This report represents Minds Mental Illness and Neurological Disorders Foundation, Inc.'s responses to Charting Impact, a joint project of BBB Wise Giving Alliance, GuideStar USA Inc, and Independent Sector. Charting Impact uses five simple yet powerful questions to encourage strategic thinking and help organizations share concise information about their plans and progress toward impact.

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Mission:
The MINDS Foundation is committed to a grassroots approach to eliminate stigma and provide educational, medical, and moral support for patients with mental illness in rural India.
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1. What are we aiming to accomplish?

Those living in rural regions are especially susceptible to the three barriers preventing them from proper mental healthcare: accessibility, economic stress, and debilitating social stigma. Through education and proper medical care, MINDS works to help rural populations successfully overcome these barriers. In the long-haul, The MINDS Foundation envisions its 3-phase model of mental healthcare delivery to be adapted and scaled up to integrate into existing healthcare institutions in multiple developing countries. Specifically, we envision working side-by-side with existing infrastructure, government, and stakeholders to implement and sustain our model to deliver services to rural populations. By the end of five years, we intend on expanding our programs not only into another region in India, but also into a rural region of Latin America. Five years from now, MINDS also aims to share its model with other health institutions like SV. This strategic plan will enable us to scale our social impact while staying true to our model of bridging existing resources and working with local stakeholders.

2. What are our strategies for making this happen?

At MINDS, we believe that treating mental illness must start with a foundation of community education. MINDS employs a full-time social worker who works with volunteers, psychiatrists and local medical students to organize educational camps in each village. A documentary explaining different disorders is screened for the adult population, while children are presented with a fifteen-minute skit developed by other children from one of the villages. These presentations explain to the villagers the meaning of mental illness and why it must be approached as a medical issue. As more patients seek treatment, we provide a bus that runs to and from the villages to hospitals in the city at regular intervals, allowing the patients’ regular appointments and check-ups. This, as well as the patients’ medication, is provided free-of-charge. Finally, we provide vocational training to stabilized patients, allowing them to support themselves and reintegrate themselves into their communities. As more rehabilitated patients become involved with local businesses, The MINDS Foundation hopes to overcome the stigma surrounding the occupational abilities of sufferers of mental illness, providing growing opportunities for patients. Currently, we are designing a Mental Health Community Health Worker (MHCHW) module to train one person in each of our target communities to sustain our mission allowing us to slowly exit and scale to more communities. Because MINDS works closely with the communities and the existing healthcare of our target villages, we can establish and run our three-phase model in other rural areas, further scaling our social impact. Throughout our progress, MINDS conducts research studies and adjusts its model in order to deliver continuously improved care, which will help us adjust our model to fit the needs of other cultures.

3. What are our organization's capabilities for doing this?

Program/Growth. ●MINDS is currently in the final stage of a 3-phase program in Vadodara, Gujarat, and has recently begun working with patients stabilized on medication to empower them with social and vocational skills to gain employment. ●In the next 3 months, staff will implement a community health worker module to enable local community members to sustain the mission and programming, allowing MINDS to scale to new villages. ●In the following 8 months, MINDS launches the 3-phase program in an additional 20 villages allowing MINDS to prove the concept with evidence-based data. ●Within the next 18 months, MINDS will implement the model in partnership with another medical institution at another location in India. ●Within the next 3 years, MINDS will implement the model in another rural region in Latin America (Colombia, Brasil, or Bolivia). Team MINDS currently has a core staff, part-time staff, and volunteers. ●2 members, the Director of Programs and CEO, are contributing a minimum of 60 hours a week, 4 core staff who work 20 hours/week, and 45 volunteers work on specific projects with our core members. ●In India, we currently have one paid social worker and a team of 11 volunteer clinicians. ●In the short-term, we are actively in the process of hiring an additional social worker and a research assistant to work at our Vadodara, Gujarat site. ●In the next 12 months MINDS will hire full-time US-based Development/Operations employee and an India-based Development/Operations employee. Board of Directors MINDS currently has a global board of 7 members. Within the next 3 months, the board will be re-structured to a total of 8 members and continuing to add to
MINDS-India’s Board consisting currently of 3 members to a total of 6. In addition, MINDS has a medical advisory board of 3 members and a general advisory council of 2 members.

4. How will we know if we're making progress?

Minds uses a Mental Health Awareness Assessment developed by the Hunter Institute of Mental Health given before and after Phase I in order to assess our impact. Analyzing the beliefs expressed in these assessments has shown significant decrease in the negative perceptions of stigma, and we hope to continue this trend. During Phase II, we run stigma perception surveys used by the WHO and other researchers to determine the change in stigma throughout the course of treatment. Qualitatively, semi structured interviews with patients have demonstrated that many of them are returning to school, work, and partaking in community activities that they used to be ostracized from. As we continue to develop our Three-phase program, we hope to see 100% of patients rehabilitated and reintegrated into their communities. Our field staff keeps track of new patients, identifies patients, follows ups, and inquires from community members by going door-to-door. Phase III has a number of measures in place, such as the WHO's Quality of Life Assessment, used throughout patients’ training to determine the impact of the program on a patient's illness. By the end of two years, we hope to expand out of our 19 original target villages to show that our model is a sustainable approach to mental healthcare in rural regions. On a fiscal level, we have put in place a product tracking system in which patients report the quantities of products that they produce to our program officer on a weekly basis. Once these patients are employed by a local business we will receive similar information from them. By keeping a tracking system, we will determine the potential revenue from these products, empowering us to effectively scale our program on solid financial grounding. For example, we have 1 female patient, with epilepsy, who has been trained in tailoring and is now earning a living by accepting small jobs in her community. We aim for revenues from patient-produced products to contribute 100% to providing salaries for patients during their training and employment-seeking time. After a few months, we aim to gain profits that can fund 10% of our phase II treatment for future patients from the revenue of product sales, allowing us to continue and expand Phase III and to develop more partnerships with local businesses.

5. What have and haven't we accomplished so far?

Thus far, our educational camps have been very successful in decreasing the negative stigma associated with mental illness in our 19 target villages. Before MINDS held its first educational camp, 84 percent of the community claimed that they did not know the definition of mental illness, but afterwards, 100 percent self-identified as having a clear understanding. While 73 percent came into the camp believing that a person would be “a failure for life” once he or she became a patient at a mental hospital, only 8 percent agreed with this statement after attending the camp. In spreading the knowledge that mental disorders are a medical illness, we have been effective and hope to continue to urge those suffering with mental disorders to seek treatment and to improve their quality of life. MINDS has also achieved in making treatment accessible to these villages, providing 19 patient consultation trips and allowing over 100 patients their treatment free-of-cost thus far. Phase III of our program, which consists of providing vocational training to rehabilitated patients, began in February 2013. We have provided training to 5 patients thus far and hope to expand this program. As mental disorders are diverse, we understand that each patient may take a different amount of time to achieve stabilization. We work closely with patients in order to accommodate their schedules and ensure long-term care. Currently, our greatest obstacles include a concrete expert-driven fundraising strategy. Although, we work with many advisors from the non-profit field who specialize in development, we could benefit substantially from working one-on-one with a development expert who has experience working with and securing individual, family and higher-level foundation support. In addition, we are actively seeking to partner with corporations that have missions and values that resonate with our cause and vision. To do so, we would like to work with an expert that is able to navigate corporate philanthropy/CSR. To aid in the progress of our programs and scale up, we are hoping to secure mutual partnerships with organizations such as the World Health Organization, Ministry of Health (India), the World Mental Health Federation, and medical hospitals/schools in India.