary
Kolkata Municipal Corporation

SIGNED AND DELIVERED

for and on behalf of the First Party,

THE KOLKATA MUNICIPAL CORPORATION

Dipankar Dal.
Chief Municipal Health Officer
Health Department (H.Q.)
Kolkata Municipal Corporation

by Mr. Arnab Roy, IAS, its Municipal Commissioner at Kolkata in the presence of :

1.

Dy. C.M.H.O. & O.S.D. (Health)
Kolkata Municipal Corporation

2.

SIGNED AND DELIVERED

for and on behalf of the Second Party,

Iswar Sankalpa

FOR ISWAR SANKALPA
Sarbani Das Roy
Secretary

by Smt. Sarbani Das Roy, its Secretary in the presence of :

GUNJAN KHEMKA
10, MAYFAIR ROAD, 3RD FLOOR, KOLKATA - 700019

1. gkhemka

2.

Dated this day 30th day of July 2012 BETWEEN

KOLKATA MUNICIPAL CORPORATION AND ISWAR SANKALPA

Hiranglesh Sekhar Mondal.
Dy. Ch. Mpl. Land Officer.

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A DOOR TO DOOR VISIT
AND A CLIENT WORKING AS A COBBLER IN THE COMMUNITY

TIMES CITY

THE TIMES OF INDIA, KOLKATA | TUESDAY, NOVEMBER 26, 2013

'Untouchables' stage a comeback in life

Sumati Yengkhom | TNN

Kolkata: When Fatima took the centre stage on Monday evening, the audience was left awe-struck. Probably, the uncanny similarity between the young woman and the character she portrayed — that of Chandalika, the untouchable — played on their minds. Picked up from the streets in a distraught mental and physical condition three years ago, the pain and anger she expressed through her dance moves looked like an outcome of her pent-up emotions. But very few in the packed ICCR hall knew that Famita can neither hear nor speak. Kudos to the young woman and Iswar Sankalpa, an organization working constantly for making the world a better place to live in for the likes of Fatima.

With Sarbani Das Roy, founder member and present secretary as the back bone, Iswar Sankalpa is making a difference in the lives of the homeless who are psycho-socially challenged. All the 23 who performed Chadalika were once homeless women — and now inmates of a shelter home by Sankalpa — with psycho-social disability.

Debobrata Shome

A scene from the dance drama

When Fatima was adopted by the organization, she would stare blankly at the sky and refuse to 'interact'. Thanks to the care-givers that she is happy today, mingling with the mainstream in her own way.

"Mental illness is one issue not too many people like to be associated with. And when they are homeless, they are the most abused, discriminated and ridiculed. I admire the courage of Iswar Sankalpa for its work," said JR Ram, the renowned psychiatrist who was in the audience.

Titled 'Ami tomari konna', the programme was aimed at creating awareness about the likes of Fatima and provide them with a platform to come back to the mainstream. "As a child, I would visit the Missionaries of Charity and wonder why these people were like this. As I grew up, I started understanding the issue," said Tollywood actor Koel Mullick, who had rescued Laxman, a youth from near her house years ago. After treatment, the youth remembered his address and was reunited with his family recently.

"I was very ignorant about the subject before I came to this function. I am touched by the gesture of the organization," said Tollywood director Raj Chabroborty. Sitting quietly in the audience were the like of Srijita Basu, wife of a senior IPS officer who had done her bit by rescuing a 60-year-old woman from the streets of Salt Lake a year ago.

14 The Statesman KOLKATA, THURSDAY 08 AUGUST 2013

KMC, NGO tie up to raise awareness on mental health

SUBHRA PRASANTA DAS
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Kolkata, 7 August

Urban Mental Health Programme (UMHP), an initiative of a Kolkata-based NGO, Iswar Sankalpa, along with Kolkata Municipal Corporation (KMC), is bringing about a positive change in the mindset of the residents of Kolkata towards the concept of mental health.

More people are acknowledging mental health problems as a serious issue to deal with. The UMPH programme has been incorporated with the KMC's governmental health schemes at Ward 78 to cater to the needs of the residents of Ekbalpore and adjoining areas and Ward 82 to serve the residents of Chetla.

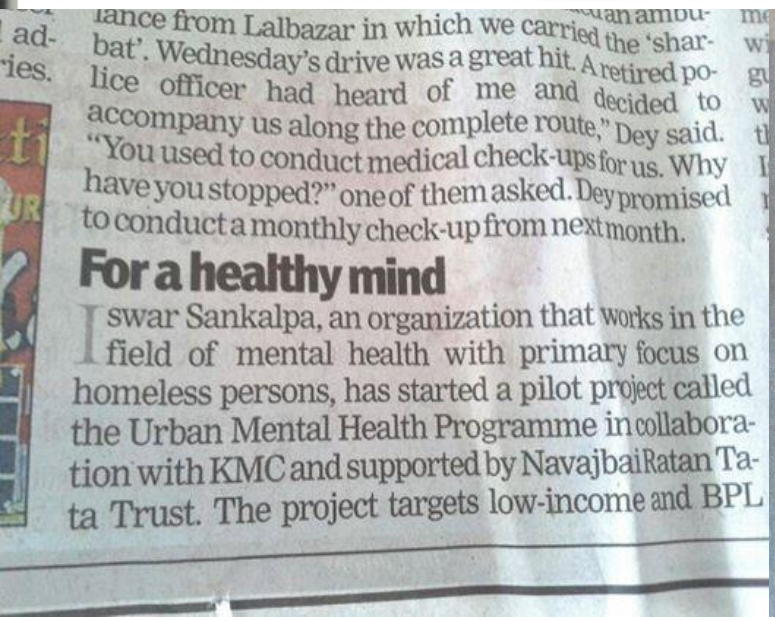
The programme, designed mostly for the people living below the poverty line, provides check up, counselling, medicines, follow-ups at no cost. UMHP is funded by Navajbai Ratan Tata Trust and KMC provides medicines and infrastructural support.

A patient gets treatment under the Urban Mental Health Programme

The clinic at ward 78 was opened in September last year and the one at ward 82 in June this year. Both the clinics have seen a steady rise in the number of patients visiting the clinics which reflects substantial change in the attitude of people as a result of various community outreach programmes conducted by UMHP. Doctors and health workers of the KMC also refer patients to the mental health clinic.

Ms Shamima Khatun and Mr Tapan Pradhan, both social workers with UMHP, attribute the rising number of patients as a result of door to door campaigns. Most of the patients and their family members are now realising that mental health related problems should not be brushed aside, he said.

Dr Aviruchi Chatterjee, a Psychiatrist with the UMHP, says the environmental factor of the wards play an important role, patients suffering from depression, anxiety results from environmental factors like domestic violence, unemployment. Most of the patients, however, are women in both the clinics, he added.



lance from Lalbazar in which we carried the 'sharbat'. Wednesday's drive was a great hit. A retired police officer had heard of me and decided to accompany us along the complete route," Dey said. "You used to conduct medical check-ups for us. Why have you stopped?" one of them asked. Dey promised to conduct a monthly check-up from next month.

For a healthy mind

Iswar Sankalpa, an organization that works in the field of mental health with primary focus on homeless persons, has started a pilot project called the Urban Mental Health Programme in collaboration with KMC and supported by Navajbai Ratan Tata Trust. The project targets low-income and BPL groups in slums and surrounding areas of Ward 78 and ward 82. The organization will offer free mental health services at the KMC health units, in conjunction with the physical health services already being offered by the KMC. Till March 2014, 840 people had been registered under this programme.

A street play to raise awareness on mental health

ORGANIZATION DETAILS

Established: 2007
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