EMERGING PERSPECTIVE

The Role of Psychiatrists in Mental Health Care Delivery Spectrum: Addressing the Challenges and Expanding the Scope

Dr. P. P. Kannan[1], Dr. R. Arul Saravanan[2]

1. Professor, Madras Medical College, Chennai.
2. Professor, SRM Medical College Hospital & Research Centre, Chengalpattu.

Psychiatry, as a medical specialty, faces unique challenges, one of which is the widespread perception that its skills are not technically distinct. This has fostered a misconception that the roles of psychiatrists can be easily replicated by other professionals, leading to an undervaluation of their expertise. This issue is particularly evident among allied health professionals and administrative decision-makers in the health sector, where psychiatrists' contributions are often seen as less rigorous compared to other specialties.[1]

Despite these misconceptions, psychiatrists engage in a diverse array of responsibilities.[2] In government service, they not only address acute psychiatric conditions but also promote mental well-being through suicide prevention initiatives, rehabilitate individuals with disabilities, and facilitate shelter homes for homeless persons with mental illness (HPWMI). These varied responsibilities underscore the depth of their role and the breadth of their expertise, which extends well beyond the confines of clinical practice to encompass public health and social care.

BRIDGING GAPS IN THE SYSTEM

In an ideal system, psychiatry professors and practitioners would focus predominantly on teaching, research, and clinical care.[3] However, systemic inefficiencies and the lack of robust frameworks often necessitate their involvement in administrative duties. They are compelled to fill gaps in organizational structures, advocating for evidence-based mental health policies and working toward more synchronized care delivery systems.

One of the most pressing gaps lies in the absence of clearly defined segments within the mental health care system. While private psychiatric services may offer outpatient care (OP), acute care, intermediate care, and long-term care (including rehabilitation and shelter homes), these segments are not uniformly structured across the sector. Many practitioners, particularly those in office-based roles, lack awareness of the needs associated with intermediate and long-term care. This often results in fragmented care, where patients receive treatment that is limited to medication or psychotherapy without addressing the broader psychosocial dimensions of recovery.[4]

For instance, a patient recovering from acute psychiatric episodes may require sustained intermediate care, focusing on their gradual reintegration into society. Without clear guidelines or established systems, such patients risk being overlooked or inadequately treated, prolonging their recovery, and potentially leading to relapses. This is more often happening due to lack of awareness in care gradient in mental health care spectrum and segments involved. This can be addressed by establishing norms as we shift patients from one segment to another till his reunion with family occurs.

***Address for Correspondence:**

P.P. Kannan, Professor, I.M.H., Madras Medical College, Chennai. Email: ppkannan@gmail.com

ORCID: 0009-0005-6971-6765

How to Cite this Article:

Kannan PP, Arul Saravanan R. The role of psychiatrists in mental health care delivery spectrum: Addressing the challenges and expanding the scope. Indian Journal of Mental Health and Neurosciences. 2024;7(2):pg 06-09.

THE ROLE OF NON-GOVERNMENTAL ORGANIZATIONS

Non-Governmental Community Service Organizations (called CSOs or NGOs) have emerged as key players in bridging the gaps in intermediate and long-term care. These organizations often specialize in areas such as rehabilitation, halfway homes, and long-term shelter care[5] areas traditionally underemphasized in medical training.

However, while their contributions are invaluable[6], there has been a noticeable trend of CSOs overstepping into domains traditionally managed by health care providers. For instance, some CSOs have expanded their focus beyond social and rehabilitative care to include aspects of diagnosis, treatment planning, and even direct medical intervention. This encroachment, while driven by the intent to fill systemic gaps, risks blurring the boundaries between health care and social care which may lead to inadequate health care many times when its required.

The overreach of CSOs into health care delivery can lead to several complications:

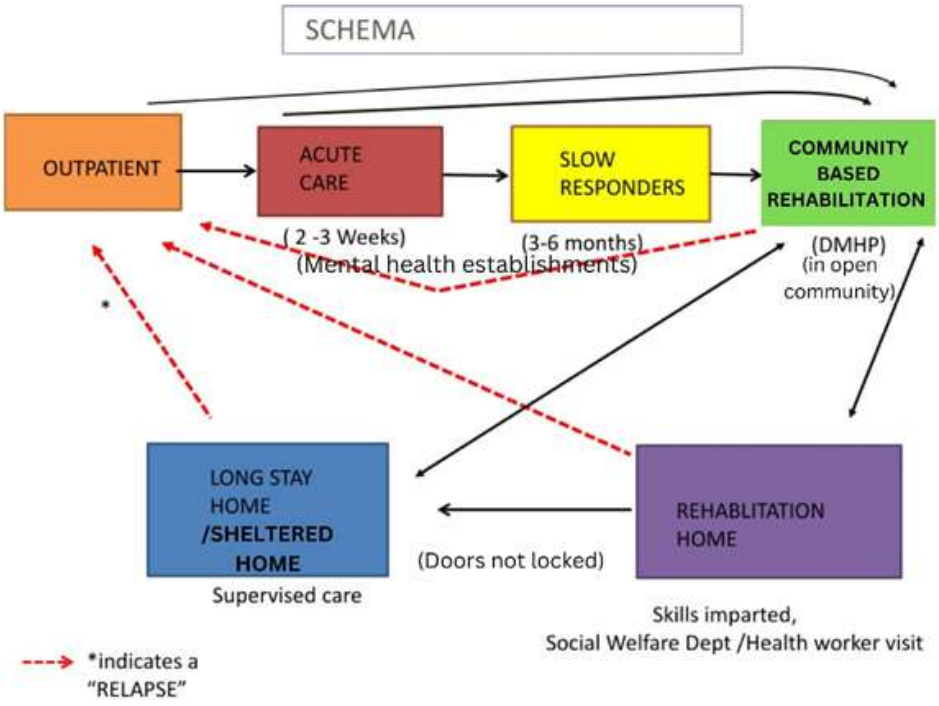
- **Lack of Standardization:** Unlike licensed medical professionals, many CSOs operate without adhering to established clinical guidelines, which can compromise the quality of care.
- **Policy Influence:** CSOs, through their increasing involvement in care delivery, have begun to influence government policies and resource allocation. This sometimes results in the marginalization of psychiatrists and other healthcare professionals, whose roles are critical in developing evidence-based mental health policies.
- **Fragmentation of Care:** With CSOs taking on responsibilities that should ideally remain within the purview of trained psychiatrists and allied health teams, there is a risk of fragmented care. Patients may receive incomplete or inconsistent treatment as they transition between health care providers and CSOs.

This overstepping highlights the need for better delineation of roles between health care providers and CSOs. This overstepping leads to shift in responsibility and has marginalized psychiatrists in areas beyond acute care and medical therapy. Their voices are often absent in broader policy discussions, further reducing their influence in shaping mental health care delivery. Over time, this has led to a diminished perception of psychiatry as a discipline capable of addressing the full spectrum of mental health care needs.

EXPANDING PSYCHIATRY'S ROLE

To reclaim their leadership role in mental health care, psychiatrists must actively participate in creating unified segmented care systems that delineate responsibilities and establish clear guidelines for patient management across all care levels. This involves collaborating with allied health professionals to ensure seamless transitions for patients between acute care, intermediate care, long-term care and community-based rehabilitation (CBR).[8]

A more integrated approach [9] in a segmented or care gradient established mental health care system would help psychiatrists to expand their scope of practice with the specialized knowledge for that segment. For example, patient in acute care or intensive care unit would require multiple visits by a psychiatrist whereas patient in intermediate care requires a visit once in 2-3 days. Beyond diagnosing and prescribing treatments, they must engage in leadership roles within rehabilitation and community-based care systems. By doing so, psychiatrists can address the psychosocial aspects of mental health, advocate for comprehensive care policies, and provide holistic treatment plans that encompass medical, psychological, and social dimensions.



DIFFERENTIATING HEALTH AND SOCIAL CARE

A key difference exists between health care and social care organizations, each playing a distinct role in mental health care. Social care organizations help individuals with mental illness (PWMI) find employment, secure housing, and access supported living arrangements. Their work addresses the socioeconomic factors that influence mental health and well-being.

Health care organizations, in contrast, focus on clinical goals, including diagnosis, treatment, symptom management, relapse prevention, and reducing disability. While they also engage in rehabilitation and some social care aspects, their main objective is medical recovery and long-term stability. Unfortunately, the high number of long-term patients in institutions like the Institute of Mental Health (IMH) has led to the misconception that these facilities primarily function as social care centres. This misunderstanding detracts from the vital clinical role they play in treating complex psychiatric conditions, painting them as primarily rehabilitation-focused. IMH provides rehabilitation as part of a gradual transition through various levels of care. The process begins with intensive medical intervention and social support, gradually moving towards less medical intervention and more focus on social support as patients transition into social care homes closer to their communities.

The rehabilitation process is often misunderstood as just providing supportive measures, but it involves continuously engaging individuals with mental illness, helping them develop skills for independent living, and, when possible, enabling them to support themselves financially. Health care institutions focus on symptom reduction, symptom stability, and psychosocial support. However, it is the responsibility of social care organizations to ensure that the psychosocial interventions introduced in health care settings continue once patients return to the community. In this context, community-based rehabilitation (CBR) after intermediate care is preferable, avoiding long-term stays in health institutions. The Directorate of Social Welfare and the Directorate for the Welfare of Differently Abled Persons, along with social care organizations, should focus on CBR rather than overlapping with the activities of health care institutions.

EVOLUTION OF MENTAL HEALTH CARE SYSTEMS

Historically, mental health care systems were integrated, with health and social care delivered under a unified framework. Over time, advancements in medical science and administrative reforms led to the specialization of these services. For example, the Directorate of Medical Services (DMS), which once operated as a single entity, evolved into multiple specialized directorates to address distinct health care needs. Similarly, the Directorate of Public Instruction (DPI) in Nungambakkam expanded into many directorates to cater to specialized areas of education.

In mental health care, similar transitions have occurred. The establishment of the Institute of Mental Health in 1794 marked the beginning of organized mental health care in South India. Over the centuries, new ministries and departments emerged, including the Social Welfare

Ministry in 1961 and the Department for the Welfare of Differently Abled in 1994. These entities gained momentum with international initiatives like the UN Convention on the Rights of Persons with Disabilities (2008) and domestic legislation such as the Rights of Persons with Disabilities Act (2016).

The introduction of the Mental Health Care Act (2017) further redefined care delivery, emphasizing patient rights and least-restrictive care models. These developments have shifted the paradigm from institution-based care to a health care-centric model, with community-based rehabilitation playing a complementary role.

TOWARD A HOLISTIC MODEL

Moving forward, establishing care gradients in a unified system, enhanced collaboration between psychiatrists and allied health professionals[10], and stronger policy advocacy will be essential. Psychiatrists must be equipped[7] and empowered to lead efforts in rehabilitation and community-based care, ensuring that all patients receive comprehensive, longitudinal, culture appropriate treatment.

By expanding the scope of psychiatry and reinforcing its leadership role in mental health care, the profession can regain its central position in shaping policies and delivering holistic care systems that address the diverse needs of patients.

ACKNOWLEDGEMENTS

Nil

SOURCE OF FUNDING

Nil

CONFLICT OF INTEREST

Nil

AUTHOR'S CONTRIBUTIONS

This work was carried out in collaboration among all authors. All authors have read and approved the final manuscript.

REFERENCES

1. *Are psychiatrists an endangered species? Observations on internal and external challenges to the profession World Psychiatry. 2010 Feb;9(1):21–28. doi: 10.1002/j.2051-5545.2010.tb00257. 2024;15:1369579.*
2. *Development of mental health human resources for mental well-being, Indian J Psychiatry. 2024 Jan 24;66(Suppl 2):S391–S402.*
3. *Advances in Psychiatry Training and Faculty Development in India. VL Narasimha • Indian J Psychol Med. 2024*
4. *Jee Young Joo, Nurs Open 2023 Jan 9;10(6):3460–3473. doi: 10.1002/nop2.1607*
5. *Roles played by civil society organisations in supporting homeless people with health care-seeking and accessing the social determinants of health in Delhi, India: Perspectives of support providers and receivers, Devaki Nambiar, SSM - Qualitative Research in Health Volume 2, December 2022, 100157*
6. *Thara R, Patel V. Role of non-governmental organizations in mental health in India. Indian J Psychiatry. 2010;52(Suppl 1):S389-95. doi:10.4103/0019-5545.69276.*
7. *The Principles and Practice of Psychiatric Rehabilitation, Srinivasan Tirupati, Vol 1 No 1 (2018): Indian Journal of Mental Health and Neurosciences.*
8. *Collaborative mental health care: A narrative review, Christopher Reist, Medicine (Baltimore). 2022 Dec 30;101(52):e32554*
9. *Ethical challenges and principles in integrated care, Br Med Bull. 2023 Jan 27;146(1):4–18. doi: 10.1093/bmb/ldac030*
10. *Mental Health Collaborative Care and Its Role in Primary Care Settings, David E Goodrich, Curr Psychiatry Rep. 2013 Aug;15(8):383*