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Conceptual framework of psychiatric care in India: moving from community psychiatry to public psychiatry

Abstract

The psychiatric care across western countries has evolved from mental hospitals to community psychiatry as a by-product of deinstitutionalisation. The psychiatric care in India traditionally followed the homecare then shifted to mental asylums, then to various forms of community care such as co-community care within mental hospitals, camps, rural mental health clinics, District Mental Health Programmes (DMHPs), and general hospital units/private clinics.

With these evolutions, the psychiatric care in India can be divided into mental hospital psychiatry and community psychiatry. This division hinders the growth of many other sub-specialties of psychiatry such as primary care psychiatry, disaster psychiatry, public psychiatry, etc.

The authors propose to abandon the concept of community psychiatry and classifying psychiatric care into two broader divisions: clinical psychiatry and public psychiatry. Clinical psychiatry is divided into hierarchy-based primary, secondary, tertiary, and quaternary care psychiatry.

In contrast, public psychiatry is to be divided into non-hierarchy-based community/local level (micro), district level (meso), state/country (macro), and global level (mega). The proposed public psychiatry cannot function in isolation or standalone field. It shall begin to synchronise with an Indianised Jacob's concept of public health to achieve its targets. The divisions proposed above should be kept in mind for framing the future policies on psychiatric care in India.

Keywords: Deinstitutionalisation. Lunatic Asylums. Persons With Mental Illness. Chlorpromazine. Community Care. Primary Care. Clinical Psychiatry. Public Health.

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'The change is the rule of the world' – The Bhagavad Geeta.

INTRODUCTION

The psychiatric care across the world has traditionally evolved in two ways: mental hospital psychiatry and community psychiatry. However, community psychiatry has evolved into different forms of psychiatric care outside the mental hospitals. Given the significant growth and development of different psychiatric care models, the concept of community psychiatry is being used beyond its intended usage, which authors believe, hindering the growth of other psychiatric fields. The authors aim to discuss psychiatric care across the globe in general and specifically in India, and critically analyse the different models of community psychiatry, bringing the contemporary definitions of community psychiatry, and at the end, propose alternate concepts for futuristic psychiatric care.

PSYCHIATRIC CARE: GLOBAL SCENARIO

The establishment of mental hospitals across western countries has played a significant role in the evolution of psychiatric care. The concept of mental hospitals originated from the idea of lunatic asylums. Before establishing lunatic asylums, persons with mental illness (PWMI) were detained in prisons with criminals. The introduction of the lunatic asylum in the 1790s paved the way for the segregation of PWMI from criminals. Still, unfortunately, PWMI were continued to be managed by the same prison authorities. The purpose of lunatic asylums was to segregate persons with mental illness (PWMI) from the community and not for the purpose of their treatment.[1] These asylums were constructed away from cities, with high enclosures, and often in military barracks where escape was impossible.[2]

Realisation of the ill effects of long-term institutionalisation in mental asylums and the advent of Chlorpromazine brought in a paradigm shift in the care of PWMI. The clinically stable patients were discharged out of the mental hospitals and were provided care outside in the community. This deinstitutionalisation gave birth to the concept of 'community psychiatry' in western countries.[3,4] At that time, community psychiatry was denoting the extension of the clinical psychiatric activities outside the mental hospitals within the community.[5]

EVOLUTION OF PSYCHIATRIC CARE IN INDIA

Psychiatric care in India had followed concepts of community psychiatry from the pre-colonial era itself, which was much before the deinstitutionalisation of western countries.[5] Table 1 provides a glimpse of the evolution of psychiatric care from mental hospital psychiatry to different forms of community psychiatry.

It is important to note here that all forms of psychiatric care outside the mental hospitals are termed community psychiatry. In short, it is conceptualised into a classical dichotomy of psychiatric care as mental hospital psychiatry and community psychiatry.

PSYCHIATRIC CARE IN INDIA: EVOLUTION OF COMMUNITY PSYCHIATRY AND ITS ENCROACHMENTS

Let us review the meaning of the term 'community' from a public health perspective. MacQueen *et al*.[14] studied to evolve an evidence-based definition of 'community' for public health perspective. Definition of community is "a group of people with diverse characteristics linked by common perspectives, engaging in joint action in geographical locations or settings."[14] The authors derive two important components of the term community: people-centric and location-centric components from this definition. In general, the professionals understand traditionally that all psychiatric activity outside the mental hospitals and large general hospitals as community psychiatry.[15] With these developments in psychiatric care, Burns[5] questions that "*is not all psychiatry now community psychiatry*?"

There are different insights with analysis of various forms of psychiatric care of India. The homecare of PWMI within the family by the family members was more acceptable even during the pre-colonial era. The '***co-community care within Amritsar mental hospital***' initiative began in the late 1950s, even before the deinstitutionalisation of western countries, which started in the 1950s-1960s.[5] Following the success of rural mental health clinics,[7,8] mental hospital psychiatrists began providing psychiatric care outside their mental hospitals. The rural mental health clinic model provided psychiatric care at primary health centres, but still, it was referred to as community psychiatry services. Later, psychiatric camp models gained popularity for discharged patients in informal non-healthcare/non-clinical settings near their residences. These included schools, temples, factories, gram panchayats, etc., on designated days (community model). Until this point, the activities justified the tag of 'community psychiatry.' However, the concept of community psychiatry began to get diluted and encroached on 'primary care psychiatry' when these camps got shifted to formal healthcare establishments. A significant drawback of the camp model at established healthcare settings was that

Table 1: Evolution of psychiatric care in India

No.	Forms of psychiatric care	Remarks
	Pre-colonial era	
1	Homecare within the community	Persons with psychiatric illnesses were cared for by their family members either in their families or in some community settings through cultural and religious methods of healing.
	Colonial era	
2	Mental hospital psychiatry	Custodial care in the mental asylums[2] without family members. Lunatic/mental asylum custodial care evolved from prison custodial care.
3	General hospital psychiatry	Began in pre-independence era and expanded and became popular in post-colonial era (as mentioned in '4e' row).
	Post-colonial era	
4	Community psychiatry	All kind of psychiatric care outside the mental hospitals.
a	Co-community care within a mental hospital	Treatment of patients in the presence of family members within the mental hospital by in-house psychiatrists.[6]
b	Rural mental health clinics	Raipur Rani and Sakalawara project with aim to integrate psychiatric care into existing primary healthcare infrastructure.[7,8]
c	Psychiatric camp (extension/ satellite/outreach clinic)[10]	Conducted on the pre-decided date and place. Moved from informal non-healthcare settings (temple, school, gram panchayat, etc.)[9] to formal healthcare settings (nearby primary health centres, taluk hospitals, private clinics, etc.).[10,11]
d	District Mental Health Programme	As an operational arm of the National Mental Health Programme, it is focused on broadening the scope of delivering psychiatric care at district hospitals, taluk hospitals, and primary health centre through primary care doctors.[7,12]
e	General hospital psychiatry units and private clinics/ hospitals	Began in India from 1933. Delivered and extended at multi-specialty general hospital settings, polyclinic, psychiatric nursing homes, office-based private clinics.[13]

there was no involvement of in-house primary care doctors in providing psychiatric care (these days, this model is known as the co-location integration model).[16]

Even though in DMHP, there is mention of awareness creation, stigma reduction, early detection, and rehabilitation of PWMI, these goals took a back seat, and the focus remained on the treatment of severe mental illnesses.[7,12] In addition, one of the goals of DMHP was establishing psychiatric care in district hospitals (tertiary care), taluk hospitals (secondary care), and even at primary health centres (primary care). So, equating DMHP to community psychiatry is inappropriate as the clinical psychiatric services are provided through healthcare establishments. In this way, the concept of community psychiatry began to encroach upon other sub-specialised areas, i.e., general hospital psychiatry, primary care psychiatry, etc. It has been suggested that in many developing countries, the majority of the activities done under the current rubric of community psychiatry are, in fact, primary care psychiatry activities. Hence, Thara *et al*.[17] opined that primary care psychiatry could effectively replace community psychiatry in developing countries. The non-clinical aspects of community psychiatry (even in DMHP), such as public education activities (talk or article) by psychiatrists on television or radio channels or social media, are meant for the general population and not for any particular community.

With the above developments over the last 70 years, the term 'community psychiatry' has been used beyond its intended meaning and has encroached on sub-specialty areas. This encroachment is hindering the growth and development of community psychiatry as well as other sub-specialties. The initial aim of 'community psychiatry' was to promote deinstitutionalisation and create psychiatric service delivery systems outside the mental hospitals, and this has been achieved to a maximum extent. Hence, it is time to abandon the term 'community psychiatry' and find a better alternative term.

Thara *et al*.[17] have rightly stated that the term 'community psychiatry' has been used in India to indicate the establishment of mental health services in the community rather than the process of deinstitutionalisation. An Indian researcher defined 'community psychiatry' as providing community mental health services to persons and families with mental illness within the community using community resources. The community settings may be any religious place: dharamsala, gurudwara, a person's own house, gram panchayats, or any other place in the community.[9] In addition, even non-clinical educational-related activities, i.e., public educational activities such as community talk, radio talk, school-related activities, public education articles in print or social media, etc., are also included in the broader rubric of community psychiatry activities. With these developments, community psychiatry has encroached upon two vastly different fields of psychiatry, that is, clinical psychiatry and non-clinical psychiatry, thereby becoming vague and diluted.

THE CONTEMPORARY MEANING OF COMMUNITY PSYCHIATRY

In a paper titled "A systematic review of anxiety prevalence in adults within primary care and community settings in Malaysia," Wong *et al*.[18] provided a contemporary definition of the 'community studies' for the studies done within a non-healthcare establishment within the community, and the 'primary care studies' for the studies done within a healthcare establishment providing primary care services.

Extrapolating from Wong *et al*.'s definition, [18] we propose a new meaning for 'community psychiatry.' Community psychiatry can mean providing psychiatric care in non-healthcare establishments either for a small homogeneous population (people-centric approach) or at a small geographic area (location-centric method). 'Primary care psychiatry' can be defined as providing psychiatric care within a healthcare establishment providing primary care services.

DRAWING THE PARALLEL FROM THE FIELD OF COMMUNITY MEDICINE

Park's preventive and social medicine textbook states that 'community medicine' is a newer concept with its successors' public health, community health, preventive and social medicine creating more confusion than clarity. Prevention of disease and promotion of health are the two things commonly shared among all these earlier concepts. Many definitions of community medicine exist. The faculty of community medicine at the Royal College of Physicians have defined 'community medicine' as a specialty that deals with populations. The specialty comprises doctors who measure the needs of people (both sick and well) to plan and deliver services. They also engage in research and teaching in the field.[19] To make things worse, the World Health Organization (WHO) study group advocated for each country to formulate their respective definition of community medicine since health problems, tradition, geography, and resources vary from country to country.[20] There is still confusion and conflict about the role, tasks, professional identity among the academic worlds of community medicine.[19,21] Even Garg[22] echoed the concerns about public health and community medicine in India.

Krishnan[21] from Centre of Community Medicine, All India Institute of Medical Sciences, New Delhi, echoed the confusion in community medicine and stated that public health and clinical medicine are entirely different disciplines with no overlap. He asserts that the public health branch should not directly connect with patient care but should have everything related to preventing illness, promoting general well-being, and advocating in policies related to healthcare delivery and associated fields.

Often, most community medicine specialists profess population-based approaches; they practice curative medicine in India. There are many reasons for it. One of the critical but neglected reasons is not understanding the unique concept of public health from the developing country's perspective, beyond medicine and primary healthcare, and trying to replicate the public health perspective of developed countries.[23,24] Jacob[23,24] proposes that water, sanitation, housing, nutrition, education, and employment should be met to successfully implement any public health programme in India (tuberculosis is a classic example).

Similarly, the concept of community psychiatry in India, despite its talk of prevention and promotion of mental health, essentially focuses on curative approaches, albeit with a shift of setting to the community, primary and secondary care locations. The authors offer Jacob's[23,24] explanation for this discrepancy in the current practice of community psychiatry.

Drawing parallels from the above arguments, non-clinical activities related to prevention of mental illness, promotion of mental well-being, active involvement in policies related to mental healthcare delivery, etc., can be termed as public psychiatry. The term 'public' in proposed public psychiatry denotes the contemporary Indianised meaning of public service delivered by both government and private settings, not as western concept of public service only by government sectors.

PROPOSED FUTURISTIC CONCEPTS FOR PSYCHIATRIC CARE: CLINICAL AND PUBLIC PSYCHIATRY

To update on clarity on conceptualisation about community psychiatry, the authors propose a newer concept of psychiatry divided into two broader categories: clinical psychiatry and public psychiatry based on the target of outcome from clinical population and the general population, respectively. These newer concepts are an adopted model of Krishnan[21] of community medicine and clinical medicine. The clinical psychiatry shall include all clinical aspects of contemporary community psychiatry, whereas public psychiatry shall include all non-clinical aspects of contemporary community psychiatry (Table 2).

Further, the 'clinical psychiatry' can be conveniently classified four-tier based hierarchy of healthcare delivery system as 'primary care psychiatry' at primary health centres by primary care doctors (MBBS), secondary care/general hospital psychiatry at district/taluk hospitals/multi-specialty hospitals/private clinics by psychiatry specialists, tertiary care/general hospital psychiatry at medical colleges, and quaternary care psychiatry at apex medical/mental health institutes.

The 'public psychiatry' can be conveniently classified in non-hierarchical four levels such as community/local level (micro), district level (meso), state/country (macro), and global level (mega), and its respective activities are provided in Table 2. The meaning of non-hierarchical level is that the different levels work occurs parallelly and complementing each other's work without depending one another. The residents in psychiatry should be trained in these areas of psychiatry as well, preferably through post-doctoral fellowship programmes in public psychiatry, which can help in development of the cadre dedicated to this work. Further discussion of non-hierarchical level is available at Krishnan.[21]

Community psychiatry may be restricted to providing psychiatric care in non-clinical settings in a small local population group, such as awareness talks, a talk on stress management/exam preparation, even for non-recurring camps at the non-healthcare establishment, etc. However, since the scope of this term is very limited in the contemporary world, we suggest entirely abandoning the term community psychiatry. Instead, 'public psychiatry' shall be used for non-clinical aspects of community psychiatry activities especially involving the general and vulnerable population (range from micro-, meso, macro-, and mega-level).

We provide examples of activities for the proposed futuristic concepts of psychiatric care.

A. PUBLIC PSYCHIATRY ACTIVITIES

The proposed public psychiatry still at the infancy stage in India. We tend to believe here that public psychiatry shall cover from the negative concept of health (illness) to positive concept of health (wellness). It is prudent to begin from individual-based illness approach with population-driven targets and outcomes given contemporary criticism/progress of community medicine and community psychiatry. With experience gained over a period, authors suggest to gradually shift the focus entirely to population-based illness and wellness approach. The Global Wellness Institute[25] defines wellness as the active pursuit of activities, choices, and lifestyles that lead to a state of holistic health. Wellness is a multi-dimensional concept with six dimensions: physical, mental, emotional, spiritual, social, and environmental. A further discussion of wellness is in the section of limitations and future directions.

However, the concept of 'public psychiatry' shall continue to deal with the promotive and preventive activities covering

Table 2: Proposed alternative concepts for psychiatric care

Public psychiatry				Clinical psychiatry			
Mega- global level	Macro- state, country level	Meso- district level	Micro- community, local level	Primary- MBBS	Secondary- MD (general hospital)	Tertiary (general hospital academic centre)	Quaternary (subspecialty)- Fellowships/ DM)
Policymaking activities, legislation, economics, epidemiology, etc.	Policymaking activities, legislation, economics, epidemiology, etc.	Capacity-building activities	Awareness programmes, screening vulnerable population, mental well-being programmes	Psychiatry care by primary care doctors	At district hospital/taluk hospitals/ private clinics	At medical colleges	At apex institutes

MBBS: Bachelor of Medicine, Bachelor of Surgery, MD: Doctor of Medicine, DM: Doctorate of Medicine. Adopted from Krishnan[21]

psychiatry and the broader category of mental health, including policy, legislation, etc., operating mainly outside the healthcare establishments where targeted outcomes are from the general population. It shall move in the direction of the individual-based illness approach towards the population-based wellness outcomes.

Authors believe that public psychiatry cannot succeed in isolation. First, it needs to synchronise with the Jacob's concept of public health from developing countries' perspective.[23,24] Further, public psychiatry is an inter-disciplinary area guided by public psychiatrists and includes various other specialties such as epidemiologists, economists, yoga practitioners, occupational therapists, basic scientists, engineers (e.g., urban designer planners), climate change specialists, paramedical, and allied health/mental health professionals.

The authors propose a few activities under public psychiatry below.

1. The focus shall be on higher prevalent common mental disorders.
2. **Wellness psychiatry**: Expanding the scope from illness to wellness, including promoting beyond mental well-being and preventing psychiatric diseases.
3. **Preventive psychiatry**: This community-level intervention falls very well under the ambit of public psychiatry.[26]
4. **Screening of vulnerable population at non-clinical/ healthcare settings**: Vulnerable groups like children, women, those who are undergoing a crisis, trauma are at increased risk of developing mental health issues. Targeting those populations in their place would help in the early identification of a mental illness. These people can be identified in schools (school children), family courts (marital discord), police stations (people in conflict with the law), juvenile homes (children in conflict with the law), people facing a natural disaster, etc. All these are vulnerable groups that need screening in the non-healthcare setting. Preventive psychiatry is a slightly grey area as there is a clinical component here in dispensing medications to those identified with mental health issues.
5. **Disaster psychiatry**: Focus on studying psychiatric epidemiology and developing an intervention for disasters.[27]
6. **Awareness creation activities**: Mental health illiteracy among the general population is very high. Educating the public about mental illness, its early detection, and the rights of the mentally ill are need of the hour.[28]
7. **Role of alternative and complementary medicine**: Promoting yoga and other alternative therapies to promote mental well-being.[29]
8. **Policymaking activities**: Public psychiatrists should liaise with the policymakers in ensuring that the policies promote the wellness of the general and the vulnerable population. Examples include guidelines regarding the mental health services during a natural disaster, educational policies involving the children, policies related to persons with mental illness, policies related to children in conflict with the law, the need for care and protection, etc.
9. **Climate change and mental health**: This is the upcoming and exciting interdisciplinary area of public psychiatry, especially from a background of basic sciences and engineers.[30]
10. **Urban planning and mental health**: It is also an upcoming area related to public psychiatry where the impact of poor urban planning affects mental health.[31]
11. **Lesson from COVID-19 pandemic**: The public psychiatry should learn from COVID-19 pandemic. At first, the care for COVID-19 began with institutional/ isolation care in COVID care centre in first wave. Later triaging done at primary health centres, with policy of homecare for mild cases and shifting severe cases to dedicated clinical/hospital care. In addition, a triad of public health interventions of preventive measures such as face mask, hand sanitisation, and physical distancing on an individual level and lockdown for universal prevention. Public psychiatry should learn from COVID-19 care to delivery of psychiatric care at primary care to reach the last persons in more significant numbers.

B. PRIMARY CARE PSYCHIATRY (PCP) ACTIVITIES

Authors believe that there are four pillars of primary care, i.e., doctors, nurses, pharmacists, and accredited social health activist (ASHA) workers who can actively provide primary psychiatric care to PWMI. In India, authors believe that most of the practicing psychiatrists provide primary care (first-line pharmacological treatment and continuity of care) to their psychiatric patients. In an ideal world, primary care of psychiatric patients should be provided in the general practice of primary care doctors (PCDs) with Bachelor of Medicine, Bachelor of Surgery (MBBS) degrees (psychiatrically integrated general practice). Unfortunately, it is not successfully addressed so far. Given that 30-50% of all patients attending primary healthcare facilities suffer from psychiatric conditions,[32] there is an urgent need to address the issue. The Tele-Medicine Centre, National Institute of Mental Health and Neurosciences (NIMHANS), Bengaluru, India, a tele-consultation wing of NIMHANS Digital Academy (NDA), has designed and developed an innovative specialised primary care psychiatry program (PCPP) dedicated to empowering practicing PCDs to provide psychiatric care among their general practice.[33,34] As a prototype, 'Diploma in Primary Care Psychiatry,' a one-year, digitally-driven, part-time course for practicing MBBS doctors, is developed with the sole aim of integrating psychiatric care in general practice of MBBS doctors. Doctors undergo innovative training in their live real-time patients without having for deputation to NIMHANS, Bengaluru. There is a need to innovate more, such PCPPs.[33-37] PCPPs need to further expand beyond PCDs to other pillars of primary care psychiatry, such as ASHA workers, pharmacists, and nurses. Please note that NDA already has tele-educational courses, Diploma in Community Mental Health for nurses, social workers, and psychologists. Pharmacists are entirely ignored to date in public psychiatric healthcare system. Few studies have assessed the effects of the participation of ASHA workers in primary care psychiatry.[38-40] There is a need

to conduct well-designed studies to evaluate aspects of such expansion, including feasibility, sustainability, and patient-level outcomes (symptom relief, continuity of care, quality of life, cost-benefit ratio), etc. Primary care psychiatry shall function as a sub-specialty of the broader field of 'public psychiatry' given the traditional link between them until it is established as in independent field.

LIMITATIONS OF THE PROPOSED CONCEPT AND FUTURE DIRECTIONS

The authors acknowledge that there are blurring of distinctions between the concepts at a few places. The authors favour the idea of public psychiatry rather than public mental health for four reasons: *first*, we are all familiar with the slogan "No health without mental health." But its vice versa is also valid such as "No mental health without health." Any mental health promotion activity improves not only mental health but also physical health. Vice versa is also true. In reality, the concept of mental health is an artificial and imaginary concept, though it survived with its attractiveness despite its inseparableness from other dimensions of health. In this background, the authors favour an integrated term covering all aspects of health, including so-called mental health. With available search, the 'concept of wellness' is combined with five parameters, including mental health. Even though the wellness concept is a newer one, but has ancient Indian roots.[25] *Second*, the authors conceptualise health is having two extreme frameworks: a positive one is wellness, and a negative one is an illness. The concepts of mental health and psychiatry depend on the direction of approach on which it is conceptualised. Public mental health is a positive-to-negative approach and shall have wellness to illness concept. Whereas, the public psychiatry shall follow the negative-to-positive approach and follow the illness to wellness concept. Authors believe this concept of public psychiatry in negative-to-positive continuum is more pragmatic and practical to implement from public health perspectives. *Third*, the current generation of psychiatrists is currently ill-equipped to exploit the growing interest in public mental health (wellness-to-illness). *Lastly*, the authors believe that public mental health is an interdisciplinary area.[41-43] Therefore, there is a need for a systematic policy to develop the proposed public psychiatry as a sub-specialty of psychiatry and abandon the contemporary concept of community psychiatry.

CONCLUSIONS

The concept of community psychiatry began as psychiatric care outside the mental hospitals and included non-clinical educational activities. This concept of community psychiatry, either people-centric or location-centric, reached a stage where every psychiatric activity could be explained under the broader definition of community psychiatry! Hence, community psychiatry is outdated with the blurring of its boundary in the contemporary world. The time has now come to update the concept of community psychiatry, either restricting its use or abandoning and replacing it with newer ideas. Abandoning the concept of community psychiatry provides clarity of the work involved. Authors suggest replacing the clinical part of community psychiatry as 'clinical psychiatry' and the non-clinical portion of community psychiatry as 'public psychiatry.'

Further clinical psychiatry to be divided into primary, secondary, tertiary, and quaternary care. This new proposal encourages further development of different sub-specialties of psychiatry such as public psychiatry, primary care psychiatry, rehabilitation psychiatry, etc.

REFERENCES

1. Rosenblatt A. Concepts of the asylum in the care of the mentally ill. Hosp Community Psychiatry. 1984;35:244-50.
2. Daund M, Sonavane S, Shrivastava A, Desousa A, Kumawat S. Mental hospitals in India: reforms for the future. Indian J Psychiatry. 2018;60(Suppl 2):S239-S247.
3. Pedersen PB, Kolstad A. De-institutionalisation and trans-institutionalisation - changing trends of inpatient care in Norwegian mental health institutions 1950-2007. Int J Ment Health Syst. 2009;3:28.
4. Yip K. A historical review of the community care movement in psychiatric services. Hong Kong J Psychiatry. 1996;6:38-44.
5. Burns T. Community psychiatry's achievements. Epidemiol Psychiatr Sci. 2014;23:337-44.
6. Chadda RK. Caring for the family caregivers of persons with mental illness. Indian J Psychiatry. 2014;56:221-7.
7. Gupta S, Sagar R. National Mental Health Programme-optimism and caution: a narrative review. Indian J Psychol Med. 2018;40:509-16.
8. Khurana S, Sharma S. National mental health program of India: a review of the history and the current scenario. Int J Community Med Public Health. 2016;3:2696-704.
9. Sidana A. Community psychiatry in India: where we stand? J Mental Health Hum Behav. 2018;23:4-11.
10. Burns T. Community psychiatry at the National Institute of Mental Health and Neuro Sciences, India: easier than working in Manchester. Psychiatr Bull. 1998;22:180-2.
11. Kapoor RL. Community involvement in mental health care. Natl Med J India. 1994;7:292-4.
12. Sinha SK, Kaur J. National mental health programme: manpower development scheme of eleventh five-year plan. Indian J Psychiatry. 2011;53:261-5.
13. Chadda RK, Sood M. General hospital psychiatry in India: history, scope, and future. Indian J Psychiatry. 2018;60(Suppl 2):S258-S263.
14. MacQueen KM, McLellan E, Metzger DS, Kegeles S, Strauss RP, Scotti R, *et al*. What is community? An evidence-based definition for participatory public health. Am J Public Health. 2001;91:1929-38.
15. Tharoor H, Thara R. Evolution of community telepsychiatry in India showcasing the SCARF model. Indian J Psychol Med. 2020;42(5 Suppl):69S-74S.
16. Blackmore MA, Carleton KE, Ricketts SM, Patel UB, Stein D, Mallow A, *et al*. Comparison of collaborative care and colocation treatment for patients with clinically significant depression symptoms in primary care. Psychiatr Serv. 2018;69:1184-7.
17. Thara R, Rameshkumar S, Mohan CG. Publications on community psychiatry. Indian J Psychiatry. 2010;52(Suppl 1):S274-7.
18. Wong CH, Sultan Shah ZU, Teng CL, Lin TQ, Majeed ZA, Chan CW. A systematic review of anxiety prevalence in adults within primary care and community settings in Malaysia. Asian J Psychiatr. 2016;24:110-17.
19. Acheson RM. Medicine, the community, and the university: a century of Cambridge history. Br Med J. 1978;2:1737-41.
20. World Health Organization. Regional Office for South-East Asia. SEA/RC25/13 - Report of the technical discussions on the teaching of community medicine in undergraduate medical school [Internet]. WHO Regional Office for South-East Asia; 1972 [cited 2021 May 16]. Available from: https://apps.who.int/iris/handle/10665/130147
21. Krishnan A. Community medicine in India - which way forward? Indian J Community Med. 2016;41:5-10.
22. Garg BS. Teaching/training and practice of public health/PSM/

community medicine. Indian J Community Med. 2017;42:127-30.
23. Jacob KS. Public health in India and the developing world: beyond medicine and primary healthcare. J Epidemiol Community Health. 2007;61:562-3.
24. Jacob KS. Public health in low- and middle-income countries and the clash of cultures. J Epidemiol Community Health. 2009;63:509.
25. Global Wellness Institute. What is wellness? [Internet] [cited 2021 Aug 28]. Available from: https://globalwellnessinstitute.org/what-is-wellness
26. Kobau R, Seligman ME, Peterson C, Diener E, Zack MM, Chapman D, *et al*. Mental health promotion in public health: perspectives and strategies from positive psychology. Am J Public Health. 2011;101:e1-9.
27. Math SB, Nirmala MC, Moirangthem S, Kumar NC. Disaster management: mental health perspective. Indian J Psychol Med. 2015;37:261-71.
28. Varghese PJ. Advocacy in mental health: offering a voice to the voiceless. Indian J Soc Psychiatry. 2015;31:4-8.
29. Hariprasad VR, Sivakumar PT, Koparde V, Varambally S, Thirthalli J, Varghese M, *et al*. Effects of yoga intervention on sleep and quality-of-life in elderly: a randomized controlled trial. Indian J Psychiatry. 2013;55(Suppl 3):S364-8.
30. Cianconi P, Betrò S, Janiri L. The impact of climate change on mental health: a systematic descriptive review. Front Psychiatry. 2020;11:74.
31. Ingle HE, Mikulewicz M. Mental health and climate change: tackling invisible injustice. Lancet Planet Health. 2020;4:e128-e130.
32. Nambi SK, Prasad J, Singh D, Abraham V, Kuruvilla A, Jacob KS. Explanatory models and common mental disorders among patients with unexplained somatic symptoms attending a primary care facility in Tamil Nadu. Natl Med J India. 2002;15:331-5.
33. Manjunatha N, Kumar CN, Math SB, Thirthalli J. Designing and implementing an innovative digitally driven primary care psychiatry program in India. Indian J Psychiatry. 2018;60:236-44.
34. Pahuja E, Santosh KT, Harshitha N, Fareeduzaffer, Manjunatha N, Gupta R, *et al*. Diploma in primary care psychiatry: an innovative digitally driven course for primary care doctors to integrate psychiatry in their general practice. Asian J Psychiatr. 2020;52:102129.
35. Agarwal PP, Manjunatha N, Gowda GS, Kumar MNG, Shanthaveeranna N, Kumar CN, *et al*. Collaborative tele-neuropsychiatry consultation services for patients in central prisons. J Neurosci Rural Pract. 2019;10:101-5.
36. Gowda GS, Kulkarni K, Bagewadi V, Rps S, Manjunatha BR, Shashidhara HN, *et al*. A study on collaborative telepsychiatric consultations to outpatients of district hospitals of Karnataka, India. Asian J Psychiatr. 2018;37:161-6.
37. Santhosh KT, Pant MB, Uzzafar F, Manjunatha N, Kumar CN, Math SB. Telemedicine-based tobacco treatment model in primary care from a low-resource setting. J Neurosci Rural Pract. 2019;10:690-2.
38. Ibrahim FA, Nirisha L, Barikar M, Kumar CN, Chand PK, Manjunatha N, *et al*. Identification of psychiatric disorders by rural grass-root health workers: case series & implications for the National Mental Health Program of India. Psychiatr Q. 2021;92:389-95.
39. Malathesh BC, Ibrahim FA, Nirisha PL, Kumar CN, Chand PK, Manjunatha N, *et al*. Embracing technology for capacity building in mental health: new path, newer challenges. Psychiatr Q. 2021;92:843-50.
40. Rahul P, Chander KR, Murugesan M, Anjappa AA, Parthasarathy R, Manjunatha N, *et al*. Accredited Social Health Activist (ASHA) and her role in District Mental Health Program: learnings from the COVID 19 pandemic. Community Ment Health J. 2021;57:442-5.
41. Mehta N, Davies SC. The importance of psychiatry in public mental health. Br J Psychiatry. 2015;207:187-8.
42. Stewart-Brown SL. Public mental health: an interdisciplinary subject? Br J Psychiatry. 2015;207:192-4.
43. Foreman DM. Psychiatry in public mental health: easy to say, but harder to achieve. Br J Psychiatry. 2015;207:189-91.

Malathesh BC, Manjunatha N, Kumar CN, Math SB, Thirthalli J. Conceptual framework of psychiatric care in India: moving from community psychiatry to public psychiatry. Open J Psychiatry Allied Sci. 2022;13:3-9. doi: 10.5958/2394-2061.2022.00007.6. Epub 2022 Jan 31.

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