Original Article

A Performance Audit of First 30 Months of Manochaitanya Programme at Secondary Care Level of Karnataka, India

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Abstract

Introduction: Lifetime prevalence of psychiatric disorders in India is about 14%, and the treatment gap is huge necessitating large-scale public health efforts. Manochaitanya programme (MCP), one such innovative program, was launched by the Government of Karnataka in October 2014. MCP entails provision of outpatient psychiatric care in subdistrict (Taluk) hospitals and primary health centers under a public–private (Indian Psychiatric Society-Karnataka chapter) partnership model, at least one Tuesday of every month. **Aim:** The aim was to do a secondary care level performance audit of MCP of initial 2½ years at all Taluka general hospitals of Karnataka. **Methodology:** Data on MCP were collected and tabulated from all 31 districts using a specially designed semistructured pro forma. This includes the number of self-reported psychiatric consultations in each Tuesday's clinic, number of psychiatrists, and their visit details. Prospective data were obtained from monthly reports. **Results:** The district coverage was 100% during initial 2½ years over this period, i.e., MCPs were successfully covered in at least one Taluka hospital in all 31 districts. A total number of estimated consultations under this initiative were 73,663 with an average of 24.1 patients per psychiatrist consultation. One hundred and eleven psychiatrists participated in a total of 3,056 visits across the state. Patient footfall increased consistently over this time period. **Conclusions:** Psychiatrist-based Manochaitanya programme at secondary care level at Taluk hospitals has noticed substantial benefits to patient care. There is a need for psychiatrist-based secondary care at Talukas (subdistrict) level across the country.

Keywords: India, Manochaitanya programme, psychiatry, public mental health program, secondary care

Introduction

The lifetime prevalence of mental disorders in India is 13.9%.[1] Among them, common mental disorders cover depression, anxiety disorder, and somatization ranging from 17% to 46%.[2] A recent survey revealed a treatment gap of 95% for these disorders.[3] Hence, there is an urgent need to bridge this gap by integrating psychiatric care into primary health care.

The "Manochaitanya programme" (MCP) is an innovative public mental health program launched by the Government of Karnataka on October 10, 2014, also called the "Super Tuesday" program.[4] This is an innovative public–private partnership (PPP) model which is also the first of its kind in India. The Karnataka Chapter of the Indian Psychiatric Society (IPS-KC, a professional society of psychiatrists as members) is the private partner for this venture.[5]

The core components of MCP[4-7] are to provide psychiatric care by establishing Manochaitanya Clinics (MCC). These clinics are to be conducted by qualified government / private psychiatrists; on at least one Tuesday of every month, at every Taluk general hospital. At Primary Health Centres, Medical Officers are supposed to run these on all Tuesdays.

Other important components of MCP are as follows: every consulting psychiatrist shall be a member of the IPS-KC. He/she will receive an honorarium of INR 1000 in addition to the travel and daily allowances per visit. There was a yearly renewable memorandum of understanding for private psychiatrists with the respective Director of Health and Family Welfare Officer to participate in MCC. Free of cost psychotropic medications were provided to all patients at these MCCs. The objective of

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this article is to report a secondary care level performance audit of MCC of initial 2½ years (October 2014 to March 2017) at all Taluka general hospitals of Karnataka.

Methodology

An administrative medical audit was conducted about the performance of psychiatrist-based consultation of MCP/MCC clinics at secondary care level, i.e., at all Taluka general hospitals of Karnataka. The Data collection was initially through a specifically designed semi-structured pro forma circulated through E-mails to all district mental health officers (DMHOs). Additional information was also obtained from the monthly reports submitted to deputy director mental health, Government of Karnataka by the respective DMHOs for year 2016–2017. In this article, we have presented only the data from psychiatrist-based consultation data at Taluk hospitals which are a secondary care level.

The outcome parameters of MCCs were the following: (a) total number of MCCs conducted, (b) affiliation of psychiatrists (government or private sector), and (c) number of psychiatric consultations provided by psychiatrists during each MCC (based on either their self-report at the end of each clinic or from a log maintained by them or allied staff). The average number of patients per visit was then calculated. The coverage of MCP was measured by calculating the number of Taluks covered with at least one MCC (per district) over this period. So, a district is considered as covered even when at least one MCC is conducted in all taluks of that district.

Results

The data from all 31 districts (30 formal plus 1 BBMP administrative district) of the state were analyzed. About 611 lakhs is the population of the state as per the latest 2011 census.[7] The density of population as per the same census is 319 persons per sq. km which was lower than the all-India density of 382.[7]

District coverage

All districts except Yadgiri were covered under MCP in the first 2 years (October 2014–October 2016) of the program. However, 100% coverage (MCP clinic conducted in at least one Taluk per district during initial 2½ years) was achieved by the next 6 months.

Affiliation of psychiatrists

The total number of psychiatrists involved was 111. About 71.17% (N-79) among them were government psychiatrists from district mental health program (DMHP), government medical college, and district hospital, whereas 25.23% (N-28) were private psychiatrists (both private practitioners and from private medical colleges), and three were from central government, i.e., National Institute of Mental Health and Neurosciences, Bengaluru. We were not able to trace details of one consultant. Twenty-two medical colleges across the state were involved, of which 11 were from the government sector and the rest were from private medical colleges.

Performance of Manochaitanya Programme across Karnataka

Karnataka state is divided into four revenue divisions for administrative purpose. Total 73,663 consultations were done across the divisions from the inception till March 2017 as shown in Table 1. The total number of patients consulted from October 2014 to October 2016 was 34,244 in 2052 MCCs (average number consultations per visit is 16.69). This however saw a huge jump from November 2016 onward (till March 2017) [Figure 1]. A total of 39,419 psychiatric consultations were provided in this period, which shifted the total average to 24.11 patients per MCC (grand total: 73,663 consultations from 3056 MCC with average consultations per MCC is 24.11).

Discussion

To the best of our knowledge, this initiative is the first of its kind in India in which a public–private partnership model has been used for public mental health delivery. The results appear promising and show that the model is undoubtedly unique and an innovative one at the state level. Although PPP models of health care span many dimensions including training and capacity building, management and operations, and telemedicine, the one involving provision of direct clinical services are not many. This is particularly relevant in case of mental health, considering the huge treatment gap, which is up to the tune of 80% in India.[3] One of the main reasons for this amount of treatment gap is the discrepancy between the availability of psychiatrists that are concentrated in urban areas and their absence in the rural areas of need. For example, 90% of the available psychiatrists are concentrated in the urban areas, whereas 70% of the population of India is still rural. Another relevant issue is that majority of psychiatrists and other mental health professionals work in the private sector. In effect, most of the state governments simply do not have enough number of psychiatrists in the public sector to cover for all persons with psychiatric illnesses. It is here, innovative models such as MCP will be of good use. Of course, this PPP model fructified because of the enthusiastic support by the Indian Psychiatric Society, a professional organization of psychiatrists of the state of Karnataka. Its members gracefully agreed to give their time to this cause. Considering its impact, the model appears eminently implementable and expandable. The coverage of the program was analyzed using data from Taluk-level clinics in each of the districts and excluded the data from district hospital as they are not a part of the MCP. Hundred percent coverage was achieved by the program, i.e., one MCP clinic in every Taluk of a district during this period.

The number of psychiatric consultations in itself (73,663) highlights the reach and benefits of the program and its utility. Through this program, the state is ensuring free psychotropic drugs and lesser travel time (and thereby reducing the cost and preventing the loss of daily wages). In addition, this "near to home service" is also reducing stigma in community by laying the pathway for community-based rehabilitation and integration. Specialized care being available nearby decreases the duration of untreated illness which results in better prognosis for chronic psychiatric ailments.

The number of psychiatric consultations in the first 2 years (N-34244) was almost equal to that done in the last

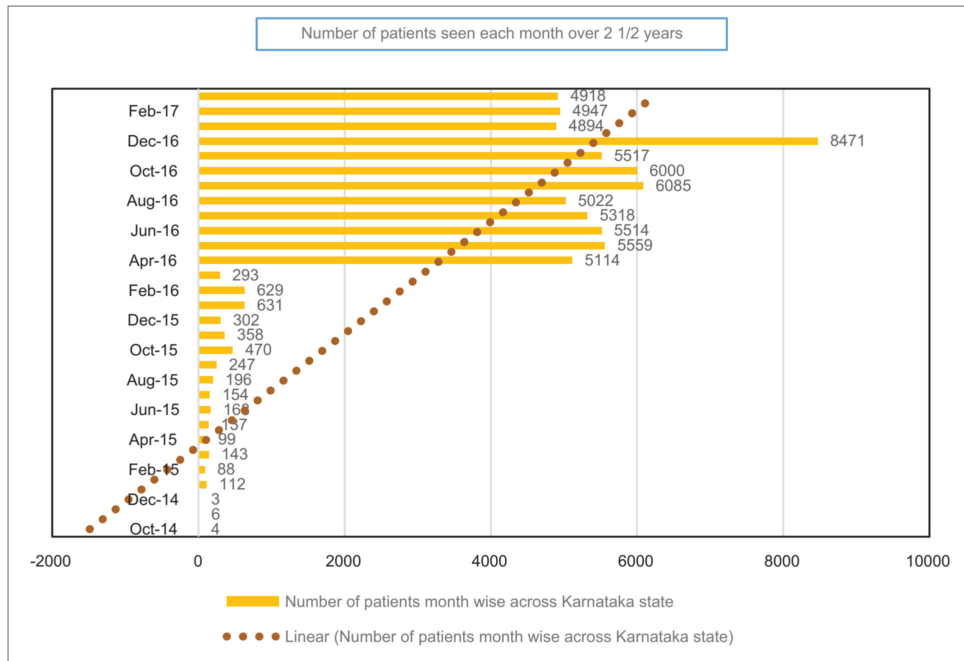

Figure 1: Month-wise performance of Manochaitanya programme across Karnataka

Table 1: Profile of Psychiatric Consultations across revenue divisions

Division (number of Taluks)	Total MCP clinics	Average number of consultations per division per clinic
Bengaluru (53)	984	29.42
Mysuru (46)	838	18.91
Belgaum (49)	798	15.96
Gulbarga (31)	436	36.97

MCP: Manochaitanya programme

quarter, i.e., November 2016 to March 2017 (N-39419). This steep increase in coverage became possible after the MCCs were integrated into the DMHP.

Hundred and eleven (N-111) psychiatrists (from various organizations and background) participated in MCCs. Their active and enthusiastic participation by private self-employed psychiatrists and those from medical colleges (both government and private) are commendable. This can be an excellent example to emulate across many places in the country.

Limitations

(a) Data covered only the Taluk general hospitals and did not cover primary health centers, (b) it is self reported data from treating psychiatrist which may has inherent memory bias. There are concerns in the regular disbursement of honorarium of INR 1000/per MCC plus travel allowance. In addition, the incentive is fixed and not dependent on number of patients seen or time spent at the clinic which deters the interest and spirit of the clinician.

Conclusions

Psychiatrist-based Manochaitanya programme at secondary care level at Taluk hospitals has noticed substantial benefits to patient care. There is a need for psychiatrist-based secondary care at Talukas (subdistrict) level across the country.

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Conflicts of interest

There are no conflicts of interest.

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