REVIEWS

‘Manasadhara’: a Day-Care Rehabilitation Programme for Persons with Mental Disorders in South India

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ABSTRACT

Purpose: *Started in 2014, the Manasadhara programme in Karnataka State, South India, offers community-based psychiatric rehabilitation services (PRS) through day-care centres. Although funded by the Health and Family Welfare Services (H&FWS) of the State government, little research has been conducted on the need, scope and challenges the programme faces. The present study aimed to understand challenges related to the psychiatric rehabilitation services delivery and the beneficial effects of the Manasadhara programme on service users.*

Method: *Various government documents that were available to the public were reviewed, concerning the funding and the number of service users. The authors relied on their personal experience of supervising the PRS delivery at one day-care centre for 18 months, in collaboration with the HDK. The experiential accounts of the staff at the centre were also noted.*

Results: *The Health and Family Welfare Services spends INR 16,14,000 (US$ 19,834) per annum per centre. Implementing this programme across the State costs INR 48,420,000 (US $ 595,022) per annum. Data suggests that INR 73.1 million (US $ 9 million) was spent between 2014 and 2020. The authors observed a range of beneficial effects to persons with mental disorders availing of day-care services, and to their family caregivers.*

Conclusion: *The Manasadhara programme appears to offer structured engagement and rehabilitation services for those who are able to access it. However further methodical research is required.*

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INTRODUCTION

Day hospital, day services, day treatment, day centres and day programmes are terms used to describe a range of outpatient treatment interventions for persons with mental disorders (Matzner et al, 1998; Marshall et al, 2001; Weir & Bidwell, 2000). However, more recently, day-care centres (DCCs) for persons with mental disorders are equated to places to keep them engaged in meaningful and stimulating activities by mental health professionals during day time (Bright et al, 2015); places that they can visit voluntarily from their homes whenever they choose to. Engagement of persons with mental disorders at day-care centres differs from the clubhouse model for them (Bouvet et al, 2015), in which the aim is to support the individuals in finding jobs. Structured occupation therapy at day-care centres is reported to reduce readmission in persons with severe mental disorders (Yoshimasu et al, 2002; Engelbrecht et al, 2019). Self-esteem and quality of life in persons with schizophrenia improved after attending rehabilitation programmes at a day-care centre (Štrkalj-Ivezić et al, 2013). Structured engagement of persons with mental disorders at day-care centres is reported to positively affect the emotional well-being of these individuals and their caregivers (Makharadze et al, 2010; Agarwal et al, 2015; Strandenæs et al, 2018 ; Rokstad et al, 2019). Similarly, engaging older people at day-care centres reduces stress in their caregivers (Zarit et al, 2011). This may be due to increased personal time and space for the family caregivers while the elderly are kept engaged.

The range of beneficial effects to persons with mental disorders who attend day-care centres depends on various influencers. Less psychopathology was associated with better occupational engagement (Tjörnstrand et al, 2015). Even so, the transition back into the community is challenging. Worries about potential challenges for transitioning into a community-based workplace are reported by some, even after engaging at a day-care centre for about six years (Phutane et al, 2012). From this it is evident that structured engagement of persons with mental disorders at day-care centres, under the supervision of mental health professionals, is likely to improve their self-esteem and well-being. An additional and extended benefit observed is the reduction in caregiver stress. Possibly, acknowledging the importance of this, the Indian Mental Health Care Act (MHCA) 2017, Sections 18 and 19, mandates that governments establish appropriate community-based day-care centres and other necessary mental health services for the care of persons with mental disorders (Mental Health Care Act, 2017).

In 2014, to improve community-based rehabilitation (CBR) in the mental health sector, the Karnataka Health and Family Welfare Services started a State-funded programme titled "Manasadhara", with a vision to establish at least one day-care centre (DCC) per district (About Mental Health Programme in Karnataka - National Mental Health Programme 2022). Karnataka is a South Indian State, estimated to have a population of 61 million spread across 30 districts, with significant variations in the spread. While Kodagu district is spread across 4100 square kilometres and has only about 600,000 people, Bengaluru district which is spread across 2196 square kilometres has about 10 million people (Karnataka Population Sex Ratio in Karnataka Literacy Rate Data 2011-2022). One credible Non-governmental Organisation (NGO) in each district is selected by a committee chaired by the District Commissioner, to run this programme. A district project officer (DPO) from the Health and Family Welfare Services (H&FWS) would supervise the quality of programme implementation by the NGO. NGOs offering day-care psychiatric rehabilitation services (PRS) under Manasadhara would be reimbursed an amount of up to Indian Rupees (INR) 134,500 (approximately equivalent to US $1654) per month, corresponding to INR 16,14,000 (US $19,834) per annum per centre. Implementation of this programme across the State costs the exchequer INR 48,420,000 (US $595,022) per annum. Systematic examination of the implementation of Manasadhara offers insights into its usefulness to mental health and rehabilitation professionals. The information and evidence obtained has implications for public health policy and funding. The government orders for implementation of the Manasadhara programme indicate that a maximum number of 6 staff may be recruited per centre; each enrolled person with mental disorders should not be engaged for more than three months continuously; and the budgetary grant towards the recurring expenditure would be offered to the NGOs only on a reimbursement basis under various heads, as described below in Table 1.

Table 1: Budget Allocation under the Manasadhara Programme, including Staff Salaries

	Staff, infrastructure and budget allowed for the recurring expenses	**Allocated maximum budget per month in Indian Rupees (US $)**
1	One social worker salary	15,000 INR (184.3 US $)
2	Transport allowance for social worker	5,000 INR (61.4 US $)
3	Staff nurse or occupational therapist or physiotherapist salary: only one staff member can be recruited in centres that have less than 25 service users	12,000 INR (147.5 US $) per staff & 24,000 INR (295 US $) for two persons

4	Housemaid or Ayah honorarium	6,000 INR (73.7 US $)
5	Security honorarium	6,000 INR (73.7 US $)
6	Rent for the building, Maintenance of building (including electricity, telephone charges, etc)	20,000 INR (245.8 US $)
7	Food and refreshments for service users	30,000 INR (368.7 US $)
8	Transport of service users	20,000 INR (245.8 US $)
9	Recreational needs or services	3,000 INR (36.8 US $)
10	Medicines	500 INR (6.1 US $)
	Total (maximum)	134,500 INR (1654 US $)

Considering the potential usefulness in improving the functionality of persons with mental disorders through occupational engagement under Manasadhara and the mandate for establishing similar centres under the MHC Act 2017, there are as yet only a limited number of such centres across the country. However, it is essential to examine the implementation and usefulness of this programme to service users as this is associated with a significant amount of funding to the State government, i.e., about INR 45 million (US $ 552,984) every year.

Objective

The study aimed to investigate the utilisation of the Manasadhara programme by persons with mental disorders, to learn about the quality of service delivery from the experiential accounts of the staff, and to understand the practical and administrative challenges involved in running this programme.

METHOD

Study Setting

Three authors supervised the running of one Manasadhara day-care centre in Chikkaballapur District of Karnataka. Synthesis of information is based on their observations after supervising the Manasadhara programme for 18 months (April 2019 - September 2020).

The Covid-19 pandemic shutdown impacted the functioning of the day-care centres. As psychiatric rehabilitation day-care centres were considered non-essential services, the centre was closed in September 2020.

Data Collection

A series of interactions with the Chikkaballapur day-care centre staff elicited their observations about the utility of the day-care centre's services to persons with mental disorders and their family caregivers, and their experiential accounts of challenges for the delivery of services. The authors also recorded their own observations on the recruited staff's motivation to work, and their competencies in delivering services.

To understand more about these issues, during a state-wide meeting organised by the Health and Family Welfare Services, the authors interacted with staff members working in other day-care centres. Information on Manasadhara implementation, the budget spent, number of service receivers, etc., was obtained from the Karnataka State Health and Family Welfare Services which maintains this data.

Ethics Approval

Permission to conduct the study was obtained from the National Institute of Mental Health and Neurosciences (NIMHANS) Ethics Committee.

RESULTS

Table 2: Year-wise Budget granted and spent for this Programme by Karnataka Government

S. No.	Financial Year	Number of districts with DCCs	Number of persons with mental disorders attending DCCs across the State	Approved budget in millions of INR	Spent budget in millions of INR	Estimated budget spent per person with mental disorders in INR (US $)
1	2016-17	14	2175	24.3	17.8	8,133 (100)
2	2017-18	14	1439	18.0	17.1	11,883 (146)
3	2018-19	13	1605	24.3	13.8	8,598 (105)
4	2019-20	17	2084	25.8	14.2	6,814 (84)
5	2020-21	15	385	25.8	3.5	9,090 (111)
	Total/ Average	-	7,688	128.3	73.1	8,903 (109)

DCC = Day-care Centre; INR = Indian Rupee; US $ = United States of America dollar

As described in Table 2, the Health and Family Welfare Services allocated INR 128.8 million (US $ 1.58 million) and spent an amount of INR 73.1 million (US $ 9 million) on providing day-care services to 8903 persons with mental disorders,

from 2014-2020. On average, Health and Family Welfare Services spent INR 8903 (US $ 109) per person with mental disorders, with amounts ranging from INR 6814 (US $ 84) to INR 11,883 (US $ 146) per person.

Table 3: Observed Beneficial Effects of Engaging Persons with Mental Disorders at Manasadhara

S. No.	Stakeholders	Method of Data Collection	Observed Impact
1	Beneficial effects to persons with mental disorders	Direct observation by the investigators	1. Offers a structure to the day and a purpose to spend time beyond their homes with rehabilitation professionals. 2. Offers them a sense of attending a workplace on par with others.
		Interaction with Manasadhara staff, persons with mental disorders and their family caregivers	1. Improves socialisation and socially appropriate conversational abilities. 2. Improves self-esteem. 3. Improves workplace behaviour. 4. Improves compliance with medication. Some persons with mental disorders consume medication at the day-care centre under the supervision of the nurse. 5. Improves follow-up rates with treating psychiatrists following the prompts by PRDCC staff.
2	Beneficial effects to the family caregivers of persons with mental disorders	Direct observation by the investigators	1. Offers respite care, personal space and time. 2. Reduces the facial contact and interaction time between persons with severe mental disorders and their family members, possibly influencing the negatively expressed emotions. 3. It helps them identify with others with similar mental health problems.
		Interaction with Manasadhara staff, persons with mental disorders and their family caregivers	1. Increases interaction with mental health professionals to find solutions related to the dysfunctionality in persons with severe mental disorders. 2. Increases awareness about disabling impacts of mental illness by observing other clients. 3. Interaction and identification with similar family caregivers. 4. Improves knowledge and awareness about disability certification and access to disability welfare benefits.

Table 4: Challenges in Delivering Services under Manasadhara

S. No.	Method of Data Collection	Observed/ Reported Challenges
1	Direct observation by the investigators	1. Staff recruited are less likely to have prior training/ work experience in engaging persons with mental disorders in day-care settings. 2. Lack of formal induction training and materials for the staff on "how to engage persons with mental disorders at day-care centres?" 3. Poor expertise and competencies of recruited nursing staff/ social workers for engaging persons with mental disorders. 4. Limitation in the range of stimulating activities that may be offered. Only simple exercises, play, recreational activities, art and craft activities, paper cover making, etc., are offered. Staff nurses and social workers have to learn skills for engaging persons with mental disorders. 5. Recruiting and retaining the staff who can do task shifting, due to less attractive salaries. 6. Task shifting is needed during the leave of absence of some staff. 7. Reluctance of family caregivers to send persons with mental disorders to PRDCC without dedicated and free transport. 8. Observed need for engaging persons with mental disorders at PRDCCs for a longer duration to improve their day structure and work behaviour, in contrast to laid-down regulation under Manasadhara that each person with mental disorders should not be engaged for more than three months. 9. Staff's poor motivation to continue under this programme due to poor scope for their career progression. 10. Access and ease of travel to the PRDCC location.

As detailed in Table 3, the authors observed various beneficial effects on persons with mental disorders and their family caregivers while the former were attending day-care services. Within a few weeks of enrolling the persons with mental disorders at PRDCC, their caregivers and staff observed a significant change in the daily routine. Persons with mental disorders were keen on getting ready in the morning to reach the centre on all working days and were interested in spending time there. Activities at this centre start with simple group exercises. This is followed by newspaper reading, paper cover making, colouring the page activities, play activities, and group interactions with staff on day-to-day and social issues in the community. The staff reported that engaging persons with mental disorders in a non-judgmental environment at PRDCC and appreciating their participation was a critical determinant of their interest in visiting the centre.

At the day-care centre the nurse would monitor their medication adherence and next appointment with the psychiatrist, and would coordinate their consultations when the need arose. The social work professional would explore the individual strengths, challenges, ambitions, past work experiences, and familial, social and economic background to discuss an individually- tailored rehabilitation plan.

Family caregivers often accompany the persons with mental disorders to drop them off and interact with the staff about their concerns. Within a few weeks of regular engagement of persons with mental disorders at the centre, several caregivers reported that they had some respite, and were happy to have some space and time to themselves while their family member was occupied at the centre. Interaction with the staff increased the caregivers' awareness about disability certification for persons with mental disorders and about various disability welfare benefits under the department of social justice. Family caregivers also reported improvement in their ward's motivation to dress appropriately and observe hygiene. A few caregivers observed that there was a reduction in behavioural issues like verbal aggression against caregivers and non-cooperation in completing household chores assigned to them, and a few caregivers said that attending PRDCC offered their person with mental disorders a purpose to go out of the house, equating it to attending formal work.

DISCUSSION

Overall, psychiatric rehabilitation services under Manasadhara is somewhat similar to a programme operational in Kerala, another Indian state (Swayamprabha, 2019). Money spent by the Health and Family Welfare Services suggests that community-based psychiatric rehabilitation is considered to be an integral part of mental health care by the Health Department. The intention of the government to offer psychiatric rehabilitation services as part of community-based mental health care deserves appreciation. The difference between the allocated budget and spent budget, as summarised in Table 2, is due to variability in the number of PRDCCs operational in a year. While there were only nine in 2014, a maximum of 17 were offering psychiatric rehabilitation services in 2019.It is unclear why the PRDCCs were not functional in all the 30 districts of Karnataka, which could have led to more service utilisation and expenditure of all the allocated budget. It is possible that either NGOs were not available to partner with the Health and Family Welfare Services in some districts. The impact of Covid-19 on the utilisation of Manasadhara has been felt across the State, as described in Table

2, and there has been a seven-fold reduction in the number of service users – dropping from 2084 in 2019/20 to 385 in 2020/21.

The staff and a few caregivers of service users attending the PRDCC informed the authors that the poor availability of logistic support is an area of concern, making it difficult to attend the PRDCC on a regular basis as per the timings of the centre. A range of observed beneficial effects to the service users availing of psychiatric rehabilitation services at the State-funded PRDCC are summarised in Table 3. The authors observed an improvement in the day structure of service users within a few weeks of their enrolment, with regard to their socialisation, interest in attending the centre, and improved medication compliance. During the informal information-gathering meetings, these observations were corroborated by the staff working at the day-care centre. Another observed benefit was the respite afforded to the caregivers when their persons with mental disorders were engaged at the PRDCC. Informal interactions with some of the caregivers and PRDCC staff further revealed that family caregivers had more time for themselves and were able to look after other family responsibilities. However, these observations need to be confirmed further by in-depth qualitative interviews and follow-up research.

During supervision of the service delivery at one PRDCC in partnership with the Health and Family Welfare Services, the authors observed a series of challenges for quality psychiatric rehabilitation services delivery under the Manasadhara programme. The recruited staff were qualified nurses and social workers, but without any formal exposure and training in the area of mental health care and psychiatric rehabilitation. The authors therefore facilitated a three-day observation session for the Chikkaballapur day-care centre staff at the day-care centre for persons with mental disorders operated by the National Institute of Mental Health and Neurosciences (NIMHANS) in Bangalore. A few sessions on the role of day-care services in improving the functionality of persons with mental disorders, and "how to engage persons with mental disorders at the day-care centre" by NIMHANS mental health professionals, were reported to be immensely useful. Subsequently the authors observed a significant change in the approach and strategies used by the staff. Lack of any developed manuals or structured induction training programmes for the recruited and inexperienced staff can be a significant limitation to maintain the quality and uniformity in the psychiatric rehabilitation services delivered through PRDCC.

Another challenge that was observed was task shifting, as these centres had limited human resources. Since there are only two professional staff available at the centre, whenever either the nurse or the social worker was absent, task shifting and fulfilling the responsibilities of the absentee was observed to be a significant challenge.

Staff at Chikkaballapur and other centres, in their informal interactions with the authors, reported reluctance and poor motivation to work at PRDCC in the long term, citing less attractive wages, the contractual nature of jobs with poor job security, and poor scope for career progression. As psychiatric rehabilitation services delivery requires a reasonable amount of expertise and experience, attrition of experienced staff like social workers and nurses, and recruitment of new staff can interfere with the quality of service delivery. However, some staff reported their desire to continue despite low wages, due to work satisfaction and the feeling that they are part of a process aimed at improving the functionality of persons with mental disorders.

Limitations of the Study

The observations made after supervising one PRDCC cannot be generalised. Recollection of the authors' experiential accounts could be prone to recall and selection bias. There is also the possibility that staff could have highlighted the beneficial effects of attendance at the day-care centres while minimising the lack of improvement in the persons with mental disorders. The authors' observations have not been substantiated by the staff, persons with mental disorders and their family caregivers through a systematic research.

Strengths of the Study

This report is the first of its kind on a publicly-funded community-based mental health care rehabilitation programme for persons with mental disorders, on which millions of rupees are being spent by the Health and Family Welfare Services of Karnataka. The authors had first-hand experience in observing the running of a PRDCC under Manasadhara for 18 months. Their observations suggest that psychiatric rehabilitation services delivered through day-care centres have a range of positive public mental health implications but more methodical research is required.

CONCLUSION

Health and Family Welfare Services of Karnataka spent INR 73.1 million (US $ 9 million) on providing day-care services to 7688 persons with mental disorders for six years, with an average expenditure of INR 8,903 (US $ 109) per service user. Overall, this programme helps meet the mental health care needs of a proportion of persons with mental disorders whose day structure is poorly organised and who are not otherwise engaged in any occupational activity. Engaging persons with mental disorders at PRDCCs offers respite to their family caregivers. Guidelines for running PRDCCs, systemic support to the recruited staff at the time of their recruitment and throughout their tenure, and logistic challenges at a few centres are the areas that require attention in order to increase the reach and utilisation of this programme. Beneficial effects to the persons with mental disorders who avail of day-care services, and to their family caregivers as reported by the day-care centre staff, add preliminary evidence to support funding for the programme. It is also essential to develop training materials and modules for the recruited staff.

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The authors declare there is no conflict of interest.

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