Clinical Schedules for Primary Care Psychiatry: Version 2.4 (September 2023)

Dr. N Manjunatha
Dr. C Naveen Kumar
Dr. Suresh Bada Math
Dr. Jagadisha Thirthalli

Primary Care Psychiatry Program
Tele-Medicine Centre, NIMHANS Digital Academy, Department of Psychiatry
NATIONAL INSTITUTE OF MENTAL HEALTH AND NEUROSCIENCES
(NIMHANS) (An Institution of National Importance), Bengaluru, BHARAT (INDIA)

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Department of Psychiatry
National Institute of Mental Health and Neurosciences
(NIMHANS), Bengaluru – 560 029, INDIA

- ✓ *This is a **point-of-care manual** designed for the clinical use of **Primary Care Physicians** (PCPs).*
- ✓ *In India, PCPs are also referred to as 'General Practitioners' (GPs), 'Family Physicians (FPs), Family Doctors' (FDs), 'General Doctors' (GDs), etc.*
- ✓ *This **point-of-care manual** contains guidelines for screening, referral, early diagnosis, first-line treatment and routine follow-ups of **ADULT patients** with psychiatric disorders at **OUT-PATIENT** settings of primary health centres or GP clinics.*
- ✓ *This manual is an adapted version of specialist psychiatry for primary care use for the wider utilization of medical doctors of India with MBBS qualification.*

WHAT ARE THE EXPECTATIONS FROM GPs/PCPs?

A. To provide the first-line treatment to new patients in their first contact

- ✓ *GPs should be able to do rapid screening of all adult patients for possible psychiatric disorders.*
- ✓ *GPs should be able to diagnose and provide first-line treatment, including the prescription of psychiatric medication and brief counselling.*
- ✓ *If patients improve in the first 3 – 4 weeks of treatment, provide regular follow-ups.*
- ✓ *If the diagnosis of patients is unclear, consider referral to a psychiatrist or collaborative video consultation with a tele-psychiatrist, if available*

B. To provide follow-up care with refill prescriptions to stable patients referred by psychiatrists

- ✓ *Along with patients, family/friends are a reliable source of information for better follow-up.*
- ✓ *Enquire about clinical condition on every visit, check for common side effects, and prescribe same medications when clinical condition is same or when there is no worsening.*
- ✓ *If any patient does not improve, worsens, does not take regular medication, has severe side effects, becomes suicidal or aggressive, refer back to psychiatrists.*
- ✓ *Referral to a psychiatrist for a second opinion whenever patients/families concernedabout how long the medication should continue, despite your advice for a particular period!*

WHAT KIND OF PATIENTS IN GPs PRACTICE ARE LIKELY TO HAVE PSYCHIATRIC DISORDERS?

*Any patient/s of GPs who are likely to receive **repeated prescriptions** of the following medications has a higher probability of having psychiatric disorders.*

1. *Analgesics/Pain killers (Diclofenac, Ibuprofen, Nimesulide, etc)*
2. *Multivitamins in tablets/capsules/tonic bottle forms*
3. *Tonic seekers & Energy syrups*
4. *Antacid / H2 Blockers /Proton Pump Inhibitors (Ranitidine, Omeprazole, Pantoprazole, etc)*
5. *Benzodiazepines (Alprazolam /Diazepam/ Chlordiazepoxide/ Nitrazepam, etc)*
6. *Repetitive Infusion of Intravenous fluids on demand from patients/family*

Hence, it is suggested that GPs pro-actively search for psychiatric disorders among these patients in their routine clinical practice.

Part I: SCREENER

Name: …… **Age**: …… years, **Gender**: ……

Presenting complaints with its duration:

1. …… 2. ……

Physical examination findings: ……

Can you explain the above symptoms and signs with known physical illness?

YES / NO

- YES → Please proceed with your diagnosis & your Rx
- NO → If illness is ***< 2 weeks,*** *reassure & ask patient to follow-up if symptoms persists*
- NO → If illness is ≥ ***2 weeks,*** *check for possible* ***psychiatric disorders*** *as below****!!!***

Please begin with these general enquiries!

1	*How is your sleep?*	*Normal / Disturbed*
2	*How is your appetite?*	*Normal / Disturbed*
3	*How is your interest in doing your daily work?*	*Normal / Disturbed*

Now, begin with specific questions for possible psychiatric disorders!!!!

4	*In the past year, have you been drinking alcohol heavily or regularly?*	*YES / NO*	If YES to any, check for ***AlcoholDisorder***
5	*In the past year, are you not getting sleep without alcohol?*	*YES / NO*	
6	*In the past year, are you getting shaking of hands/body whenever you reduce or stop alcohol?*	*YES / NO*	
7	*Do you use Beedi/Cigarettes/Gutka or other tobacco products within one hour of waking up early in the morning?*	*YES / NO*	If YES, check for ***Tobacco Addiction***
8	*In the past few weeks, did you get any sudden attack/s of fear or anxiety?*	*YES / NO*	If YES to any, check for ***Panic disorder (PD)***
9	*In the past few weeks, does the above attack/s come without any reason/s?*	*YES / NO*	
10	*In the past few months, have you often been anxious/tensed/ stressed/nervous/worried for no obvious or minor, trivial reasons?*	*YES / NO*	If YES to any, check for ***GAD***
11	*In the past few months, are you unable to control or stop this tension?*	*YES / NO*	
12	*In the past few weeks, have you been feeling tired all the time?*	*YES / NO*	If YES to any, check ***Depressive disorder***
13	*In the past few weeks, have you lost interest or pleasure in your daily activities?*	*YES / NO*	
14	*In the past few weeks, have you been feeling sad / depressed?*	*YES / NO*	
15	*In the past many months, does this patient have any physical symptom/s (listed in diagnostic criteria of Somatization disorder) that is unexplainable with current medical knowledge or with depression/anxiety?*	*YES / NO*	If YES to any, check for ***Somatization Disorder***
16	*In the past many months, has this patient shown the signs of doctor shopping (repeatedly consulting you or other doctors) for these similar physical symptoms?*	*YES / NO*	
17	*In the past few weeks, has he/she had talking or smiling-to-self / hallucination*	*YES / NO*	If YES to any, check for ***Psychotic Disorder***
18	*In the past few weeks, has he/she had poor self-care / wandered aimlessly*	*YES / NO*	
19	*In the past few weeks, has he/she had suspiciousness/ big claims/ delusion*	*YES / NO*	
20	*In the past few weeks, has he/she been talking excessively/ sleeping less/hyperactive*	*YES / NO*	
21	*In the past few days, did he/she have suicidal, self-harm, or aggressive behaviour*	*YES / NO*	$ *PFA & Refer*

Note: *Items 1-14 for patients, 17-20 for family & friends, 15, 16 & 21 for clinical interpretation of doctors*

$ Provide ***Psychological First Aid*** & refer to a psychiatrist

Behavioural observation/ Psychiatric Examination/ Mental Status Examination: ……

Primary Care Taxonomy/ Diagnosis: *(Tick appropriately)*

1	**Alcohol Disorder:** *Harmful use (Frequent / Infrequent type)/ Addiction*
2	**Tobacco Addiction**
3	**Common Mental Disorders (CMDs)/ Neurosis**
	a. Predominantly Depressive Disorder
	b. Predominantly Anxiety Disorder (Panic Disorder / Generalized Anxiety Disorder)
	c. Predominantly Somatization Disorder
	d. Mixed Disorder (Depressive, anxiety, or somatic symptoms)
4	**Severe Mental Disorders (SMDs)/ Psychotic Disorders:** *Acute / Episodic / Chronic*

Treatment plan: ***1. Prescription*** **2. Brief counselling** **3. Follow-up notes with dates**

Prepared by Department of Psychiatry, NIMHANS, Bengaluru
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Part II: MANAGEMENT GUIDELINES

I. DIAGNOSTIC GUIDELINES

- ✓ The diagnoses of psychiatric disorders are based on a cluster of symptoms and signs described below.
- ✓ Many physical illnesses in clinical practice can present as typical psychiatric disorders. Hence, it is advisable to ***rule out these physical conditions*** based on clinical symptoms and signs of that physical illness, if present.
- ✓ Thyroid and cardiac dysfunctions are common medical conditions that can mimic psychiatric disorders.
- ✓ If a physical illness is found, priority should be given to the treatment of this physical condition.

DIAGNOSTIC CRITERIA OF DEPRESSIVE DISORDER

The **core symptoms** are 1. *Depressed mood*
2. *Loss of interest or pleasure in activities that were usually pleasurable earlier &*
3. *↓ Energy level or ↑fatigue/tiredness.*

Additional symptoms

1. *Disturbed sleep*
2. *Disturbed appetite*
3. *↓Concentration & Attention*
4. *↓ Activity/thinking level*
5. *↓Sexual interest*
6. *↓ Self-esteem /self-confidence*
7. *Ideas or acts of self-harm or suicide*
8. *Ideas of guilt and unworthiness*
9. *Bleak and negative view of future*
10. *Weight loss*

Presence of ***at least 2 of above core symptoms*** and ***at least 3 additional symptoms*** pervasively (in almost all activities) & persistently (present throughout the day) **for more than TWO WEEKS** confirm the diagnosis of "depressive disorder".

DIAGNOSTIC CRITERIA OF GENERALIZED ANXIETY DISORDER

An experience of excessive and uncontrollable anxiety /tension/worries/stress/nervousness with no obvious or trivial reasons for many months (often for ***> 6 months)***. ***The characteristics of these anxiety /tension/worries/stress/nervousness are***

1. Generalized in nature (involving several aspects of life involving family, health, finances, or work, such as family tragedy, ill health, job loss or accidents even when there are no obvious signs of trouble).
2. Persistently (present throughout the day)
3. Free-floating anxiety (means anxiety does not have an obvious cause / without pinpointing any source of worry/anxiety, but with capability to move on freely without being connected to one reason/source of anxiety **(unattached/uncommitted to a cause/a situation /independent of a cause, but capable of relatively free movement)**

These anxiety symptoms usually present with the following multiple symptoms.

1. ***Mental tension / Apprehension*** (nervousness or exaggerated and uncontrolled *"worries about future misfortunes"* of everyday events and problems, feeling "on edge," difficulty in concentrating, etc.);
2. ***Physical / Motor tension*** (being restless, fidgeting, *tension headaches*, trembling, *inability to relax, trouble sleeping*);
3. ***Physical arousal / Autonomic over-activity*** (*light-headedness*, sweating, tachycardia or tachypnoea, *epigastric discomfort*, *dizziness*, dry mouth, etc.).

DIAGNOSTIC CRITERIA OF PANIC DISORDER

The characteristics of an attack of severe anxiety or fear **(panic attack)** are as follows

1) Repetitive (more than one attack) 2. Spontaneous (sudden onset without any reasons), and 3) Unpredictable

These panic attacks are usually associated with

1. Sudden onset of palpitations, chest pain, difficulty breathing/choking sensations, dizziness, dry mouth, and feelings of unreality are common.
2. There is also a secondary fear of dying, losing control, or going mad.
3. Having a fear of *'anticipatory attack'* leading to avoidance of certain situations where these attacks occurred.
4. These attacks begin abruptly, peak in 5 minutes, and resolution occurs in 10-20 minutes.

However, a panic attack, which is not spontaneous and predictable, could be a panic attack as a part of GAD/Depressive disorder but may not be panic disorder per se.

DIAGNOSTIC CRITERIA OF SOMATIZATION DISORDER

These patients present with various physical complaints without a physical explanation determined by a full history and physical examination. These symptoms may be single, multiple, or variable physical symptoms referred to any part or system of the body.

Following list includes the commonest symptoms.

1. Pain symptoms at multiple sites (such as abdominal, back, chest, dysmenorrhea, dysuria, extremity, head, joint, rectal) are often present.
2. Gastrointestinal sensations (pain, belching, regurgitation, vomiting, nausea, etc.),
3. Abnormal skin sensations (itching, burning, tingling, numbness, soreness, etc.) and blotchiness.
4. Sexual and menstrual complaints (ejaculatory or erectile dysfunction, hyperemesis of pregnancy, irregular menses, menorrhagia, sexual indifference) are also common.

For a definite diagnosis of somatization disorder

1. For many months (at least 6 months) of symptoms of the illness explained above
2. Doctor shopping (repeated visits to doctor/s and/or repeated investigation reveals no abnormality).
3. Some degree of social and family dysfunction.

DIAGNOSTIC CRITERIA OF PSYCHOSIS- Acute *(up to 6 months)****/Chronic*** *(> 6 months)* ***/Episodic*** *(more than one episode)*

1. Agitation or restlessness
2. Bizarre behaviour
3. Hallucinations (false or imagined perceptions, e. g., hearing voices)
4. Delusions (firm beliefs that are obviously false, e.g., patient is related to the royal family, receiving messages from television, being followed or plan to kill/harm)

5. Social withdrawal (sitting alone, not interacting with others, etc.)
6. Low motivation or interest, self-neglect (poor self-care, not going to work, etc.)
7. Un-understandable speech
8. Over-cheerfulness/ Over-talkativeness/ reduced sleep/ hyperactivity/ grandiose thinking

Alcohol Disorders:

Alcohol Harmful use- *(Two types: Frequent /Infrequent) [Frequent type: ≥ 4 drinking sessions per month]*

1. Heavy alcohol use leading to socio-occupational and/or health problems, even if not regular use

Alcohol Addiction

1. Regular use of alcohol almost every day, especially early morning drinking
2. Experience **simple withdrawal symptoms** whenever he/she reduce or stops alcohol, such as tremors, sleep disturbance, sweating, palpitation, etc, within 4-12 hours of the last drink. **Complicated withdrawal symptoms** include seizure within 24-48 hours of the last drink and delirium tremens within 48-72 hrs of the last drink. (Need emergency Rx)

Tobacco Addiction

A person uses any tobacco products regularly and/or heavily and is unable to control their quantity

II. INVESTIGATIONS GUIDELINES

- ✓ Laboratory or radiological investigations are NOT used routinely in psychiatric disorders
- ✓ The need for investigations depends on clinical findings to exclude other physical illness that can explain psychiatric symptoms
- ✓ Serum thyroid stimulating hormone (TSH), and Electrocardiogram (ECG) are commonly used investigations
- ✓ CT/MRI of the Brain is rarely used in routine clinical psychiatry.

III. TREATMENT GUIDELINES

A. General Treatment Guidelines of Psychiatric Medications

- ✓ ***The onset of action*** *is slow, i.e., around 2 to 3 weeks, and it takes 4 to 6 weeks for complete action.*
- ✓ ***A longer course of medications:*** *Once improvement occurs with any medication, there is a need to continue medicines at the* ***same dose*** *for at least 6 months.*
- ✓ *Once decided to stop, it is advised for gradual taper of the dose and then stoppage of medication.*
- ✓ ***DO NOT stop medications abruptly*** *until & unless it is an emergency, such as severe side effects, etc*
- ✓ ***Continue medication*** *after symptom improvement during* ***a symptom-free period*** *to prevent relapse of symptoms* ***for the probable duration of Rx*** *mentioned in the table below.*

No	Diagnosis	First line Rx	Probable duration of Rx
1	**CMDs**		
A	Predominantly Depressive Disorder	SSRI + BZDs + Counselling	SSRI for 9 -12 months
B	Predominantly Anxiety Disorder	SSRI + BZDs + Counselling	BZDs for initial 2-4 weeks
C	Predominantly Somatization Disorder	TCA + Counselling	2 year
D	Mixed Disorder (Depressive, Anxiety/Somatic symptoms)	TCA > SSRI + Counselling	1-2 year
2	**SMDs/ Psychosis**		
A	Acute	Atypical antipsychotics	6-9 months
B	Chronic	Atypical antipsychotics	2 years
C	Episodic	Need psychiatrist referral	Variable
3	**Alcohol Disorder**		
A	Alcohol Harmful use – Not so frequent type	Counselling + B1 vitamin	Follow up advised
B	Alcohol Harmful use – Frequent type	SOS Naltrexone 25 mg ½ hour before every drinking session	
C	Alcohol Addiction	Anti-craving medications + B1 vitamin + BZDs detoxification	9-12 months
4	**Tobacco Addiction**	NRT/Bupropion	3-6 Months

B. Counselling

- ✓ *It shall be brief in duration (to be completed in < 5 minutes).*
- ✓ It is one of the non-medication treatment modalities practiced by all doctors in their everyday practice, often without their knowledge.
- ✓ Similarly, the same thing shall also be offered for patients with psychiatric disorders.
- ✓ *The core contents of counselling shall include an education about illness and setting realistic expectations from treatment and practical tips to handle stressors, whenever present.*
- ✓ Counselling shall include information about nature of illness, when to expect a benefit from medication, how long to continue, and need for repeated follow up.
- ✓ Please provide practical tips to handle stressors whenever present.
  - ➢ ***Psychotherapy (talk therapy) is a specialised form of counselling aimed to relieve symptoms which takes multiple sessions of 40 -60 minutes each.***
  - ➢ ***Please don't confuse for counselling with psychotherapy which psychiatrists practice.***

C. Medications (Anti-depressants and Antipsychotics)

Antidepressants (All are oral adult dose in mg) This is an empirical guideline for the clinical use of antidepressants in primary care.

Name	Initial dose	Max dose (GPs)	Max dose (Psy)	Common side effects (usually dose-dependent)			Sexual side effects	Remarks, if any
				Sedation	Orthostatic hypotension	Anticholinergic		
Selective Serotonin Reuptake Inhibitors (SSRI)								
Fluoxetine	20	40	80	± insomnia	0	0	++	Preferably in morning
Escitalopram	10	20	30	±	±	0	±	Hyponatremia especially in old age
Citalopram	20	30	60	±	±	0	±	
Sertraline	50	100	200	±	±	0	Delayed ejaculation	Safe in old patients & medical comorbidities
Paroxetine CR	12.5	25	37.5	+	0	±	Retrograde ejaculation	Agitation
Fluvoxamine	25	100	300	±	±	±	Anorgasmia	
Newer antidepressants								
Duloxetine	20	30	60	±	±	±		Dry mouth, ↓ appetite
Venlafaxine ER	37.5	75	225	±	±	±	↓sexual drive	BP monitoring
Desvenlafaxine	50	100	400				Sexual dysfunction	
Mirtazapine	7.5	15	45	+++	+	±	Very less	
Bupropion	150	300	450	Activating	0	0	Very less	Priapism & seizure at higher dose
Tri Cyclic Antidepressants								
Amitriptyline	10	50	300	+++	+++	+++	++	Avoid in old patients & comorbidities
Imipramine	25	75	300	++	++	++	++	
Dothiepin	25	50	225	+++	+++	++	++	Relatively Cardio safe
Clomipramine	25	75	300	++	++	++	++	
Nortriptyline	50	50	200	+	++	+	+	

Severity of side effects is graded as 0 = Absent; ± = Probable/Very little; + = Mild; ++ = Moderate; +++ = Severe. Anticholinergic side effects are dry mouth, constipation, blurred vision, urinary retention, giddiness, etc. Max-Psy: Maximum dose used by psychiatrist, Max-GPs: Maximum dose recommended for General Practitioners.
*There is a risk of a **manic switch** (< 5%) with antidepressants (TCA > SSRI); to be managed by stopping antidepressants and refer to a psychiatrist.*

Prepared by Department of Psychiatry, NIMHANS, Bengaluru
For feedback & clarification, contact manjunatha.adc@gmail.com

ANTIPSYCHOTICS- ORAL (All are in adult dose in mg). *This is an empirical guideline for the clinical use of antipsychotics by GPs.*

Name	Initial dose	Max dose (GPs)	Max dose (Psy)	Common side effects (Mostly dose dependent)					Remark
				Sedation	Hypotension	EPS	Weight gain	↑ Prolactin	
Atypical Antipsychotics ***[****Safer than typical antipsychotics]*									
Risperidone	2	4	8	+	++	+	++	+++	
Olanzapine	5	10	30	++	+	±	+++	+	
Quetiapine	25	200	800	++	±	0	++	0	
Aripiprazole	7.5	15	30	0	0	0	±	0	
Paliperidone	3	6	12	0	+	+	++	+++	
Amisulpride	100	200	800	±	+	+	+	+++	
Levosulpride	50	100	300						
Clozapine*	25	100	600	+++	+++	0	+++	0	Seizure risk above 600 mg, Agranulocytosis (at any dose), cardiomyopathy
Typical Antipsychotics									
Chlorpromazine	25	100	600	+++	++++	+	++	++	Anticholinergic side effects
Flupenthixol	1	3	6	+	+	++	++	++	
Haloperidol	0.5	10	30	+	+	+++	+	+++	Cardio safe

** EPSE means Extrapyramidal side effects are graded as 0 = Absent; ± = Probable/Very little; + = Mild; ++ = Moderate; +++ = Severe.*
Increased prolactin lead to Amenorrhea, galactorrhoea, and other sexual side effect
****Clozapine is to be begun under the supervision of a psychiatrist***

Antipsychotic- Depot Preparations$

No	Name	Route	Dose (in mg)	Frequency
1	Inj Fluphenazine Decanoate	IM	12.5 to 100	Every 2 to 4 weeks
2	Inj Flupentixol Decanoate	IM	20 to 60	Every 2 to 4 weeks
3	Inj Haloperidol Decanoate	IM	25 to 100	Every 4 weeks
	Inj Zuclopentoxol Decanoate	IM	200 to 400	Every 2 to 4 weeks
4	Inj Olanzapine Pamoate	IM	150 to 300	Every 4 weeks
5	Inj Risperidone Consta	IM	25-50	Every 2 weeks
6	Inj Paliperidone Palmitate	IM	39, 78, 117, 156, and 234	Every 4 weeks

$To be given only to patients who do not take medicine regularly leading to relapses. These depot injections preferable to begin by a psychiatrist, and follow-up may be done with their GPs

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D. EXTRA-PYRAMIDAL SIDE EFFECTS (EPS) includes

No	Name	Description	Likely onset*	Rx
1	Dystonia	Twisting of arms/legs/eye balls	Within a few hours (10 minutes to 4 hours)	Inj Phenergann (Promethazine) 25 /50 mg deep IM/ slow IV or Diazepam 10 mg IM/ slow IV *STAT* & then begin tab. Trihexyphenidyl 2-4 mg for 2 to 3 weeks
2	Akathisia	Motor restlessness	Within a few days (1 to 4 days)	Reduction or change of offending drug. Beta blockers like Propranolol up to 40 mg/day or Benzodiazepines (BZDs). i.e., Clonazepam 0.5 – 1 mg
3	Drug-Induced parkinsonism	Tremor & slowness	Within a few weeks (1 to 2 weeks)	Trihexyphenidyl 2 to 6 mg. It is often added as a prophylactic agent

* *After of the administration of antipsychotics*

E. BENZODIAZEPINES tablets

No	Name	Type	Dose /day	Addiction potential	Schedule
1	Clonazepam	Long-acting	0.5-6 mg	+	OD /BD
2	Diazepam	Long acting	5-30 mg	+++	OD /BD
3	Chlordiazepoxide	Long-acting	10- 100 mg	++	OD /BD
4	Nitrazepam	Long acting	5-20 mg	++	OD /BD
5	Lorazepam	Short acting	0.5-2 mg	++	BD/TDS
6	Oxazepam	Short acting	15-60 mg	++	BD/TDS
7	Alprazolam	Short-acting	0.25 – 4 mg	++++	BD/TDS

F. ALCOHOL AND TOBACCO DISORDERS

A general guideline (Relapse Enrichment Program)

1. *Please remember patients with alcohol & tobacco addiction need **MANY TREATMENT ATTEMPTS** as several relapses (maybe 4 – 6 times) are common, and relapses are a rule rather than an exception (even with proper treatment) for complete stopping.*
2. For any kind of alcohol & tobacco disorders, advice always to stop completely. If willing for Rx, follow the below guidelines
3. ***If the patient/s is not willing to stop,** a) Never force any patient/s to begin treatment, b) Self abstinence by gradual reduction, especially for milder severity, shall be encouraged, c) Inform about availability of medications to stop, d) Counsel about benefits of abstinence and damages of continued use, e) Always ask them to come whenever they wish to stop. These steps build up a better doctor-patient relationship for long-term treatment for addiction Rx.*
4. Encourage their friends & family to cooperate and help the patient for multiple treatment attempts.

ALCOHOL DISORDERS

- ✓ **Alcohol harmful use (Infrequent type)**- Counselling includes the short-term and long-term benefits of stopping and harm of continued use**.** You may prescribe thiamine supplementation. Advise for regular follow up.
- ✓ **Alcohol harmful use (Frequent type)**- SOS use of Naltrexone 25 mg ½ an hour before every drinking session (Sinclair method). This method gradually reduces the harm by reducing the quantity of alcohol and eventually helps to stop alcohol completely.
- ✓ **Alcohol Addiction*:***

1. Detoxification with BZDs only if there are withdrawal symptoms (Diazepam preferred up to 40 mg/day on 1st & 2nd day, 30 mg/day for 3rd & 4th day, 20mg/day for 5th & 6th day, 10mg/day for 7th & 8th day, then stop).
2. Thiamine supplementation up to 300 mg/day for the first 3 months.
3. ***Anti-craving medications*** (gradual hike is advised) such as Topiramate to 100 mg/day, Baclofen up to 40 mg/day, Acamprosate up to 999mg/day (333 mg TDS) may be used for 9 months to 1 year.

These anti-craving medications can be given from the first day of Rx. They reduce craving and reduce the quantity of alcohol even if a person drink alcohol on it. Hence, anti-craving medications can also be given even if a person continues to drink alcohol; thishelps reduce/prevent withdrawal symptoms / hangover / craving the next morning.

***Disulfiram** is an aversive drug (NOT anti-craving) and not advisable for use at the primary care level. If GPs prefer, please use cautiously, preferably after informed consent from patients and supervision by a family member. Start ONLY after 5 days of completely stopped alcohol. The dose is 250 mg OD, preferably in the morning.*

Tobacco Addiction

1. ***Nicotine Replacement Therapy (NRT)***
   Nicotine transdermal patch to apply on clean, dry, non-hairy area of skin (typically upper arm or shoulder) in 21/14/7 mg regimen: 21 mg OD for 6 weeks, then 14 mg patch OD for 2 weeks & then 7 mg patch OD for 2 weeks) and
   Nicotine gum to be used in chew and park technique (2 & 4 mg: Max 16 mg/day, to be used hourly for first 2 weeks, then gradual taper and stop in 3 months). Please be aware nicotine gum has poor acceptability and unpredictable effects, i.e., it may not get the desired effects.
2. ***Bupropion*** is available in 150 & 300 mg tablets. Preferably in the morning; begin 150 mg for the first 5 days & then 300 mg for 3 to 6 months.
3. ***Varenicline*** is also effective. 0.5 mg OD on Days 1-3:, 0.5 mg BD on days 4-7:, then 1 mg BD for 3 to 6 months.

G. MANAGEMENT OF PSYCHIATRIC DISORDERS IN COMORBID MEDICAL ILLNESS

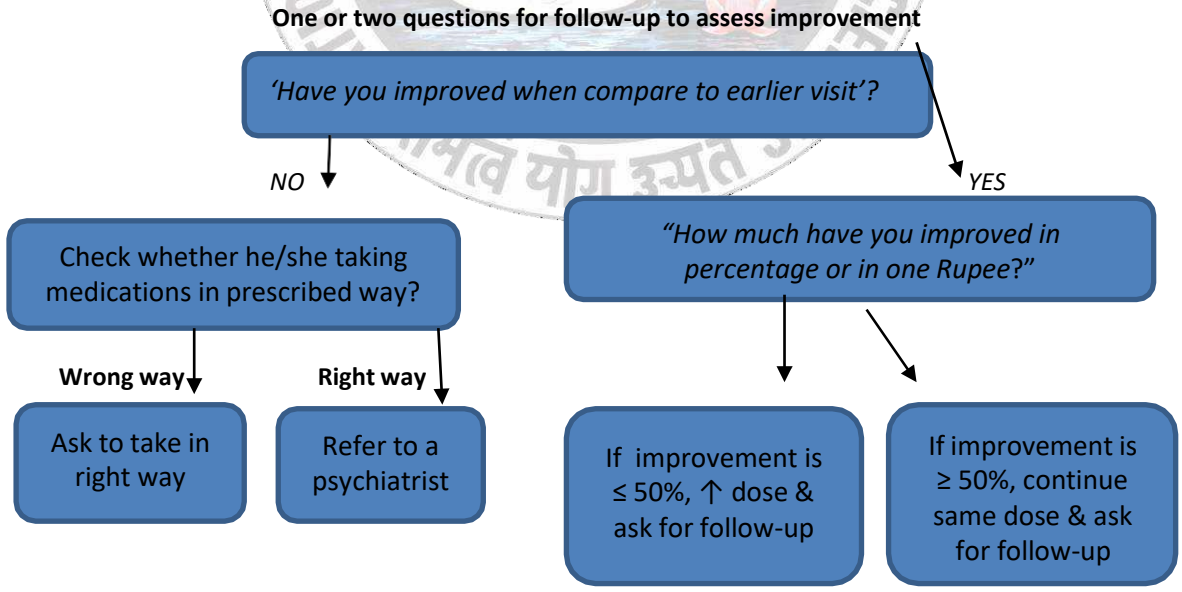
- ✓ *Psychiatric disorders can be present in patients with diabetes mellitus, essential hypertension, ischaemic heart disease, stroke, cancers, etc.*
- ✓ *Avoid poly-pharmacy.*
- ✓ *Begin low (dose), go slow (for escalation of dose)*
- ✓ *However, the medicines and dose mentioned in this point-of-care manual contains reasonably safe medications, and GPs dose are in a lower dose, which is considered safe.*
- ✓ *If doubt, refer to a psychiatrist.*

H. TREATMENT OF PSYCHIATRIC DISORDERS IN PREGNANCY AND LACTATION

- ✓ *General rules of Pregnancy and Lactation are also applicable for psychiatric disorders, such as avoid in the first trimester, caution in 2nd & 3rd trimesters.*
- ✓ *Preferable to refer to a psychiatrist*

IV. FOLLOW-UP (CONTINUITY OF CARE) GUIDELINES

Frequency of follow-ups: *First follow-up at 2 weeks (to assess side effects), second at 4 weeks (to assess effects), and then every month (for maintenance).*



Addiction follow-up

1. *Check whether he/she stopped completely or not. If stopped completely, continue anti-craving Rx for 9-12 months*
2. *If not stopped completely, consider increasing the dose of anti-craving medication*
3. *Refer to a psychiatrist in case the person goes back for repeated drinking episodes despite being on an adequate dose of anti-craving Rx*

1. ***Rx for Depressive & Anxiety Disorders***

1. Tab. **FLUOXETINE** 20mg, 1-0-0 **2.** Tab. **CLONAZEPAM** 0.25mg 0-0-1 X 10 days & then **STOP** ***Or*** Tab. **DIAZEPAM** 5mg, 0-0-1 X 10 days & then **STOP**	**OR**	1. Tab. **ESCITALOPRAM** 10mg, 0-0-1 **2.** Tab. **CLONAZEPAM** 0.25mg 0-0-1 X 10 days & then **STOP** **Or** Tab. **DIAZEPAM** 5mg, 0-0-1 X 10 days & then **STOP**	**OR**	Tab. **AMITRIPTYLINE** 25mg, 0-0-1 /2 X 4 days 0-0-1X 4 days 0-0-2 (continue)
Counselling to includes action begins at 2-3 weeks, full action is at 4-6 weeks & Course of treatment is 6-9 months once improvement occur				
Follow up @ 1 Month		**If improvement, follow-up with you every month**		**If NO improvement, Refer to a Psychiatrist.**

2. Rx for Somatization Disorder

Tab. **AMITRIPTYLINE** 25mg 0-0-1/2 X 4 days 0-0-1 X 4 days 0-0-2 (continue)	**Counselling to includes** action begins at 2-3 weeks, full action is at 4-6 weeks & Course of treatment is 2 years.	
Follow up @ 1 Month	**If improvement, follow-up with you every month.**	**If NO improvement, Refer to a Psychiatrist.**

3. Rx for Psychotic Disorders

1. Tab. **RISPERIDONE** 2mg, 0-0-1 X 4 days 0-0-2 (Continue) 2. Tab. **Trihexyphenidyl** 2mg, 1-0-0	**OR**	Tab. **OLANZAPINE** 5mg,0-0-1 X 4 days 0-0-2 (Continue)
Counselling to includes action begins at 2-3 weeks, full action is at 4-6 weeks & Course of treatment is 6-9 months once improvement occur		
Follow up @ 1 Month	**If improvement, follow-up with you every month.**	**If NO improvement, Refer to a Psychiatrist.**

Prepared by Department of Psychiatry, NIMHANS, Bengaluru
For feedback & clarification, contact manjunatha.adc@gmail.com

• ***Rx for Alcohol Addiction***

1. Inj. **OPTINEURON FORTE** (containing thiamine 100mg) 1ampule deep IM once a day for 5 days. 2. Tab. **DIAZEPAM*** 10mg,1-1-2 X 2 days 0-1-2 X 2 days 0-0-2 X 2 days 0-0-1 X 2 days, then **STOP** 3. **B-Complex** tablet containing a high dose of THIAMINE(100mg/day) 0-0-1 for 3 months.	4. Tab. **BACLOFEN** 10mg, 0-0-1 X 1 day 1-0-1 X 1 day 1-1-1 X 1 day 1-1-2 (Continue) **OR** Tab. **TOPIRAMATE** 25mg, 0-0-1 X 2 days 1-0-1 X 2 days 1-0-2 X 2 days 2-0-2 (continue)	** Diazepam is meant only to control the first five days of alcohol withdrawal symptoms. Hence, Diazepam to be started only if withdrawal symptoms are present. The dosage schedule of Diazepam in serial no. 2 is for simple withdrawal symptoms. But first day dose of Diazepam for withdrawal seizure & DT are 50 mg & 60 mg respectively, then gradually taper & stop in 5 days.*
Counselling: Please refer to page 7 of this manual. **Follow up after 10 days.**	**The course of Rx with anti-craving medicines is 9 -12 months.**	

• **Rx for Tobacco Addiction**

Tab. **Bupropion** XL 150mg 1-0-0 X 5 days 2-0-0 (continue)	
Counselling: Please refer to page 7 of this manual.	**Treatment course is 4-6 months.**
Follow up once every 30 days.	

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DIPLOMA IN PRIMARY CARE PSYCHIATRY

(One-year, part-time, modular, digitally-driven, clinical course for MBBS doctors)

Tele-Medicine Centre, NIMHANS Digital Academy, Department of Psychiatry

National Institute of Mental Health and Neurosciences (NIMHANS), Bengaluru

Disclaimer: This diploma is approved in accordance with section 14(h) of NIMHANS Act 2012. This is a sponsorship based course. This diploma does not confer the title of a psychiatrist.

Aim of this clinical course is to integrate psychiatric care in general practice of primary care doctors (PCDs) using a training methodology that offers higher translational quotient (i.e., primarily direct skill transfer) due to incorporation of adult learning principles.

Objective is to empower the already serving primary care doctors (possessing MBBS degree) with skills necessary to identify and manage common psychiatric disorders presenting to primary care facilities. Tagline for the course: ***"Earn clinical diploma with learning from your live, real-time, clinic"***

SALIENT FEATURES: *It consists of the following modules*

1. Curriculum: Clinical Schedules for Primary Care Psychiatry (CSP), an adopted and validated manual for PCDs use (J Neurosci Rural Pract. 2019 Jul;10(3):483-488).

2. Clinical Modules:

a. On-site module: Brief (3-6 days) contact training sessions at NIMHANS or equivalent venue. This consists of consultation based training during the forenoons and classroom teaching during the afternoons

b. Virtual Classroom (VCR): This module is based on peer learning. This is an online CME / webinar-kind of virtual class (one hour/week) using multipoint videoconference technology. It consists of verified and vetted case conferences and seminars presented by PCDs in rotation as well as interactive sessions by experts on topic of primary care importance.

c. Point of care training modules

i) Telepsychiatric On-Consultation Training (Tele-OCT): A tele-psychiatrist trains PCDs during their real time consultations in clinics. Each training session goes on for 2 hours. Tele-Oct occurs three times at baseline, 3rd and 7th week covering about 40 general patients.

ii) Collaborative Video Consultations: It is a walk-in clinic for PCDs who can ask a tele-psychiatrist to provide consultations to their selected general patients. It is similar to 2nd opinion tele-clinic for PCDs.

3. Public Health Modules: Tele-psychiatrist encourages PCDs to design public education materials and to deliver public lectures/talk related to psychiatry.

Evaluation (Quality control): Each PCD will be evaluated throughout the course (1-year) by 10 formative assessment criteria. Only those PCDs who successfully complete these formative assessments are eligible for final/ exit exam. This exit exam will be conducted on-camera for both theory (multiple choice questions and short essay) and clinicals.

Contact:

Dr N Manjunatha, *MBBS, MD*
Additional Professor of Psychiatry,
Coordinator, Primary Care Psychiatry Program,
Tele Medicine Centre, Department of Psychiatry
National Institute of Mental Health and Neurosciences (NIMHANS), Bengaluru- 560029
E-mail: manjunatha.adc@gmail.com Phone: 080-2699 5859 / 5250