Primary Care Psychiatry: A Clinician's Companion

NIMHANS DIGITAL ACADEMY

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PREFACE

To achieve the aim of increasing the mental health of human resources, the NIMHANS Digital Academy was inaugurated by the Honorable Minister for Health and Family Welfare, Govt. of India, on 27th June, 2018. The NIMHANS Digital Academy (NDA) has helped to consolidate and expand the tele-activities initiated at NIMHANS throughout the country. This activity was approved as part of a larger mental health informatics initiative on 30th April, 2018. The NIMHANS Digital Academy was started following the objectives of the Institute in the NIMHANS Act 2012, Section 13. This is also by the National Mental Health Program.

The Diploma in Community Mental Health for Doctors was one of the courses that was started, and it aimed at increasing mental health resources by training doctors at the community level. To date, the course has run 40 batches and has enrolled 2093 doctors, equipping them with skills and knowledge to help them treat and give the first line of treatment for patients with psychiatric illness at the primary healthcare levels.

The content of this book has been curated from the feedback of all the doctors trained in the course and resource persons, and this curriculum has been approved by the NIMHANS Digital Academy Board of Studies (24/12/2018).

We are very hopeful that this manual will educate doctors and general practitioners and make them feel more confident in assessing and managing psychiatric illness at the primary healthcare level. This manual is designed to enhance theoretical and practical knowledge in primary care management (first line of treatment) of psychiatric disorders in the community. The manual deals with topics that help in **CARE** of patients with psychiatric illness at the primary health care level.

C- Case identification

A - Assessment and first-line management

R - Referral of severe and comorbid cases

E - Evaluation and follow-up of cases

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FOREWORD

As articulated by the World Health Organization, 'There is no health without mental health.' In our collective journey toward community well-being, mental health stands as both a cornerstone and compass. We recognize that optimal mental health extends beyond the mere absence of illness, weaving together genetics, personal well-being, relationships, and productivity. The National Mental Health Survey 2016 (NMHS) has revealed that 10.6% of people currently have a mental illness. At the same time, the treatment gap for these disorders has been estimated to range from 72% to as high as 91%. The National Drug Use Survey, 2019, estimates that about 2.9 crore persons have alcohol dependence and 25 and 28 lakh persons respectively have dependent use of cannabis and opioids. This is of serious concern, as delayed recognition and treatment leads to an increase in morbidity and disability. This, in turn, is very detrimental to the family and the community and, in the long term, to the nation.

Hence, the urgent need of the hour is to strengthen human resources to provide accessible and appropriate mental healthcare for all in the community. It is with this objective that NIMHANS Digital Academy is making efforts to upskill primary care doctors, who are the first line in the community, to identify and manage these disorders in a stepped-care model.

I hope this manual will serve as a handy guide for primary care doctors and will be a vital step in the integration of mental health care into primary health care in the country as per the National Mental Health Program.

Prof. Pratima Murthy
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ACKNOWLEDGEMENTS

We extend our deepest appreciation to the individuals whose unwavering commitment and expertise have played a pivotal role in the creation and enhancement of our manual. Their contributions have been indispensable, shaping the manual into a valuable resource for primary care doctors.

First and foremost, our sincere gratitude goes to Dr. Pratima Murthy, Director of NIMHANS, for her invaluable guidance throughout the manual development process. Dr. Murthy's expertise and insights have been instrumental in refining the content, ensuring its relevance and efficacy.

We express our gratitude to primary care doctors, namely Dr. Ashish Pundhir, Dr. Deepali Goel, and Dr. Rini Raveendran, for their significant contributions following the completion of the Diploma in Community Mental Health for doctors offered by NIMHANS Digital Academy. Their thorough reviews have been instrumental in enhancing the quality of our work.

The staff and faculty of the NIMHANS Digital Academy deserve our sincere thanks for their unwavering support and cooperation throughout the manual creation process.

We extend our sincere appreciation to Dr Hetashri Shah, Dr Gajanana Sabhahit, Ms Gauri Mullerpattan, Ms Sahana Nujella and Ms Nishtha Bawa, who graciously provided their consent for the inclusion of their photographs in this manual. Your willingness to contribute has enriched the visual content and overall quality of this resource. We thank you for your invaluable support.

A special mention goes to Ms. Gauri Mullerpattan and Ms. Sahana Nujella for their photography, enhancing the visual appeal of the manual. Additionally, our appreciation extends to Dr Hetashri Shah, Dr Chandana Sabbella, Ms Gauri Mullerpattan, and Ms Sahana Nujella for their valuable contributions and support in creating the graphic content.

Ms. Harsha, the graphic designer, deserves special recognition for her outstanding work on the cover page design and layout. Her artistic skills have brought the manual to life.

To all contributors, whether esteemed professionals or dedicated primary care doctors, we extend our heartfelt gratitude for their time, effort, and expertise. Their collective contributions have elevated the guide to meet the highest standards of comprehensiveness and practicality. We are truly thankful for their dedication to advancing mental health support in the community, and we are confident that this guide will serve as an invaluable resource for doctors in their essential work within primary care.

ABOUT THE MANUAL

How was the Manual developed?

At NIMHANS, based on our experiences, we have found the hybrid mode to be the most valuable and effective way of training doctors. We have good experience using this mode in training mental health professionals in the states of Karnataka, Odisha, Haryana, Uttarakhand, Bihar, and Chhattisgarh via projects like Chhattisgarh Community Mental Healthcare Tele-Mentoring Program (ChaMP), Tele-mentoring For Rural Health Organisers of Chhattisgarh (TORENT), and Karnataka Telemedicine Mentoring and Monitoring Program (KTM). This training was done in batches, with each batch trained over 3-6 months. To aid, the courses have run 40 batches and enrolled 2093 doctors, equipping them with skills and knowledge to help them treat and give the first line of treatment for patients with psychiatric illness at the primary health care levels. Previous DMHP training of primary care doctors was 3 to 5 days of in-person training per year. This method failed as there was no handholding of primary care doctors in treating, prescribing and follow-up of psychiatric disorders. Most of the patients require treatment for many months to years. Hence, it is prudent to handhold the primary care doctors in treating patients at the primary care level, both through online and in-person training. This manual stems from the vast experience in training and handholding primary care doctors and has been enriched by feedback from both primary care doctors and experts in the field of mental health.

Who can use the manual?

The manual can be used directly by all primary care doctors across the country to provide the first line of treatment. This manual should be used along with the Clinical Schedule for Primary Care Psychiatry (CSP).

This manual is prepared to be used by DMHP psychiatrists to train primary care doctors.

The treatment mentioned is based on the medication availability at the primary health care level.

How to use the manual?

This manual should be used along with online training (synchronous and asynchronous training), completion of assignments and handholding of primary care doctors. If the users of this manual, i.e., primary health care doctors, doubt the diagnosis, treatment, follow-up, or any other issues, they should immediately contact their supervisor/trainer/DMHP psychiatrist. This manual should be used under the supervision of a DMHP psychiatrist/qualified psychiatrist for training primary care doctors in hybrid mode (online and in-person).

This manual can be freely used for educational purposes and not for any commercial purposes. While using it for educational purposes, kindly give credits to the NIMHANS Digital Academy.

People who want to get certified in the Diploma in Community Mental Health course can contact NIMHANS Digital Academy.

All the chapters in the manual are linked with respective video QR codes for online asynchronous learning.

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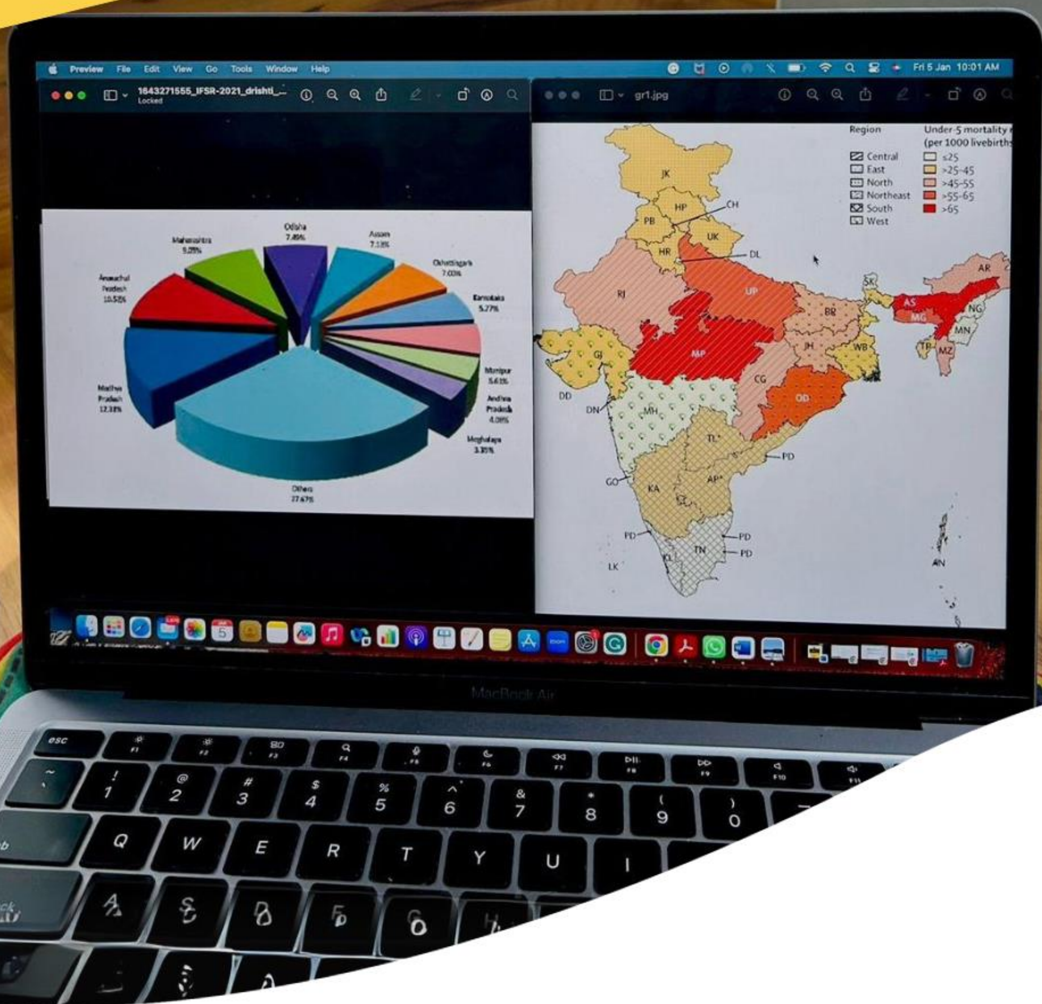
1 | EPIDEMIOLOGY AND TREATMENT GAP OF PSYCHIATRIC DISORDERS IN PRIMARY HEALTH CARE AND GENERAL POPULATION



Chapter 1.1: Epidemiology of Psychiatric Disorders in Primary and General Healthcare Settings

Health is a state of complete physical, mental, and social well-being and not merely an absence of disease. There is no health without mental health, and most of the epidemiological studies have shown that psychiatric disorders are quite common. Epidemiology of psychiatric disorders helps in understanding the magnitude of psychiatric disorders and their risk factors and in planning interventions in the community. This chapter will address the epidemiology of psychiatric disorders within primary and general healthcare settings.

What is Primary Care?

As per the World Health Organisation (WHO), primary healthcare is a whole-of-society approach to health and well-being centred on the needs and preferences of individuals, families, and communities.

Pathway to Psychiatric Care in India:

Pathway to care for mental health issues in India is traditionally different than the higher income countries, as shown in the figure below.

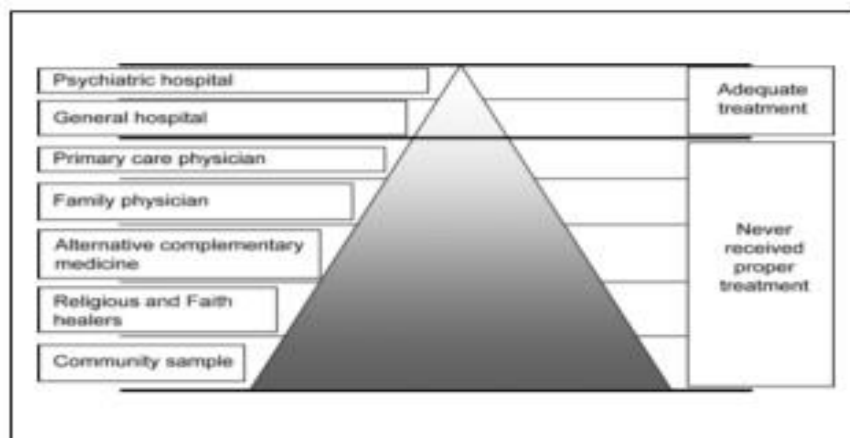


Figure 1: Pathways to mental health care pyramid in developing countries

(Math SB, et al. 2010)

India also faces a scarcity of human resources, with around 8000-9000 psychiatrists, as well as a scarcity of infrastructure, which is primarily reflected by the considerable treatment gap that has been reported by National Mental Health Survey (NMHS) 2016, i.e., 85% for common mental disorders and 73.6% for severe mental illnesses. As per the NMHS 2016, the prevalence of any psychiatric disorder is 10%, which means almost 14 crores of the population require mental health services.

The lack of adequate training in the MBBS curriculum makes it imperative to address this issue by training Primary Care Doctors (PCD) in providing mental healthcare.

Salient takeaway points from some selected studies on the burden of psychiatric illnesses:

1. Most studies indicate a high prevalence of common mental disorders. Around 30%-40% of patients visiting primary care settings have psychiatric disorders, with depression being the most common psychiatric condition.

Disorders	Prevalence in General Population	Prevalence in Primary Health Care
Overall	13.7%	47.5%
Common Mental Disorders	5.1%	35.2%
Severe Mental Disorders	1.4%	2.6%
Substance Use Disorders	22.4%	9.5%

2. People with psychiatric disorders may experience a reduction of 10-15 years in their Quality adjusted life-year (QALY), indicating that these conditions significantly affect the quality of life. On the other hand, the measure of Disability Adjusted life-year (DALY) considers both premature mortality and years lived with disability due to psychiatric disorders. It shows that individuals with psychiatric disorders may experience premature mortality, which means they tend to die about 10 years earlier than those in the general population. Additionally, they also live with a substantial burden of disability.

3. Help-seeking behaviour was noted in the Primary Health Care settings, predominantly for symptoms of pain such as multiple body aches, headache, and medically unexplained pain.

4. In addition to this, there has been a rampant increase in the use of substances. The following table gives the burden of SUDs that need medical attention.

The burden of substance use (magnitude of substance use in India, 2019)

Substance use	Prevalence of Dependence
Alcohol	2.9 crore (2.7%)
Cannabis	25 lakh (0.25%)
Opioids	28 lakh (0.26%)

According to the Global Adult Tobacco Survey (GATS) conducted in 2016–17, 28.6% currently consume tobacco, either in a smoked or smokeless form.

5. Another pressing concern within the realm of mental health is the alarming issue of suicide. In 2021, the country reported a staggering 1.64 lakh suicides. According to the WHO, daily, there are approximately 450 suicide deaths, and for every suicide death, there are an estimated 20 attempted suicides, highlighting the gravity of the situation.

6. Moreover, according to the National Mental Health Statistics (NMHS, 2016), the prevalence of psychiatric disorders is estimated to be approximately 10%. This suggests that in a region covered by a single primary health centre serving a population of 30,000 individuals, at least 3,000 people may be affected by psychiatric disorders.

Emphasizing the shift of mental health treatment to primary healthcare centres is crucial due to the potential to address these issues early, preventing an escalation of health conditions. This approach not only reduces stigma but also offers cost-effective, community-centred screening and intervention, promoting holistic care.

Conclusion

The presentation of patients with psychiatric disorders in primary health care varies significantly from what can be seen in urban/mental asylum setups. There's a complex interplay of physical symptoms and psychological underpinnings with various social aspects of patients.

It's also quite evident that the current workforce is quite under-equipped and undertrained in identifying and treating/referring a case with a psychiatric diagnosis, which contributes to the enormous treatment gaps that have been quoted.

This underlines the need for strengthening current mental health programs with customized training for primary care doctors in mental disorders, top-down drive with adequate and appropriate use of technology required for the various programs to reach the grassroots.

Through training, a doctor at the Primary healthcare centre should be able to do the following:

C- Case identification of mental health disorders like Anxiety disorders, Depressive Disorders, Alcohol Use Disorders, Nicotine Use Disorders, and Psychotic Disorders.

A-Assessment and provision of the first line of treatment and low-intensity psychological interventions for Depressive Disorders, Anxiety Disorders, Alcohol Use Disorders, and Nicotine Use Disorders.

R-Referral of patients to mental health institutions or psychiatrists when required.

E-Evaluation of follow-up of the case at the primary health care level.

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To gain a comprehensive understanding of primary care psychiatry, scan the QR code or click on the topic provided for access to a concise and informative video presentation on the subject.

Primary Care Psychiatry

Chapter 1.2 Treatment Gap in Psychiatric Disorders:

The treatment gap is the difference between how many people need help for mental health problems and how many receive that help. Failure to address these mental health disorders in their early stages can lead to their exacerbation and increased complexity, rendering them more challenging to treat.

According to NMHS 2016, there is a huge treatment gap for psychiatric conditions in the country, as shown below:

- Mental Health Problems (84.5%)
  - Common Mental Disorders (85.0%)
    - Neurotic Disorders (84.0%)
    - Major Depressive Disorders (85.2%)
  - Severe Mental Disorders (73.6%)
    - Bipolar Affective Disorders (70.4%)
    - Schizophrenia and Other Psychotic Disorders (75.5%)

- Substance Use Disorders (91.1%)
  - Alcohol Use Disorders (86.3%)
  - Tobacco Use Disorders (91.8%)
  - Other Substance Use Disorders (72.9%)

The reasons for this high treatment gap are as follows:

1. Lack of awareness about mental health problems
2. Stigma
3. Limited access to mental healthcare
4. Limited availability of medications
5. Irregular supply of medicines
6. Lack of adequate psychiatry training in the MBBS curriculum
7. Socio-cultural beliefs
8. Increased out-of-pocket expenditure for mental healthcare

To decrease the gap, all the above issues need to be addressed at the individual, community, and policy levels. To begin with, all the Primary Care Doctors who undergo training need to sensitize pharmacists, social workers, religious leaders, faith healers, farmers, and other significant members of the community.

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2| ASSESSMENT IN PSYCHIATRY

Chapter 2.1: History and Mental Status Examination

Introduction

History-taking is the most crucial part of a psychiatric examination. It is the gold standard for evaluation. There is no blood, laboratory, or radiological investigation that can diagnose a psychiatric disorder definitively. The sole method for diagnosing psychiatric conditions is through obtaining a patient's history, general physical examination, and mental status examination. Hence, it is essential to take a detailed and comprehensive history.

It is crucial to note that the history that is collected must be kept private and confidential, the reason being that most psychiatric disorders have a stigma attached to them.

History Taking in Psychiatry

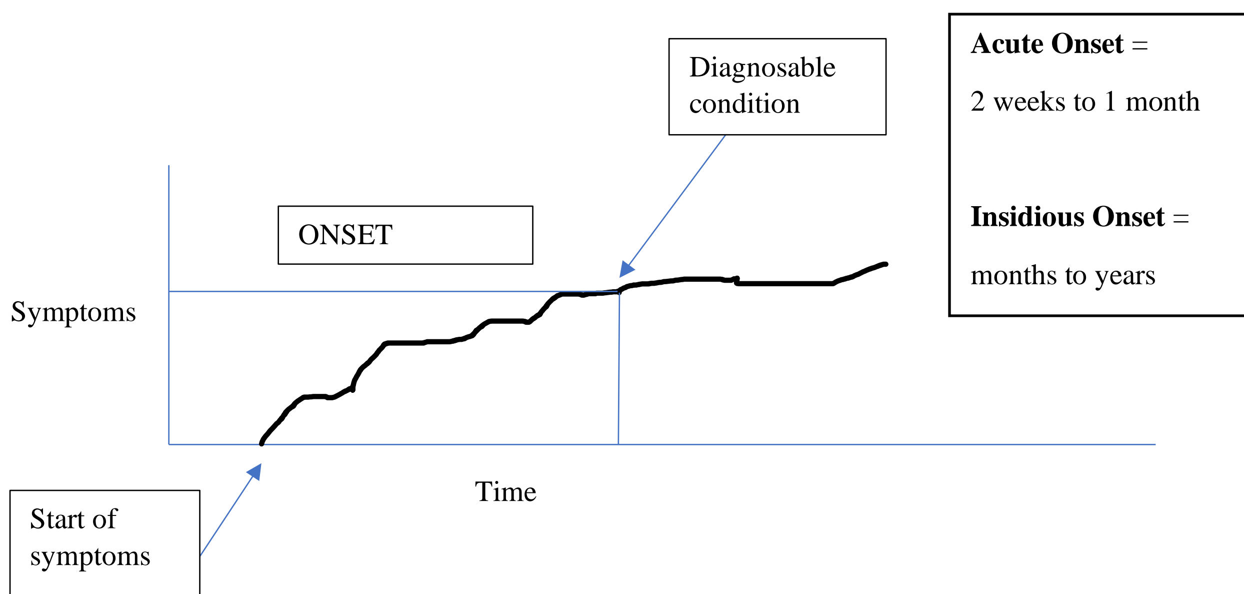
The information can be collated from many sources such as the patient, their family, friends, school, workplace and any medical records or documents. This is because with more sources, the information becomes more complete, and the diagnosis gets more accurate.

Kindly follow the below-mentioned steps to obtain a good history –

1) Demographic Details – Name, age, gender, occupation, education, socio-economic status, marital status, address, and mobile number should be collected. This is especially important for identification purposes, and it also serves to develop a good rapport with the patient.

2) Chief Complaints – It is a record of why the patient has come to the clinic. It should be in the patient's own words without technical terms. Complaints should be noted chronologically and cover only the most essential complaints, for example – poor sleep, low mood and fearfulness.

3) Onset – Duration from the start of symptoms to the point when the condition was diagnosed.



4) Course

It indicates the progression of illness.

- **Episodic Illness -**This is the course of illness where discrete episodes are seen with complete recovery between the episodes. To call it an episodic illness, the period of normalcy should be at least 2 months.
- **Chronic Illness** - This is a continuous illness with no period of normalcy after the onset of the illness.

5) History of Presenting Illness (HOPI)

This must be presented in chronological order.

In the context of HOPI (History of Present Illness), it is essential to provide a detailed description of each symptom. To do so, you can categorize each symptom using the following aspects:

- Duration
- Context
- Frequency
- Increasing Factors
- Decreasing Factors
- Progression of Symptom
- Outcome of Symptom

In all patients, it is essential to enquire about the risk of harm to self, risk of harm to others, and inability to take care of themselves.

Finally, associated impairment in the following needs to be investigated-

- Biological functions – sleep, appetite, hygiene, bowel & bladder function
- Occupational function
- Social function

The doctor should also check for any legal, financial, or family issues.

6) Negative History

It is essential to rule out any organicity (as mentioned in the red flag signs in the table below), chronic illness, medication intake, substance use, other mood, anxiety, or psychotic symptoms.

7) Medical History

Here, inquiries should be made about past or present medical illnesses, medication intake, allergies and other chronic medical conditions.

8) Past History

It is essential to enquire about any past psychiatric illness and, if present, what were the number of episodes, what treatment was sought, what was the response to treatment, and the duration of treatment.

9) Family History

Any history of medical or psychiatric illness in the family should be enquired about. The family's understanding of illness and attitude towards the patient should also be assessed. Enquiry about the primary caregiver (the person who provides care to the patient) should also be done, so that he/she can be involved in treatment.

10) Personal History

This consists of enquiring about any abnormal behavior in childhood, academic performance during school & college, substance use history, marital history, menstrual history in females and occupational history.

11) General Physical Examination

This consists of assessing -

◉ Nutrition/ Build/Height/Weight/Body Mass Index

◉ Vitals (Pulse, BP, RR, Temp)

◉ PICCLE – Pallor, Icterus, Cyanosis, Clubbing, Lymphadenopathy, Edema

◉ Respiratory System

◉ Cardiovascular System Examination

◉ Abdominal Examination

◉ CNS Examination

Red Flag Signs of Organicity

- **Onset after the age of 40**
- **Urinary incontinence**
- **Bowel incontinence**
- **Gait disturbances**
- **Disorientation**
- **Any focal neurological signs**
- **Seizures**

Any of the above will almost always point towards an organic cause!

How to do a Follow-Up?

While treating patients with psychiatric disorders, it is the duty of the primary care doctor to follow up with the patient regularly. This is because psychiatric disorders are generally chronic conditions and thus require long-term care. The patient should be followed up at least once a month (can be followed up weekly or fortnightly if required). At each follow-up, enquiry should be made about – the percentage of improvement in the patient's condition, any side effects of the medicine, and any risk of danger to self or others. For further details, kindly refer to the section on Clinical Schedules in Psychiatry (CSP) (Page no. 8)

It is prudent to send the patient for review to a psychiatrist every 6 months.

Mental Status Examination

A mental status examination is an essential tool that aids physicians in making psychiatric diagnoses. It is analogous to the physical exam in general medicine. It's crucial for fully understanding the patient and making a diagnosis.

Procedure

It is a series of observations and examinations at one point in time. The mental status examination includes a historic report from the patient (past one month) and observational data gathered by the physician throughout the patient interview. Also, additional information can be taken from patients' attendees and previous file records.

The patient's appearance, behaviour, speech, thought, mood, perception, and cognitive functions are systematically studied.

Components

1) General appearance and behaviour – It is a general observation of how the patient appears throughout the interview and how they behave towards the clinician.

2)Psychomotor activity – Psychomotor activity is defined as motor/physical activity that is secondary to or dependent on a psychic component and is mostly non-goal-directed. Psychomotor activity can be increased in conditions like mania or decreased in conditions like depression and must be noted as such.

3) Speech – This can be assessed by asking the patient to give a speech sample by asking an open-ended question and writing down the patients verbatim. (example – "tell me about your favourite movie"). The clinician can then comment on whether speech is normal or abnormal in terms of amount and content.

4) Thought – The following are important abnormalities in thought-

- **Delusions** – these are false fixed beliefs that have an unexplainable origin and are beyond the patient's socio-cultural background.
- **Depressive cognitions** – these include the patient expressing thoughts that there is no hope for them in the future (hopelessness), that they are a person who is 'useless' and has no value (worthlessness), that no person can help them out of their current situation (helplessness).
- **Suicidal ideas/death wishes** – these should be described in terms of the intensity & frequency of these thoughts, any plan for attempting suicide that the patient might have made, and any help the patient has sought. It also includes any attempts done in the past month (kindly refer to a psychiatrist if present).

5) Mood – Continuous and sustained emotion colours the perception of the external world. It is commented on subjectively by the patient as sad, anxious, tense, happy, etc., and objectively judged by the clinician as 'affect' being euthymic(normal), dysphoric(sad), or anxious.

6) Perception – Perceptual abnormalities like hallucinations are described here. Hallucinations are perceptions without any external stimuli. These can be of the following types- auditory, visual, tactile, gustatory, or olfactory. While describing hallucinations, the experience of the patient should be recorded verbatim. An important distinction is that hallucinations should be present only when the patient is awake and is in clear consciousness.

7) Cognitive Functions – A brief cognitive function test can be done. The patient's orientation can be checked by asking them the current time, which place they are in, and the identification of people accompanying them. Attention and concentration can be tested by asking the patient to tell the days of the week backwards, the months of the year backwards, or count back from 20 to 1.

Assessment of memory includes recent memory, which can be assessed by asking the patient to recall what they had for their last meal or how they came to the hospital today, as well as remote memory, which can be tested by asking the patient the year of their birth and other such autobiographical information. Finally, insight of the person into the illness, i.e., awareness of having an illness, can be commented on as present, partially present, or absent.

Take Home message:

Taking a thorough patient history, general physical examination and mental status examination are the most important aspects of a psychiatric evaluation. It's the primary way to diagnose psychiatric disorders because there are no blood tests or other investigations for it. Hence, a detailed history is essential.

Scan the QR code/Click on the topic below to learn more about clinical assessment in Psychiatry:

Clinical Assessment in Psychiatry (CSP)

Chapter 2.2: Clinical Schedules for Primary Care Psychiatry (CSP)

As the presentation of psychiatric illnesses is high in the community, and there is limited time and resources for doctors in primary care settings, the National Institute of Mental Health and Neuro Sciences (NIMHANS) has developed the Clinical Services Program (CSP) manual. It is a validated, all-in-one,12-page manual that covers the identification, diagnosis, and first-line management of psychiatric disorders in general practice.

The manual can be used in 5 minutes in busy practice of the Outpatient Department (OPD) for adult patients.

The illnesses covered under the CSP are the most common psychiatric illnesses – (TAPSAD)

T – Tobacco Use Disorders

A – Alcohol Use Disorders

P - Psychosis

P – Panic Disorder

S – Somatisation Disorder

A – Anxiety Disorder

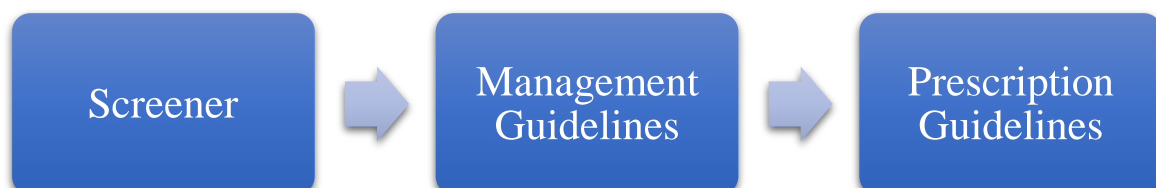
D – Depressive Disorder

A high index of suspicion must be kept for patients who are on analgesics, multivitamins, benzodiazepines, and those with vague or unusual symptoms, and the CSP must be used proactively for them.

When to Refer the Patient?

- When they become dangerous to self or others
- When you observe worsening of symptoms or no improvement after 4 weeks
- When the patient experiences unmanageable side effects of medicines

Primary Care Taxonomy



1) Screener/Case Record Form

This has demographic details and the guiding path. The guiding path states that if the symptoms and physical examination do not point towards a known medical illness and the symptoms have been present for more than two weeks, then the 21-item General Screening Questionnaire is to be used. The first three questions are general inquiries about sleep, appetite, and interest in daily work. The subsequent questions are specific to seven specific psychiatric disorders. These questions cover the patient's family's reports and the doctor's clinical judgment. The last question is related to psychiatric emergencies, and psychological first aid must be given to the patient, who should then be immediately referred. Behavioural observation must also be documented here, which refers to the patient's behaviour towards the doctor and their family members during the interview. Finally, this section contains a box with the diagnosis and further treatment plan.

2) Management Guidelines

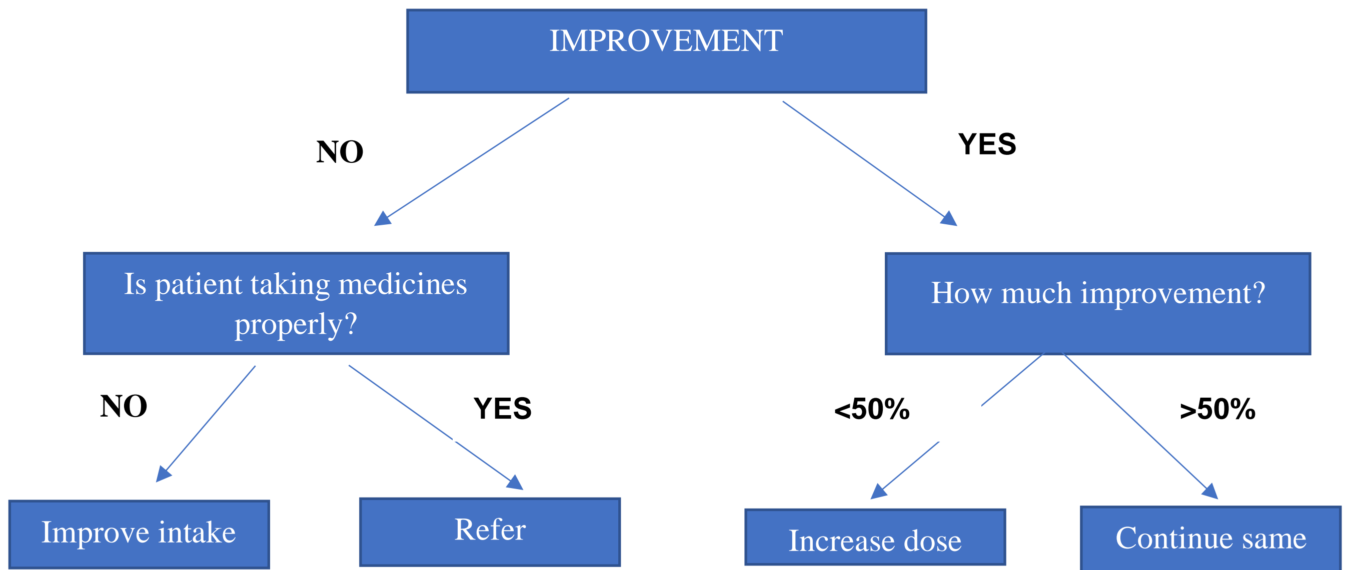
This includes -

Diagnostic Guidelines – The CSP manual includes diagnostic criteria for all seven disorders mentioned earlier. If a patient shows positive symptoms on the screener, these diagnostic guidelines can be used to make a diagnosis.

Investigation Guidelines - There are no diagnostic tests for psychiatric disorders. The investigations aim to rule out medical conditions or monitor the side effects of medicines.

Treatment Guidelines - The manual provides general treatment guidelines for each condition, including guidelines for counselling. Counselling should be brief and cover the medical nature of the illness, the need for medication, follow-up, and a healthy lifestyle. Specific drugs and their doses are also provided. Additionally, there is a section on managing side effects. For patients with comorbid medical conditions, the manual advises avoiding polypharmacy and to "begin low, go slow," meaning starting with the lowest possible dose.

Follow-up Guidelines – The first follow-up (2 weeks) is used to assess side effects, while subsequent follow-ups (4 weeks and onward) are used to evaluate the effectiveness of the treatment.



3) Prescription Modules

This contains the prescription for each disorder, including the medicines and the doses. It also mentions counselling and follow-up guidelines.

When should a Neurology referral be made:

- Disorientation
- Seizures
- Urinary & Bowel incontinence
- Gait disturbances
- Focal neurologic deficits

Scan the QR code/ click on the topic to get more information on the method of using the Clinical Schedules for Primary Care Psychiatry:

Clinical Schedules for Primary Care Psychiatry (CSP)

Chapter 2.3: Communication and Counselling Skills

Counselling involves a professional relationship that helps individuals, families, and groups achieve mental health, wellness, education, and career goals. The aim of counselling is empowering patients to find solutions and develop the skills to solve their problems. Communication skills are at the core of counselling. The two essential elements of effective communication skills are rapport and empathy.

Rapport is a harmonious and accordant relationship between the patient and the healthcare provider, characterized by trust, empathy, and mutual responsiveness.

Empathy is the ability to share the psychological and emotional state of another person as if you were able to sense their private world. It includes being non-judgemental and trying to see the world from other's perspectives. Understanding the patient's emotions, behaviour, and thoughts and responding to them in a way that they feel like the doctor has comprehended their issue is what empathy is all about in a clinical setting.

An empathetic person possesses certain qualities, such as:

1. Open-mindedness: To comprehend other people's emotions, one must set aside one's own opinions, biases, and attitudes.
2. Imagination: Ability to picture the circumstances, ideas, and feelings of others.
3. Commitment: Striving to comprehend the feelings and thoughts of others.
4. Understanding and accepting of oneself: Empathy for others can be developed by understanding one's own beliefs and values.

Being sympathetic only addresses the patient's emotions and feelings, whereas empathy enables the counsellor to comprehend the client's thoughts and point of view. The differences between the two are elucidated below:

Aspect	Empathy	Sympathy
Emotional Connection	Establish a deep emotional connection with the patient by putting oneself in their shoes, attempting to feel what they feel.	Acknowledges the patient's emotions without necessarily experiencing them personally; focuses on offering comfort and support.
Focus	Centers on the patient's experience, emotions, and perspective, aiming to validate their feelings and provide understanding.	Centers on the doctor's feelings and desire to alleviate the patient's suffering may not fully grasp the patient's experience.
Non-judgemental Attitude	Maintaining a non-judgmental and non-critical stance allows the patient to express themselves freely without fear of judgment.	It may unintentionally convey a sense of pity or condescension, which can be perceived as judgmental.

Active Listening	Actively listens to patients, validates their emotions, and responds with reflective statements or open-ended questions.	It tends to offer reassurance, sympathy, and solutions rather than active listening and understanding.
Communication Style	Uses phrases like "I can see how you might be feeling" or "I understand this must be difficult for you" to reflect the patient's emotions.	Uses phrases like "I'm sorry you're going through this" or "I feel bad for you" to express sympathy and compassion.

Skills for communication include:

1. Active listening
2. Verbal and non-verbal communication
3. Attending
4. Responding
5. Paraphrasing and
6. Summarizing

Active Listening

Active listening involves techniques to make the person being listened to feel heard and understood. The four essential rules of active listening are:

1. To seek to understand before seeking to be understood
2. Be non-judgmental
3. Give undivided attention to the speaker
4. Use silence effectively

Differences between active and passive listening:

- When someone listens passively, they merely hear what the speaker says and do not give any feedback.
- Receiving, interpreting, and responding to the speaker's message are all parts of listening.

Components	Active Listening	Passive Listening
Receiving	+	+
Interpreting	+	-
Responding	+	-
Effective Communication	+	-

Verbal Communication

It includes:

- Speaking in a language that the client can understand
- Repeating the client's narrative in different words, clarifying the client's statements

- Effectively explaining, summarizing, and addressing the main message
- Using encouraging phrases
- Providing appropriate information for the client's age

Open-ended questions are essential for verbal communication, as they allow the client to explain themselves in detail and understand their problems better. Examples of **open-ended questions** include:

"How can I help you?" & "Tell me more about it,"

Open-ended questions are important because they encourage the person being questioned to pause, consider, and reflect on their thoughts, feelings, and opinions. They also give the person control of the conversation rather than the person asking the questions.

Nonverbal Communication

It includes all aspects of communication that are not represented through words, such as

- Facial expressions
- Gestures
- The tone of voice and
- Body language.

It is essential to be aware of nonverbal communication and use it appropriately to build trust and rapport with patients.

Nonverbal communication also includes silence, which can be a powerful tool in communication. Silence can be used to allow emotional responses, express suppressed emotions, and create a sense of comfort in the counselling session.

Responding

Responding and reflecting are also crucial for communication and should be used at the right time, such as when the client raises a concern or is unsure about something that was said.

However, responding should be avoided when the client or counsellor is tired, stressed, or anxious. Reflective feelings, reflecting meanings, and probing are different types of responding and reflection.

- Reflective feelings involve reflecting the client's feelings back to the client.
- Reflecting meanings involves clarifying the client's statements
- Probing involves asking for more details in a non-judgmental way

Paraphrasing

Paraphrasing is a way to demonstrate understanding and can be used to reinforce, clarify, highlight, or double-check the information.

When to use it?

- When you have a hypothesis regarding the client's condition

- When there is a conflict in the client's decision-making
- When the client has given you a lot of information, and you are perplexed

There are four steps in effective paraphrasing:

- Listen and recall
- Determine the message's content
- Rephrase the client's key phrases and concepts
- Perception check is usually a brief question, e.g., "It sounds like..."; "Let me see if I understand this."

Summarizing

Summarizing is a way to make feelings more understandable, connect the client's message components, assess progress, and set the pace of a session.

Purpose of Summarizing

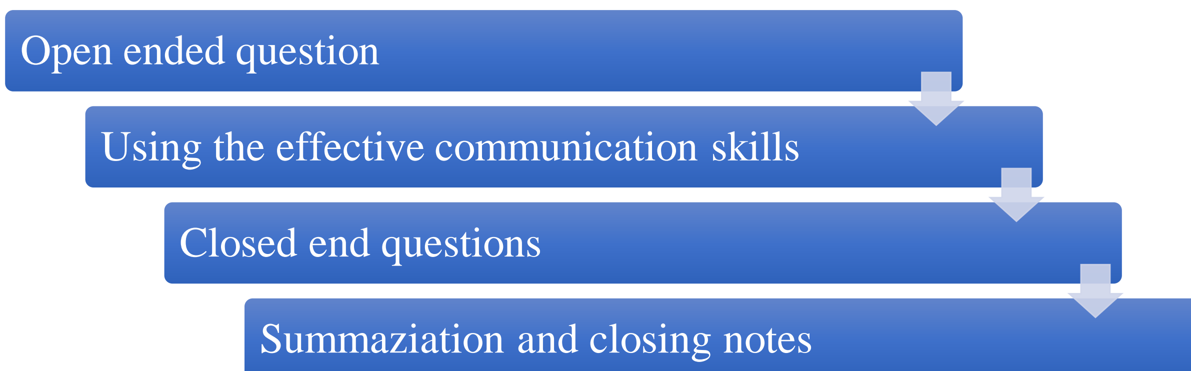
- To make feelings more understandable for the client and the helper/counsellor.
- To connect several client message components.
- To assess the work that has been done thus far.
- To conclude a meeting by tying together the key points of the conversation.
- A session's conclusion.

Displaying Communication Skills- How to Show Empathy:

Skills	Instruction	Example
Active Listening	Pay full attention to the person speaking, maintain eye contact, and avoid interrupting. Show that you are genuinely interested in what they have to say.	*"I can see you're feeling upset. Please take your time and share what is bothering you."*
Non-verbal Communication	Use open body language, maintain a warm and approachable demeanour, and employ appropriate facial expressions and gestures to convey empathy.	• Maintaining good eye-to-eye contact during the conversation • Nodding frequent • Offering a genuine smile
Reflective Listening	Repeat what the person said in your own words to show that you've understood their feelings and thoughts.	*"It sounds like your workload has been overwhelming and is taking a toll on you, right?"*

Asking open-ended questions	Encourage the person to share more about their experiences and emotions by asking questions that cannot be answered with a simple "yes" or "no."	*"Tell me more about what's been on your mind lately."*
Cultural Sensitivity	Be aware of cultural differences and demonstrate respect for diverse beliefs and practices.	*"I want to make sure we respect your cultural values. Can you tell me if there are any specific beliefs or preferences we should consider in your care?"*
Shared Decision-Making	Involve the person in decisions related to their care or situation. Explain options, risks, and benefits clearly.	*"Let's discuss your treatment options together. Your input is important in making the right choice for you."*
Emotional Support	Offer comfort and reassurance, and connect the person with additional support, such as counselling or support groups.	*"I'm here to offer emotional support. Please don't hesitate to reach out if you need someone to talk to or have questions."*
Self-Care	Ensure you take care of your well-being to prevent burnout and maintain the capacity for empathy.	• Taking regular breaks away from work • Having defined working hours • Seeking psychosocial support for oneself where necessary

COURSE OF CLINICAL INTERVIEW



Behaviours to be Avoided in Counselling

In counselling, it is vital to avoid certain behaviours that can be unhelpful to the client.

- Advice-giving should be avoided if the problem has not been fully understood or the patient is not ready to listen. However, in a crisis, advice can be used more liberally.
- Lecturing and preaching should also be avoided as they can create a power struggle between the patient and the doctor.
- Excessive questioning should be avoided, and verbal interactions should include statements, observations, encouragement and questions.
- Other non-helpful behaviours to avoid include being dismissive, blaming, interrupting, storytelling, and yawning.

These behaviours can create communication barriers and can impede the effectiveness of the counselling session.

Primary care doctors need to have good communication and counselling skills to help patients with their mental health issues effectively. By understanding and utilizing empathy, rapport, and various communication techniques, doctors can build trust and effective relationships with their patients and empower them to find solutions and improve their mental health.

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Scan the QR code/ click on the topic to watch a video on Communication skills:

Communication skills

3| DEPRESSIVE DISORDERS

Chapter 3.1 Classification and Assessment of Depressive Disorders

Depressive disorders are a common and leading cause of disability worldwide. These disorders are characterized by a persistently low mood, loss of interest in pleasurable activities, easy fatiguability and other behavioural symptoms. These symptoms usually last for at least two weeks to months. Depression is different from normal sadness which occurs in day-to-day life, both qualitatively and quantitatively. Normal sadness is brief and short-lasting whereas depression is long-lasting.

This chapter aims to provide primary care doctors with a basic understanding of the assessment and classification of depressive disorders.

Diagnosing depressive disorders in the primary care settings:

Cardinal features of depression:

- Feeling sad/low for most of the time in a day and all settings (home, work/school/ in social settings)
- Loss of interest or pleasure in most activities (particularly in previously enjoyable activities)
- Tiredness most of the day in a week
- Irritability or restlessness
- Death wishes / Suicidal ideas
- Early morning awakening
- Changes in appetite and weight.

These symptoms must be present for most days for at least two weeks.

The following things must be kept in mind while assessing for depression:

- These symptoms must be pervasive for at least 2 weeks, i.e., they should be present for most of the time. It should not be transient.

- Co-morbid chronic medical conditions must to be assessed while assessing for depression.

Classification of Depressive Disorders:

Depressive disorders can be classified into several types, including:

- **Single-episode depressive disorder**
    - Depressive episode occurring for the first time or one single episode of depression in the person's lifetime.
- **Recurrent depressive disorder**

  - This is characterized by a history of two or more depressive episodes separated by at least several months without significant mood disturbance.
- **Dysthymic disorder/Chronic low depression**
  - This is characterized by persistent low mood, lasting at least two years.

Epidemiology in the primary care settings:

"In primary healthcare settings in India, approximately 14 -20 out of every 100 people experience depression, as revealed by a study."

Normal sadness can be easily mistaken for depression. However, the following points can help to differentiate them**:**

Sadness	Depression
Normal human emotion which is contextual/temporary	Abnormal emotional state
Often, the temporary response to a specific event/trigger	Often persists for weeks to months and is not solely linked to trigger
Usually, it doesn't impair daily functioning.	Significant decline in a person's ability to function

Another condition which is commonly misdiagnosed as depression is grief. Grief is the normal response to the loss of a loved one.

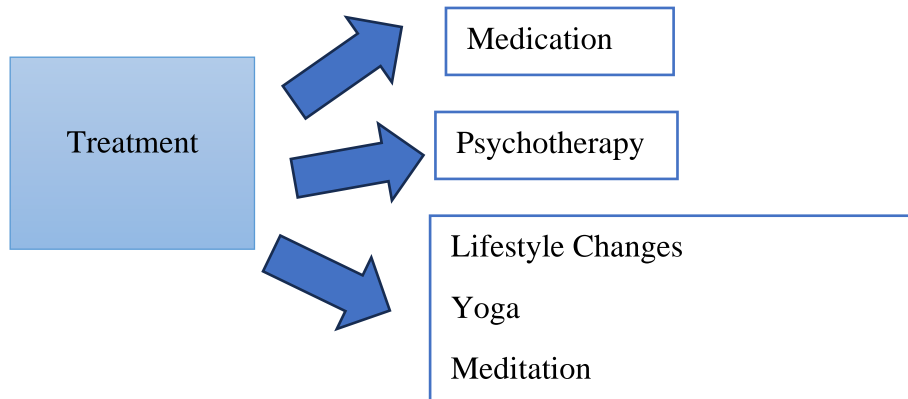
Grief	Depression
It tends to come in waves	Continuous sadness
Triggered by the reminders of their loss	Not solely linked to a trigger
Mixed with moments of positivity	Negative thoughts and emotions
Not significantly impact a person's self-esteem	Low self-esteem

When to Refer (Red Flag Signs):

- Recent suicide attempt
- Voicing out of suicidal thoughts, ideas or plans
- Severe agitation
- Risk of harm to others
- Unable to take care of themselves
- No response to treatment after 4 weeks
- Special population e.g., pregnancy, elderly, children

Management and Follow-Up

After the initial assessment and diagnosis, primary care doctors should provide appropriate treatment options and follow-up care.



Medications commonly used to treat depressive disorders include selective serotonin reuptake inhibitors (SSRIs), serotonin and norepinephrine reuptake inhibitors (SNRIs), and tricyclic antidepressants. In addition, primary care doctors should provide support and education to the patient and their family and monitor their progress over time.

Take home points

1. Depressive disorders are widespread and lead to personal distress and social-occupational issues.
2. Primary care physicians are crucial in detecting and addressing these disorders.
3. Treatment typically includes medication, psychotherapy, and lifestyle adjustments.
4. Consistent follow-up and progress monitoring are essential components of care.

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Scan the QR code/ click on the topic to learn more about Depression.

Depression

Chapter 3.2 Chronic Medical Conditions Associated with Depression

Depression is a common co-occurring disorder in patients with chronic medical conditions. It can be challenging for primary care doctors to distinguish between symptoms caused by chronic medical conditions and those caused by co-morbid depression. For example, symptoms such as fatigue, anorexia, and weight loss can be mistaken for depression when they are caused by a medical illness such as diabetes, hypertension, chronic kidney disease, ischemic heart disease, cancer, arthritis, etc.

Furthermore, it is essential to note that depression and anxiety often occur alongside other medical disorders and can worsen biological, social, and occupational functioning and decrease adherence to prescribed treatments. They are also associated with adverse health behaviours and can increase mortality.

How to diagnose?

Depressive Disorder due to another medical condition is diagnosed when:

- There is a clear episode of depression.
- A definite medical condition diagnosed by either symptoms/or investigations.
- There is significant distress and difficulties in functioning.

Aetiology

Depression can occur through two pathways: psychological and biological. Medications used to treat several chronic medical conditions have also been reported to cause depression.

The following are the commonly used medications at the primary care level that can cause depression.

- Beta-Blockers
- Angiotensin Receptor Blockers
- Angiotensin-converting enzyme Inhibitors
- Calcium Channel Blockers
- Anti-Obesity Drugs
- Steroids

Prevalence of Depression in Primary Health Care Settings:

The prevalence of depressive disorder varies depending on the age of the patient, stage/severity, and duration of the medical condition.

Depressive symptoms are common in people with chronic medical illnesses, ranging from 15% to 50%, depending on the specific condition.

Medical condition	Prevalence
Cancer patients	12-16%
Cardiovascular disease patients	3-48%
Diabetes	15-23%
Respiratory conditions	12-40%
Neurological disorders like stroke, Parkinson's, and Alzheimer's	15-50%

Management

Assessment:

To screen for depression associated with a medical illness, primary care doctors can ask patients these simple questions:

1) Have they been feeling down/depressed/hopeless in the past month?

2) Have they experienced little or no interest/pleasure in activities they previously enjoyed?

3) Are they getting tired easily?

If either answer is "yes," further questioning is necessary to meet the criteria for major depression. If the answer is "no' to all the three questions, the patient is unlikely to have depression.

Treatment:

Educating the patient and family members about depression and its symptoms is the first step in managing comorbid depression with chronic medical conditions. A primary care doctor can spend a few minutes assessing the knowledge of caregivers about the illness, explaining the condition, and assuring the patient and caregivers that they can relieve distress and improve functionality with adequate compliance with pharmacological management. This initial assurance or counselling can help patients and caregivers prepare for further interventions.

Treatment of depression in medically ill patients should involve a combination of pharmacological and counselling interventions. Antidepressant medication is effective in treating depression in patients with medical illnesses. It is important to note that the dose and duration of treatment may need to be adjusted for patients with comorbid medical conditions.

In addition to pharmacological factors, it is crucial to address any modifiable risk factors for depression, such as lack of exercise, disturbed sleep, and lack of exposure to daylight. A healthy lifestyle, including regular exercise and a balanced diet, can help improve mood and overall health.

Take home points

1. Depression often accompanies chronic medical conditions.

2. Primary care doctors are vital in identifying and managing such patients.

3. Treatment involves a mix of medication and therapy and addressing modifiable risk factors.

4. This comprehensive approach can enhance the quality of life of patients with chronic medical conditions.

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Scan the QR code/ click on the topic to watch video on Medical Conditions Associated with Depression:

Medical Conditions Associated with Depression

Chapter 3.3 Antidepressants: Focus on Escitalopram, Fluoxetine, and Amitriptyline

Antidepressants are the first-line treatment for depression, especially in India. Despite several effective options, less than one-fifth of affected individuals receive treatment. This chapter discusses antidepressant medications for primary care doctors in the community, focusing on escitalopram, fluoxetine, and amitriptyline, which are relatively safe and are easily available at the primary care level.

Antidepressants:

Antidepressant drugs inhibit the reuptake of monoamines, restoring chemical balance and treating depression. They are prescribed for several psychiatric and non-psychiatric conditions, including major depressive disorder, generalized anxiety disorder, migraine, tension headache and neuropathic pain. Selective serotonin reuptake inhibitors (SSRIs) are the safest and most used antidepressants.

Prescribing Principles:

- The onset of therapeutic action is delayed, usually four weeks.
- The adequate trial is 6-8 weeks at a therapeutic dose.
- If there is no response, increase the dose or change the medication.
- Continue treatment until all symptoms are resolved.
- Do not stop the medication immediately after remission to prevent relapse.
- Continue medicine at least-
    - One year for a single episode,
    - Two years to lifelong for second and subsequent episodes

Individual Antidepressants

Escitalopram

Escitalopram is a selective serotonin reuptake inhibitor (SSRI) antidepressant medication.

- Use - It is commonly used in the treatment of major depressive disorder, obsessive-compulsive disorder, and generalized anxiety disorder.
- Dose - The initial dose is 10mg/day and can be gradually increased to a maximum of 20mg/day for community settings by the general physician. It can be taken in the morning or at bedtime.
- Formulation - Escitalopram is available in 5mg, 10mg, 15mg, and 20mg tablets.
- Side Effects - Escitalopram has the least chance of side effects and drug interactions among all the selective serotonin reuptake inhibitors. Common side effects include nausea, decreased appetite, and sexual dysfunction.

Fluoxetine

Fluoxetine is the longest-acting SSRI antidepressant medication.

- Use - It is approved for the treatment of Major Depressive Disorder, Obsessive Compulsive Disorder.
- Dose - It has a starting dose of 20mg/day and a maximum dose of 40mg/day for GP in primary care settings. It is usually taken in the morning.
- The formulation is available in 10mg, 20mg, and 40mg capsules and tablets.
- Side Effects - Common side effects include nausea, decreased appetite, and sexual dysfunction. It also has the highest chance of drug interactions among all selective serotonin reuptake inhibitors.

Amitriptyline

Amitriptyline is a tricyclic antidepressant medication.

- Use - It is used to treat depression and chronic pain conditions such as neuropathic pain, fibromyalgia, headache, and low back pain.
- Dose - The initial dose is 10mg/day and can be gradually increased to a maximum of 50mg/day for GP in primary care settings. It is usually taken in the night.
- The formulation is available in 10mg, 25mg, and 50mg tablets.
- Side Effects - It can cause side effects such as constipation, dry mouth, nausea, sedation, and weight gain. Baseline ECG and body weight/BMI should be taken before starting treatment and monitored regularly. It is to be avoided in the elderly and patients with cardiac disorders and seizures.

Points to Convey While Counselling Patients before Starting Antidepressants
Depression is a real medical issue: Depression is a medical condition that affects mood and emotions. **Antidepressants restore balance:** Medication helps balance chemicals in the brain, improving mood. **Benefits take time:** It may take a few weeks to feel better, but the medication can reduce symptoms and improve daily life. **Possible side effects:** Some may experience mild side effects like nausea or drowsiness, which usually go away quickly. **Regular follow-up is essential:** Regular check-ins help monitor progress and make any needed adjustments. **Don't stop abruptly:** Avoid stopping the medication suddenly and talk to me if you want to discontinue it. **Healthy coping strategies:** Exercise, good sleep, and talking to loved ones can complement the medication's effects. **Seek immediate help:** If you have thoughts of self-harm or suicide, reach out for emergency support. These medicines don't have addiction (habit-forming) properties.

Take home points

1. Antidepressants are the main treatment for depression at the primary care level.

2. When prescribing antidepressants, it's important to consider factors like delayed onset of therapeutic action, adequate trial duration, dose adjustments, and the duration of treatment based on the episode type.

3. Common Antidepressants include

- Escitalopram: Used for major depressive disorder. Starts at 10mg/day with a maximum of 20mg/day for GP in primary care settings.
- Fluoxetine: Effective for major depressive disorder. Begins at 20mg/day with a maximum of 40mg/day for GP in primary care settings.
- Amitriptyline: Used for depression and chronic pain, starting at 10mg/day and going up to a maximum of 50mg/day for GP in primary care settings. Requires monitoring, especially in elderly patients and those with cardiac issues or seizures.

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Scan the QR code or click on the topic to watch video on Antidepressants:

Antidepressants

4| RISK ASSESSMENT AND MANAGEMENT OF SUICIDE AT PRIMARY CARE CENTRE

Definitions

- Suicide is a self-initiated, potentially injurious behaviour with the intent to die, leading to the death of the individual [1]. Many stakeholders are involved in managing suicide. It is as equally a social concern as it is a medical concern.
- A suicide attempt is a self-initiated potentially injurious behaviour with the intent to die having a non-fatal outcome.
- Deliberate self-harm is a self-initiated injurious behaviour without intent to die and having a non-fatal outcome.

Burden of Suicide

In India, according to the 2021 NCRB data, the suicide rate has exhibited a steady rise over the years, reaching 12 per lakh population in 2021, up from 9 per lakh population in 2017. This increase amounts to an annual increment of 1 per lakh population. Globally, in 2021, the World Health Organization (WHO) reports that more than 1 out of every 100 deaths can be attributed to suicide,[6] and a significant 58% of all suicides occur before individuals reach the age of 50. [4] Every day, there are 450 deaths by suicide; every 45 seconds, there is a death by suicide. The NCRB data also highlights the alarming 70% rise in student suicides from 2011, amounting to 36 suicides per day in India, most attributed to failure in examinations.

Assessment of Suicidal Risk

Recognizing warning signs for suicide is crucial, as it provides insights into the distress someone might be experiencing. These signs are not always obvious and can be easily missed, but they should never be ignored. It's essential to pay attention to these signs when they are unusual or more severe than before. Here are some essential verbal and behavioural warning signs:

- Talking about ending life: When someone expresses thoughts like, "Sometimes I feel like I just want to die," it's a clear indication of their emotional pain.
- Talking about guilt or sin: It could reflect their internal struggles if someone discusses feeling guilty or having committed a sin.
- Expressing hopelessness: If someone talks about having no reason to live or feeling hopeless, it suggests they are grappling with despair.
- Feeling trapped or in pain: Expressions of feeling trapped or unbearable emotional or physical pain can signal significant distress.
- Being a burden to others: If someone talks about being a burden to those around them, it might indicate they perceive themselves as causing difficulties.
- Changes in substance use: Increased alcohol consumption or use of other substances might signify an attempt to cope with emotional pain.
- Eating pattern changes: Significant shifts in eating habits, whether eating less or more than usual, may be related to emotional difficulties.
- Social isolation: Withdrawal from family and friends, especially if the person was previously outgoing, could cause significant emotional turmoil.

- Extreme anger or revenge: Expressing intense rage or talking about seeking revenge may signal inner turmoil and distress.
- Mood swings: Sudden and extreme mood swings, such as crying spells or hyperactivity, might point to emotional instability.
- Preparatory behaviours: If someone starts giving away belongings or collecting potentially harmful substances like medicines or pesticides, it may indicate they are considering suicide.

Risk factors for suicide

S – Sex: 1 if male; 0 if female; (more females attempt, more males succeed)

A – Age: 1 if < 20 or > 44

D – Depression: 1 if depression is present

P – Previous attempt: 1 if present

E –Ethanol abuse: 1 if present

R – Rational thinking loss: 1 if present

S – Social Supports Lacking: 1 if present

O – Organized Plan: 1 If the plan is made and lethal

N – No Spouse: 1 if divorced, widowed, separated, or single

S – Sickness: 1 if chronic, debilitating, and severe

Guidelines for action with the SAD PERSONS scale at the primary care level (Refer to Appendix III for SAD PERSONS Scale) [4]

Total points	Proposed clinical action
0 to 2	Send home with follow-up
3 to 4	Close follow-up; Referral to high centre
5 to 6	Referral to high centre for hospitalization
7 to 10	Referral to high centre for hospitalization

Protective factors

- Person has a desire to get better
- Person is willing to get help
- Strong sense of responsibility towards their family members (parents, children; spouse)

- Strong affection and bond with any or all family members
- Having good support from family, friends, and colleagues
- Ability to resolve problems and difficulties in relationships
- Previous positive and helpful experience from care-providing services
- Easy local availability of help providing hospitals
- Access to support from counsellors and doctors
- Cultural and religious beliefs that discourage suicide

Steps in managing suicide:

1. Approach and Initial Inquiry:

- Express concern and indicate care: Approach the person showing warning signs with empathy and concern.
- Normalize the discussion: Begin with normalizing questions that discuss suicide as a common mental health issue to create a comfortable environment.
- Encourage sharing: Use open-ended questions like "I've noticed..." or "You seem..." to encourage the person to express their distress.

2. Risk and Protective Factors:

- Systematic inquiry: Ask about risk factors (e.g., mental illness, substance use, past suicide attempts) and protective factors (e.g., family support, coping skills).
- Explore relationship and life stressors: Inquire about relationship problems, work stress, financial issues, and recent life events that could contribute to distress.
- History of self-harm: Ask if they've engaged in self-harming behaviours in the past and the outcomes of those situations.

3. Inquiring About Suicidal Thoughts:

- Passive and active thoughts: Ask about any thoughts of wanting to be dead (passive) or actively planning to end one's life (active).
- Normalizing approach: Use phrases like "Sometimes when people feel disturbed..." to make the discussion more comfortable.
- Frequency, duration, and intensity: Inquire about how often they have these thoughts, how long they last, and the intensity of their feelings.

4. Suicidal Intent and Lethality:

- The intent behind the attempt: Understand the intentionality of their actions, whether seeking attention, escape, or a serious desire to die.
- Lethality assessment: Assess the degree of harm resulting from the self-injury, the ease of rescue, and the need for medical intervention.

5. Follow-Up and Support:

- Establish a safety plan: Collaborate on a crisis plan, including strategies for coping, confidante contact, and crisis helpline numbers.

- Encourage follow-up: Schedule regular visits or check-ins, involve family or support systems, and ensure they have access to necessary resources.

6. Immediate Hospitalization:

- If the person is medically unstable, ensuring their physical well-being precedes the assessment.
- Conduct a formal suicide evaluation when the person is conscious and responsive.
- Refer for higher centre for further management of psychiatric illness.

Immediate Intervention:

- Assessment: Thoroughly assess the person's risk factors, including dynamic (fluctuating) and static (unchanging) factors.
- Active Listening: Listen attentively, validate concerns, and be non-judgmental to encourage open expression of thoughts and feelings.
- Instilling Hope: Offer support, instil hope, and assure that problems can be resolved with time. Provide practical help and referrals.
- Crisis Plan: Develop a personalized crisis plan, including distraction techniques, physical activities, confidante contact, and helpline numbers.
- Safety Net: Reduce access to lethal means, identify a confidante, and assure accessibility to healthcare professionals. Follow up to ensure safety.

Referral:

- Risk Assessment: Determine risk level (high, moderate, low) based on risk factors
- Crisis Plan: Formulate a crisis plan, including productive activities, confidante contact, and professional help.
- Referral Process: Arrange referral to a mental health facility based on risk level. Maintain communication, follow-up, and support after referral.

Take home points

1. Suicide is a social concern as well as a health concern
2. Attempting suicide/suicidal thoughts is a cry for help
3. Every individual who has either a suicide idea/ non-suicidal self-injurious (NSSI) behaviour/suicide attempt must be treated equally and seriously
4. Every case of suicide attempt must be referred to a psychiatrist for detailed evaluation
5. Stigma remains one of the main barriers to treatment seeking, which must be broken by increasing awareness
6. *Social causes of every suicide must be managed during the treatment process with the help of the social work department.*

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Scan the QR code or click on the topic to watch video on Suicide:

Suicide

5| ANXIETY DISORDERS

Chapter 5.1 Anxiety Disorders

Anxiety is a feeling of unease and worry that is not clearly linked to a specific threat. It can create tension and cause the body to react with autonomic symptoms like palpitations, trembling, hyperventilation, etc. Anxiety is a general sense of concern, while fear is a response to a known, specific danger. The patient usually presents with unusual symptoms and might not be able to verbalize anxiety symptoms.

In some cases, anxiety is a normal and helpful response that helps people recognize potential problems. However, when anxiety becomes too intense and persistent, it can disrupt daily life and become a disorder. Anxiety disorders are characterized by excessive and irrational anxiety that causes significant impairment. These conditions can last long and seriously impact a person's quality of life.

EPIDEMIOLOGY

The NMHS India 2015-2016 found that about 2.57 out of every 100 adults had anxiety disorders. Women aged 40-59 and those living in big cities were at a higher risk.

In another study, among adult patients at general healthcare clinics, about 5 out of every 100 had an anxiety disorder.

ETIOLOGY OF ANXIETY DISORDERS

Anxiety disorders are caused by the complex interplay of biological and environmental factors. Biological factors include abnormal genes and dysregulation in the neurotransmitter systems like epinephrine, nor-epinephrine, serotonin, dopamine, and GABA. Social factors include difficult life experiences, being raised in a dysfunctional family, childhood trauma, etc.

COMMON SIGNS AND SYMPTOMS OF ANXIETY DISORDERS

These symptoms are common to all anxiety disorders. However, their presentation may vary according to the sub-type of the anxiety disorder. For example, in generalized anxiety disorder, symptoms are present continuously, while in panic disorder, they may be present episodically.

1)Physical Manifestations

- **Motor Manifestations** – Tremors, restlessness, twitching of muscles
- **Autonomic Manifestations** – Palpitations, sweating, flushes, dizziness, choking sensation, dry mouth, constriction in the chest, diarrhoea, blurring of vision

2)Psychological Manifestations

- **Cognitive Manifestations-** poor concentration, distractibility, hyperarousal, vigilance, negative thoughts
- **Perceptual Manifestations** – a sense of unreality of atmosphere

- **Emotional Manifestations** - vague sense of apprehension, fearfulness, inability to relax, irritability, feeling like something bad will happen (feeling of impending doom)

- **Other Manifestations** – insomnia(initial), increased sensitivity to noise, exaggerated startle response

COMMON PRESENTING COMPLAINTS OF PATIENTS WITH ANXIETY DISORDERS

Generalized Anxiety Disorder: headache, sleep disturbances

Panic Disorder: giddiness, sudden breathing difficulty/chest discomfort, fear of death

Agoraphobia: fear and avoidance of situations like going in a lift, crowded place, confined places, etc

Social Anxiety Disorder: fear and avoidance of going to a gathering, speaking in a group, stage presentation, etc

Phobia: fear and avoidance of blood, injections, lizards, spiders, etc

The signs and symptoms of anxiety described above are **additional** to the core and may be encountered in any of the five anxiety disorders described above.

DIAGNOSTIC CRITERIA OF DIFFERENT ANXIETY DISORDERS

The **core criteria** of the subtypes of anxiety disorders are described below.

1. GENERALISED ANXIETY DISORDER(GAD)

An experience of excessive and uncontrollable anxiety/tension/worries/nervousness with no apparent reason or for trivial reasons for many months (often for **> 6 months)**. In GAD, the anxiety and excessive worries (preoccupation) are surrounding day-to-day activities & mundane events. **The characteristics of these anxiety/tension/worries/nervousness are:**

1. Generalized in nature, usually involving several aspects of life like family, health, finances, or work. Worry may revolve around events like a family tragedy, ill health, job loss, or accidents, even when there are no apparent signs of trouble.
2. Persistent (present throughout the day)
3. Free-floating anxiety (means anxiety does not have an obvious cause/without pinpointing any source of worry/anxiety. Rather, the anxiety moves freely without being connected to one cause/source of anxiety)
4. There is a chronic tendency to worry, and symptoms may last for months. The patient may always feel on edge.

2. 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

- Sudden onset of palpitations, chest pain, difficulty breathing/choking sensations, dizziness, dry mouth, and feelings of unreality.
- Secondary fear of dying, losing control or going mad.
- A fear of anticipation of another attack ('anticipatory attack') leading to avoidance of certain situations where these attacks may have previously occurred.
- Abrupt beginning, reaching a peak in minutes, and resolution in 10-20 minutes.

However, a panic attack that is not spontaneous and predictable could be an anxiety attack as a part of GAD/Depressive disorder but may not be panic disorder per se. It is essential to rule out any organic conditions in such presentations.

3. AGORAPHOBIA

Agoraphobia is characterised by irrational and excessive fear of situations in which **escape is perceived as difficult,** resulting in marked disturbance in daily functioning. These situations may include fear of travel in public transportation, fear of open spaces, enclosed spaces, crowded places, standing in line, or being alone. They may engage in **safety** behaviours to avoid the above situations. E.g., not stepping outside the home on holidays as streets might be more crowded, etc.

4. SOCIAL PHOBIA

It includes being irrationally afraid of others judging them or paying too much attention to how they are seen in social causes a marked disturbance in daily functioning. This may include situations like conversation or meeting with unfamiliar people, performing in front of others like giving a speech, etc. They may engage in behaviours that may result in avoidance of the above situations.

5. SPECIFIC PHOBIA

Irrational and excessive fear of a specific object or situation causes a marked disturbance in daily functioning. This may include fear of flying, heights, animals, receiving an injection, or seeing blood. They may engage in behaviours that may result in avoidance of the above situations or objects.

Summary of Pathognomonic Features of Anxiety Disorders

The anxiety and excessive worries (preoccupation) around day-to-day activities & mundane events.	Generalized Anxiety Disorder
Abrupt onset, episodic anxiety with an impending sense of death	Panic Disorder
Excessive anxiety about a situation from which easy escape is not available leads to avoidance	Agoraphobia
Excessive anxiety in a social situation leads to avoidance	Social Anxiety Disorder
Irrational anxiety of Specific objects or situations with avoidance	Phobia

INVESTIGATIONS

For a patient with one or two episodes of panic attacks, ECG, blood sugar level and thyroid function tests are advisable to rule out an organic cause. The investigations may not be necessary for patients with a long-standing history consistent with the above-described symptomatology.

COURSE OF ANXIETY DISORDERS

About one-third of patients will have complete resolution of symptoms, a third will have a chronic illness, while another third will have a relapsing and remitting course of illness.

TREATMENT

The treatment for anxiety disorders includes both pharmacotherapy and counselling. However, in the Indian scenario, pharmacotherapy is the first line of treatment due to a lack of resources and limited expertise.

- **PHARMACOTHERAPY**

Selective Serotonin Reuptake Inhibitors (SSRIs) like Escitalopram and Fluoxetine are the mainstay of treatment. Benzodiazepines are simultaneously added for immediate relief of physical symptoms, as SSRIs may take up to 3-4 weeks for action. Benzodiazepines like diazepam can be used for short-term (2-3 weeks). Benzodiazepines should not be used beyond 2-4 weeks as they have addiction potential.

For detailed guidelines on how to start and continue medicines, kindly refer to CSP v2.4 Page number 4-7 (Appendix I)

- **COUNSELLING**

- Patients and relatives need to be educated that anxiety can have physical symptoms like shortness of breath and chest pain.

- Educate about the medical nature of the illness. Specific information needs to be provided in case of panic attacks that are not life-threatening.
- Educate that medication may only bring out improvement in part. Engagement in activities/hobbies, engaging with friends, lifestyle changes like exercising, and a healthy diet are important in accomplishing complete improvement.
- Educate that treatment may last for a term of 9-12 months, and one-third of the patients may have a relapsing and remitting course.
- Teach relaxation methods like breathing exercises and progressive muscular relaxation.
- Educate about complete abstinence from any substance use as it may worsen anxiety.
- Yoga and meditation are also advisable in mild to moderate cases.

Take Home Points

1. Anxiety is a vague sense of unease and tension, while fear is a response to a known external threat. Anxiety can be normal but becomes a disorder when it's excessive and persistent.
2. The prevalence of anxiety disorders in the Indian adult population is around 2.57 out of every 100 people. Risk factors include gender, age group (40–59), and urban living.
3. Anxiety disorders result from a complex interplay of biological and environmental factors.
4. **Treatment:** Escitalopram/Fluoxetine + Diazepam + Counselling
5. **Probable duration of Treatment:** Escitalopram/Fluoxetine for 9 -12 months, Diazepam for initial 2-4 weeks

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Anxiety disorders

Chapter 5.2 Somatization Disorder

Somatization Disorder is often found in lower socio-economic groups, especially in remote and rural areas. It is characterised by multiple unexplained physical (somatic) symptoms, significantly affecting patients' day-to-day activities. Somatisation is also associated with lost workdays, especially for daily wage workers, and unnecessary expensive medical tests. Raising awareness about this disorder across healthcare levels can help reduce its economic impact on patients and the healthcare system.

EPIDEMIOLOGY

In primary healthcare settings in India, the prevalence of somatization disorder is 13.5%, and key risk factors include being female, having lower education, and having lower socioeconomic status.

ETIOLOGY

People with this disorder often have a low tolerance for physical discomfort. They can unintentionally exaggerate physical sensations, even turning mild discomfort into pain. These physical/somatic symptoms worsen during stressful life situations.

SIGNS AND SYMPTOMS OF SOMATISATION DISORDER

These patients present with various physical complaints without a physical explanation, as evidenced by a detailed physical examination. The signs and symptoms often do not have any neurological basis or easily identifiable medical cause.

These symptoms may be single, multiple, or variable physical symptoms that often change. The focus is on bodily symptoms and expecting relief from them. They may interpret the bodily symptoms as disproportionately life-threatening. Persistent attribution to medical illness despite medical reassurance is noted.

The following list includes the most common symptoms

- Pain symptoms at multiple sites (such as abdomen, back, chest, dysmenorrhea, dysuria, extremities, head, joint, and rectal) are often present.
- Gastrointestinal sensations (pain, belching, regurgitation, vomiting, nausea, etc.).
- Abnormal skin sensations (itching, burning, tingling, altered temperature sensations, numbness, soreness, blotchiness etc.)
- Persistent unexplained pain at one site e.g. persistent headache

These are often expressed dramatically with gestures and may be accompanied by multiple help-seeking behaviours. The expression usually has terms and phrases from the local language that are a culturally acceptable, for instance, "gas is getting into the head.", "electric sensations throughout the body", "complete twisting of the body", "feeling of tingling/numbness"(which does not follow the nerve distribution pattern).

For a definite diagnosis of somatization disorder

- Symptoms of the illness explained above present for at least 6 months
- Doctor shopping - The patient often repeatedly visits the same doctor or several doctors and may request multiple investigations like MRI and CT scans or may be persistent for some form of treatment like "saline drip." There may be requests for ECG, often confusing shortness of breath and retrosternal heartburn for heart attack.
- There will be some degree of social and family dysfunction. The symptoms usually worsen during stress.

DO NOT MAKE DIAGNOSIS OF SOMATISATION DISORDER AFTER THE AGE OF 40 YEARS (usual onset is in the 2nd and 3rd decade)

INVESTIGATIONS

No mandatory investigation is advised. The goal is to check for other medical issues that might be causing the symptoms, as somatization disorder often involves many unclear symptoms. Medical disorders which present with multiple vague symptoms, like hypothyroidism, infections, diabetes, hypertension and carcinomas, must be ruled out. Baseline blood investigations like complete blood count, liver function test, renal function test, and CRP may be ordered for new patients. The investigations may not be necessary for patients with a long-standing history consistent with the above-described symptomatology.

COURSE AND PROGNOSIS

About one-third of patients will have a complete resolution of symptoms, a third will have a chronic illness, and another third will have an episodic course of illness. Somatization disorders are often chronic and difficult to treat, having a significant impact on the quality of life of an individual.

TREATMENT

The treatment for Somatization Disorder includes both pharmacotherapy and counselling.

➢ PHARMACOTHERAPY

Tricyclic Antidepressants (TCAs) are the mainstay of treatment. Low-dose TCAs Amitriptyline (starting dose 12.5mg to maximum dose 50mg for GP) are preferred for somatization disorder. However, the side effects of TCAs should be monitored, especially with comorbid medical illnesses and in old patients.

For detailed guidelines of management for somatization, please refer to CSP v2.4, page number 2-9.

➢ COUNSELLING

- Validate the presence of an illness. Convey the message that he/she has an illness, but not life-threatening. Never convey he/she has no illness.
- Patients may not accept medications if their symptoms are labelled to be psychological. Try to steer the conversation from "purely mental" or "purely physical" to "mental as well as physical."
- Listen, validate, and empathize. Avoid repeated reassurance.
- Educate about the nature of the illness. Symptom exacerbation after a fight can be explained. Frequent follow-up for brief counselling of about 10-20 minutes to discuss life situations may alleviate symptoms to a significant extent.
- Educate that treatment may last for a longer period (2 years), and one-third of the patients may have a relapsing and remitting course.
- Try to shift focus from physical symptoms to other areas of functioning like work, other leisurely activities, and sleep. Educate that medication may bring out 50-60% improvement. Rest improvement is dependent on mood-enhancing activities.
- Engagement in mood-elevating activities of their personal choice contributes to accomplishing complete improvement. Advise to include healthy lifestyle activities like walking, exercising, playing, and other entertaining activities. Teach about prioritizing when overwhelmed with multiple chores and timelines.
- Identification and treatment of other comorbid medical conditions go hand in hand.
- Yoga and meditation are helpful.

WHEN TO REFER:

- **No improvement with Amitriptyline 50 mg after 1 month of treatment**
- **They are persistently requesting for investigations.**
- **Change in the clinical picture from the initial presentation**
- **The onset of symptoms after 40 years of age**

Take Away Points

- Somatization disorder primarily impacts women, particularly those from lower socioeconomic backgrounds, and imposes a significant financial burden on affected individuals.
- It often co-occurs with conditions such as depression, anxiety, and substance use, which should be considered in treatment.

- In India, Tricyclic Antidepressants (TCAIs) are the primary treatment. Treatment typically involves a combination of pharmacotherapy and counselling for effective management.

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Somatization

Chapter 5.3: Obsessive-compulsive Disorder and its treatment

Introduction:

Obsessive-Compulsive Disorder (OCD) is a chronic and distressing mental health condition characterized by unwanted and recurring thoughts (obsessions) that lead to repetitive behaviours or mental acts (compulsions), which are aimed at alleviating the distress caused by these thoughts.

Epidemiology in the General Population:

OCD is a highly prevalent mental disorder worldwide. According to the National Mental Health Survey 2016, the prevalence of OCD in India is approximately 0.8%. Interestingly, studies in primary care settings in India have indicated lower prevalence rates compared to Western studies.

OCD in Primary Health Care (PHC) Population:

In primary care settings, identifying OCD can be challenging due to patients' limited ability to express their obsessions and compulsions. However, initial assessment is crucial in recognizing potential cases. The following mnemonic can aid in evaluating obsessive thoughts and behaviours:

D	Disturbing, Distressing thoughts/behaviours	Repetitive, Intrusive, Distressing
O	Own thoughts/behaviours	
I	Intrusive thoughts	
R	Repetitive thoughts/behaviours	
S	Senseless thoughts/behaviours	

When suspecting OCD, primary care assessment can start with broad questions:

- Do certain thoughts or images repeatedly intrude your mind despite efforts to suppress them?
- How do you attempt to counter these thoughts?
- Do you feel compelled to perform certain actions repeatedly, even if you don't want to?
- Do these actions seem reasonable or excessive to you?

Clinical Features and Common Presentations of OCD:

OCD is characterized by distressing obsessions and compulsions that significantly interfere with daily functioning. Some common obsessions and their corresponding compulsions include:

DIMENSIONS	OBSESSION	COMPULSION
CONTAMINATION	Concerns about dirt, germs	Washing, Cleaning
PATHOLOGICAL DOUBT	Concerns about uncertainty	Checking, Repeating
HARM RELATED	Concerns about harm	Checking
UNACCEPTABILITY	Intrusive, aggressive, sexual or religious thoughts	Praying, Mental rituals

Comorbid Conditions and Suicidality:

OCD frequently co-occurs with other mental disorders like depression, dysthymia, and anxiety disorders. Suicidality can affect nearly 40% of individuals with OCD, emphasizing the importance of thorough evaluation.

Management:

Pharmacological Treatment:

Selective Serotonin Reuptake Inhibitors (SSRIs) are the first-line pharmacological treatment for OCD.

Higher doses of SSRIs are required for OCD compared to depression. Referral to a psychiatrist is recommended for management.

At the primary care level, initiating SSRIs at a lower dose and referring to a specialist after failure of 4 weeks trial.

Maximum Doses of SSRIs for OCD at the primary health care level:

Fluoxetine: 20 mg (minimum) – 40 mg (maximum for GP)

Escitalopram: 10 mg (minimum) – 20 mg (maximum for GP)

Non-Pharmacological Treatment:

Psychoeducation is vital, conveying that OCD is treatable and requires long-term medication and psychotherapy.

Cognitive Behavioural Therapy (CBT) is the most effective psychotherapy for OCD, significantly reducing symptoms in both adults and children.

Primary care physicians should refer suspected OCD cases to mental health professionals for comprehensive evaluation and treatment.

Take Away Points

- Obsessive-Compulsive Disorder (OCD) is a chronic mental health condition characterized by distressing obsessive thoughts and corresponding compulsive behaviours.
- OCD is treated with a combination of pharmacological and non-pharmacological approaches. Selective Serotonin Reuptake Inhibitors (SSRIs) are the primary medications, and cognitive-behavioural therapy (CBT) is effective for psychotherapy.
- Medicines might be required for a longer duration (2 or more years)
- Suspected cases of OCD should be referred to mental health professionals for comprehensive evaluation and treatment, given the complexity of the disorder.

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Obsessive Compulsive Disorder

Chapter 5.4: Low Intensity Psychological Interventions (LIPI)

Introduction

Low-Intensity Psychological Interventions (LIPI) are simplified, evidence-based treatments that non-specialists in primary care can give. They are termed 'Low intensity' as they require less training, resources, and time as compared to traditional psychological interventions.

Due to the high rate of mental illness in the community, as evidenced by the 2016 NMHS survey (which found a prevalence of 10.6% in India) and a shortage of mental health professionals, LIPI interventions are necessary. Additionally, primary care doctors have limited time, so LIPI, which is short-term, is ideal.

LIPI can be provided in various forms, such as brief individual therapies (not lasting more than six sessions), brief group therapies (involving family members), and providing the patient with self-help material or links to internet resources. However, in this module, we will describe brief individual therapies.

Many studies prove that low-intensity psychological interventions work well for various mental health problems in different places. The World Health Organization (WHO) has also recognized the effectiveness of these interventions and has developed a manual on low-intensity psychological interventions for common mental health disorders.

Ideal Candidates for LIPI – (MSD)

1) Mild to Moderate intensity of symptoms

2) Specific clinical problems (for example, anger outbursts, stress, sleep disturbances)

3) Depression and anxiety, which are highly prevalent

Contraindications for LIPI -

1. Children & Adolescents (<16 years) and elderly patients (>65 years)
2. Past history of suicidal attempts, recent self-harm attempt, or suicidal attempt
3. Forensic or criminal involvement
4. Patients who are recently unemployed, have had recent major relationship loss, and are expressing significant hopelessness.
5. Patients who have severe intensity symptoms of mental illness.

Steps in Administering LIPI

Before beginning to administer LIPI, it is essential to remember **ABC** –

- **Active Participation** from the patient is a prerequisite for any psychological intervention.
- **Building rapport** which means creating an environment where a patient feels informed and in control of his/her treatment, is crucial for the patient to participate fully.
- **Choosing an appropriate problem & patient,** as has been described above.

If all these requirements are met, the LIPI can be initiated in the following way -

1) Explain the purpose & structure of the LIPI (1-2 sessions)

At the start, the patient should be given clear information about each step of the LIPI, they need to be informed about the time-limited nature of the intervention, and most importantly, they need to be informed of the need for active participation.

The patient must also be given general counselling. They must be told in clear, understandable terms about the nature of the illness, the treatment options, and the long-term prognosis. Lifestyle modifications such as a healthy diet, regular exercise, and maintaining a routine must be explained. The patient and the family's emotions and distress should be enquired about & given positive validation.

2) Assessment (1-2 sessions)

This is one of the most important steps. It is the process by which the doctor can understand the patient's current problems, decide the modality of treatment, link problems with the goals of the patient, and make a structured treatment plan.

Assessment can be done using the **5 'W's** approach –

What – What occurs during the problem? What improves or worsens it?

Who – Who specifically causes the problem? Who improves or worsens the problem?

Where – Where does the problem happen? Where does it not happen?

Why – Why does the patient think the problem occurs? (i.e., their understanding)

When – When is the problem most likely to happen? When is the problem least likely to happen?

Also, it should be made sure in the assessment to include **OPD -**

Onset– How did it start? What triggers the problem each time?

Progress – Has it increased in intensity? Is it causing problems in the daily life of the patient?

Duration – How long has it been happening? Once starting, how long does the problem last?

Always make sure to assess for suicidal risk. In case it is present, refer to a psychiatrist at the earliest.

At the end of the assessment, the doctor can give his formulation, i.e., his conceptualization of the problems, to the patient. This will not only help the patient better understand their illness but also serve as a glimmer of hope that their problems can be solved.

3) Psychological Tools & Techniques (3 sessions)

Based on the assessment, the psychological tools and techniques to be used for each patient can be individualized and initiated.

The following table is a brief summary of some commonly used techniques –

Life style modifications	
Technique	***Method***
Stress Management Techniques	• Yoga • Breathing retraining techniques (Deep Breathing techniques) to reduce hyperventilation • Muscle Relaxation techniques – Ask the patient to focus on sequentially tensing and relaxing muscles of each part of the body
Sleep Hygiene	• These are techniques to improve sleep in patients with insomnia. This works on the principle of promoting behavioural & environmental changes which increase sleep and reduce factors in the environment that decrease sleep. • The basic principles are o Ask the patient to keep a regular sleep schedule of going to bed and waking up o Patients should have a relaxing bedtime routine – They should turn off the television and mobile phone during bedtime. They should only use the bed for sleeping. They can take warm baths before bedtime. o The patient's bedroom should be dark, cool, and with less noise o The patient should avoid any daytime napping o Patients should not have big meals at night-time. They should avoid caffeine/alcohol after the evening. o The patient can use deep breathing or muscle relaxation techniques at night while lying on the bed.
Problem-Solving Techniques	• This consists of teaching patients some skills to effectively solve problems rather than worrying about adverse outcomes. • It teaches patients flexible ways of thinking, which consist of generating many solutions to the problem and evaluating each solution's positives and negatives. • A patient can be asked to o Identify a problem in detail; it's maintaining factors and goals o List all possible solutions

	○ Evaluate the advantages & disadvantages of the top 5 solutions ○ Decide on a solution write down what steps they will take, and fix a timeline to implement each step ○ Implement the solution ○ Judge the effectiveness and then decide whether a new plan might be needed to address the problem better
Anger Management	• These are techniques by which patients can learn to control or reduce the intensity of their anger. These consist of • Reverse Counting from 20 before saying anything • Deep breathing exercises • Punching pillows in their bedroom – taking out anger on non-living things • Taking a 5-10-minute walk before responding • Mentally challenging oneself before responding – 'What is the source of anger? What is the degree of my anger? What is the other person's role in the situation? How would I want to be treated if the other person felt like me?' • Leave the situation where they are being provoked • Write out a response in their diary before saying it orally

4) Termination of LIPI (1 session)

The last session consists of –

- Summarizing all the previous sessions
- Revising goals
- Making the patient aware of what they have achieved till now and how they can achieve much further in the time to come
- Addressing any anxiety, fear, or sadness, the patient may feel on terminating sessions.

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Click on the topic or Scan the QR code below or to learn more about LIPI:

LIPI

Chapter 5.5: Brief intervention for substance use

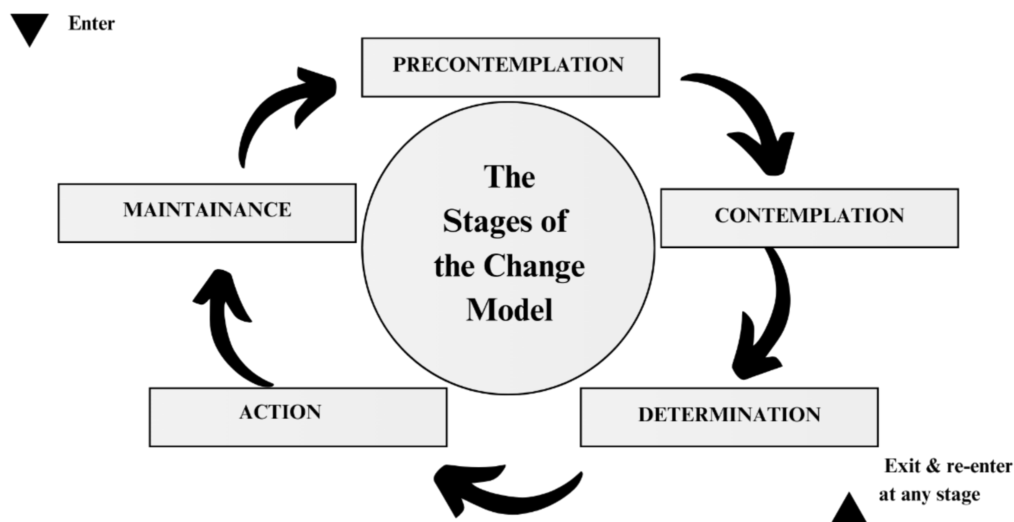
Brief intervention (BI) is a short, focused counselling approach to reduce harm from substance use disorders, like alcohol and tobacco, in a busy practice. It's based on motivational interviewing (MI), which is the idea that behavior change is a process that needs motivation. BI is patient-centered and can be done in primary or community care.

BI is mainly for people with hazardous, harmful, or mild to moderate substance use. For those with severe dependence, it is better to refer the patient to a mental health professional. Evidence shows BI decreases drinking days, heavy drinking, average amount of alcohol used and hospital visits.

To do BI, screen the person for substance use (type and quantity of alcohol used), understand their motivation, and identify their needs. Create a personalized plan using the FRAMES technique, and be non-judgmental and supportive.

Kindly remember relapse is the norm in substance use. Prepare yourself, the patient and your family for relapse and to start treatment again as soon as there is a lapse.

Stages of change by Prochaska and DiClemente (1983):



The models of brief intervention for alcohol and tobacco use are FRAMES and 5 As, respectively.

FRAMES:

	Components	Definitions	Examples
F	Feedback	Personalized and meaningful feedback on the pattern of use, existing or potentially harmful	"You've scored 16 on the screening test, which indicates that you are at high risk of harm from drinking."

		effects, and, when available, laboratory parameters.	"Your liver functions are deranged greatly, and quite possibly, it is due to excessive alcohol intake."
R	Responsibility	Emphasis on the need for change in substance use being the individual's personal responsibility.	"What you do with the information I give is up to you." "How concerned are you about your LFT reports."
A	Advice	Professional opinion, clear and precise with no beating around the bush.	"Considering your family history of addiction, you should moderate your drinking behaviour." "Best way to reduce the risk of liver disease is to stop alcohol completely."
M	Menu of options	Various treatment options available, the pros and cons of each, and the best suited for the individual	Keeping a diary of use Activity Scheduling Drinking with Food Identifying high-risk situation Attending Counseling Info on Treatment Centres
E	Empathy	Understanding and acknowledging the person's feelings and experiences.	"You have tried stopping multiple times before, it must be important to you." "I know this process can be confusing. Let's see if we can solve this together."
S	Self-efficacy	Helping the person to believe in their ability to change their substance use.	"I appreciate that you agreed to come for the next session to work on this. You are very courageous to manage these stressors."

5 As:

Ask: screening for tobacco use.

Advise: provide specific, personalized advice to quit.

Assess: assessing the person's willingness to make

Assist: provide support and assistance with pharmaceutical or non-pharmaceutical interventions such as Nicotine Replacement Therapy (NRT) or behavioural therapy.

Arrange: scheduling follow-up appointments or referrals to specialized treatment services if needed.

Take away points

1. Brief Intervention (BI) is a short, patient-centered counseling approach used in primary or community care to reduce harm from substance use disorders, like alcohol and tobacco.
2. It's important to recognize that relapse is a common occurrence in substance use. Be proactive in readiness—both yourself and the patient, along with their family, acknowledging the possibility of relapse and the need to promptly resume treatment in the event of a lapse.
3. BI is most effective for people with hazardous, harmful, or mild to moderate substance use. Severe cases may require referral to a specialist.
4. Evidence supports that BI can reduce drinking days, heavy drinking, average alcohol consumption, and hospital visits.
5. When conducting BI, screen for substance use, understand motivation, and tailor the intervention using the FRAMES technique or the 5 As model, depending on the substance, all while being empathetic and supportive.

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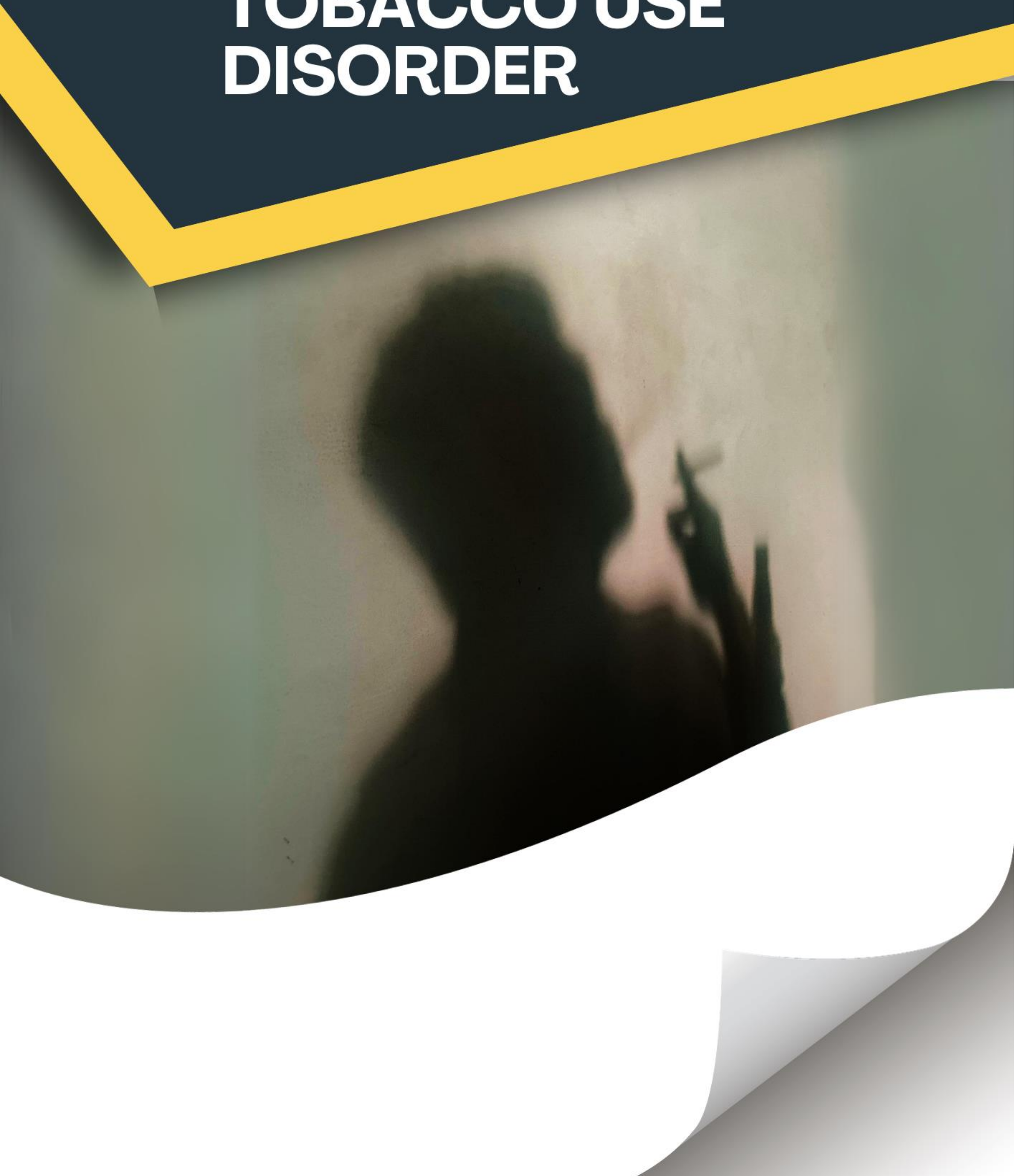
Click on the topic or scan QR code below to watch a video on Brief intervention:

[Brief intervention](#)

6| ALCOHOL AND TOBACCO USE DISORDER



Chapter 6.1 Diagnosis of Alcohol and Tobacco Use Disorder

Alcohol and Tobacco use is highly prevalent in the Indian population, and this has a big impact on health and quality of life. Habit-forming substances are drugs or medications which, on using over a period of time, can cause the person to become addicted. That is, the person continues to use it despite its harmful consequences to his health and his functioning (studies, job), and to his family relationships.

Epidemiology for substance use disorders:

Around 15% of people aged 10 to 75 drink alcohol in India, which means approximately 16 crore individuals. Among them, men are much more likely to drink (about 27.3%) compared to women (1.6%). Out of the 16 crore drinkers, around 5.7 crore face problems due to alcohol, and about 2.9 crore are dependent on it, according to the National Survey on Magnitude of Substance Use in India (2019).

Risk Factors for Substance Use Disorder:

Both genetic and environmental factors play a role in the development of substance use disorder. Substance use disorder is often influenced by factors like family, school, community, economic and peers.

Diagnosing Substance Use Disorders:

There are specific criteria, mentioned in diagnostic books like ICD 11, that need to be fulfilled to diagnose dependence or opine that a person is addicted to a habit-forming substance(s).

This includes a pattern of recurrent episodic or continuous substance use with where the person has trouble controlling their use which is shown by 2 or more of following -

- **Loss of control over substance use:** Taking larger quantities of substances or for a longer duration than what was initially planned.
- **Salience:** They start to prioritize drinking alcohol more than anything else in their life, like taking care of their health or doing daily tasks, and they keep drinking even when it causes health problems or negative consequences.
- **Craving:** A strong irresistible desire to take the substance.
- **Physiological features which suggest brain adaptation -**
    1. **Tolerance:** The need to take more amount of the substance to experience pleasure (Commonly described as 'high' or 'Kick'), which was previously possible with lower doses.
    2. **Withdrawal symptoms**: When not taking or consuming the substance, the person starts developing physical symptoms (ex: in alcohol, they can develop tremors, sweating, worry, and sleep disturbances) or psychological symptoms (feeling restless). Other withdrawal symptoms could be severe such as seizures (commonly known as Fits) and confusion (not being able to identify time, place,

person, or memory problems). If such scenarios occur, please refer them to a hospital immediately.

3. **Repeated use of substance to prevent withdrawal symptoms**

The diagnosis may be made if use is continuous (daily or almost daily) for at least 3 months.

ALCOHOL:

- ✓ Alcohol is one of the commonly used and licit psychoactive substances.
- ✓ The prevalence of Alcohol Dependence Syndrome is 3.3% at the primary health care level.[3]
- ✓ The acute and chronic effects of alcohol consumption on a person's health depend on two factors-
  - (1) The amount of alcohol consumed and
  - (2) The drinking pattern
- ✓ There are various patterns of alcohol consumption. These include:
  - **Social drinking**: Occasionally drinking when it is socially appropriate. This pattern of drinking does not usually cause any adverse consequences.
  - **Problem drinking**: This pattern of drinking involves drinking alcohol in excessive quantities, and having occasional problems but no physical symptoms of dependence.
  - **Harmful drinking**: This pattern of drinking leads to negative physical, mental, and/or social effects.
  - **Alcohol dependence:** In this pattern of alcohol consumption, there are physiological, psychological, and behavioural changes that result in the person giving excessive importance and priority to alcohol consumption as compared to other essential activities in his life.

Alcohol consumption in a harmful or dependent pattern is associated with multiple physical, mental, and social problems.

Withdrawal symptoms in Alcohol

- These are symptoms that are seen in a dependent person when the amount of alcohol consumption is less than the usual amount or is completely stopped, abruptly.
- These symptoms are usually seen 6-8 hours after the last intake of alcohol.
- Some patients with severe dependence start consuming alcohol early in the morning as an '**eye opener**' in order to avoid withdrawal symptoms
- The common withdrawal symptoms that are seen in alcohol dependence are sleep disturbance, restlessness, irritability, tremors, increased heart rate, increased blood pressure, sweating, etc.
- In severe cases, people with alcohol withdrawal may experience hallucinations

(hearing voices or seeing things without the presence of any actual stimulus), disorientation (the person becomes confused and unaware of his surroundings), or seizures (fits).

- 'Delirium tremens' – This is a serious and life-threatening complication of alcohol withdrawal. It is characterised by sudden onset of disorientation and tremors. This is a medical emergency and the patient should be immediately referred

Severe withdrawal symptoms(especially delirium tremens) could be potentially life-threatening. All cases of complicated withdrawal should be immediately referred to a doctor (preferably a secondary or tertiary care hospital)

Red Flag Signs of Alcohol use:

- Daily consumption of alcohol
- Consistently increasing use of alcohol
- Complications after stopping alcohol use
- Harm to others or self after drinking
- Difficulty in walking, memory difficulties, visual difficulties due to alcohol use (Wernicke-Korsakoff syndrome)

TOBACCO

Tobacco is another commonly used substance that is legal to use across the globe. Unfortunately, the number of deaths due to tobacco consumption is way more than any other psychoactive substance. Tobacco is available in various forms. They can be classified into either smoking (e.g., beedis, cigarettes, chillum, hookah, etc.) or chewable (gutka, khaini, snuff, mishri, betel quids) products.

Tobacco consumption in either form is associated with several harmful physical consequences. These include the following:

- Cancer of various organs like lungs, oesophagus, stomach, mouth, head & neck, etc.
- Respiratory problems like infections, asthma, emphysema, etc.
- Diabetes mellitus
- Hypertension
- Heart disease
- Stroke

Steps to follow:

Step 1 : Establish rapport with the patient

- If the person refuses to talk or take help, do not force them.
- Request politely to answer a few questions.
- Check for any immediate medical issues - if present refer to nearest hospital; if no medical issues then, encourage them to come back.

Step 2 : Patient agrees to take help - Assessment for Addiction

- Are you drinking alcohol heavily or regularly?
- Do you have any difficulty falling asleep without alcohol?
- Do your hands/body parts tremble whenever you abruptly reduce or stop using alcohol?

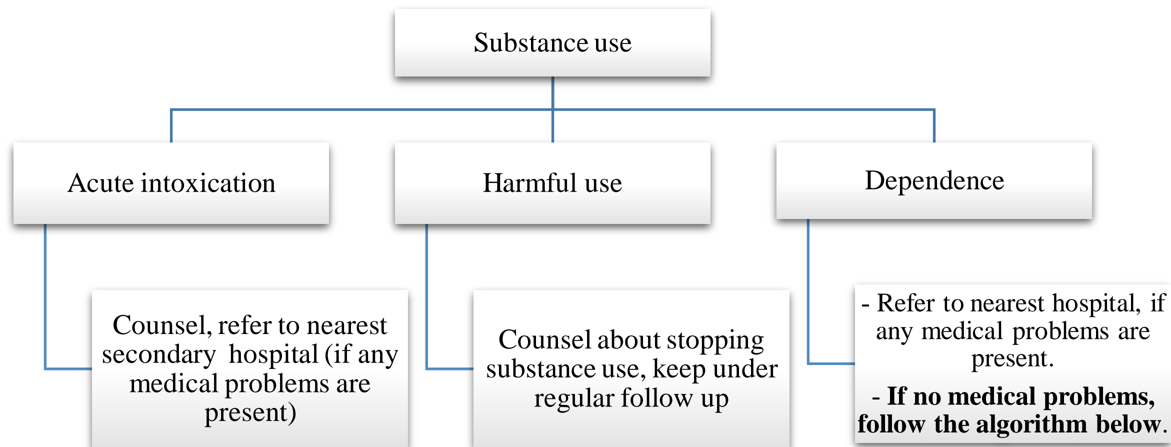
NOTE: IF YES TO ANY OF THE ABOVE 2 QUESTIONS THEN IT IS LIKELY TO BE ALCOHOL ADDICTION

- Check for any diffculties currently - if withdrawal (shaking of hands, sleep disturbances, wanting to take alcohol present - then refer to nearest health facility if patient is in the community)

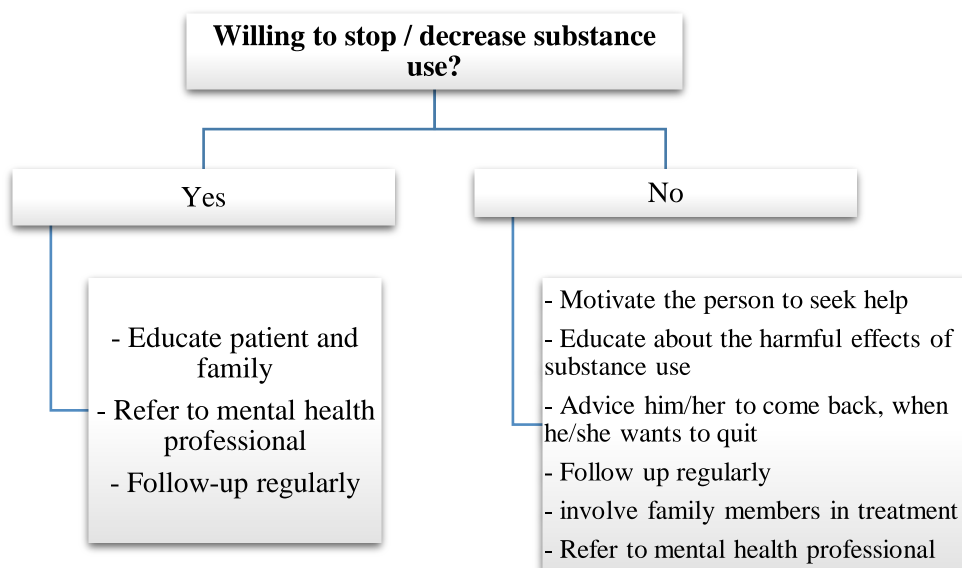
Step 3 : Intervention

- Encourage abstinence, if not then focus on harm reduction- minimize use.
- Encourage to seek help from friends and family.
- Engage in other activities to distract from substance use.
- Discuss how to handle craving:
  - Delay the use of substance
  - Distract: engage in activities and home, indoor games.
  - Discuss with friends and family about substance use.
  - When craving occurs – Drink water or eat some food – a full tummy helps in curbing craving.

Approach to Substance Use Disorder/Problem



Approach to take with patients with Dependence but with no immediate medical problems



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Chapter 6.2 Identification & Management of Alcohol Withdrawal

Alcohol withdrawal syndrome (AWS) is a set of symptoms that occur when a person who has been drinking heavily suddenly stops or reduces their alcohol intake from their usual amount.

The symptoms of AWS range from minor ones, such as insomnia, anxiety symptoms and tremors, to severe ones, such as seizures and delirium tremens.

AWS is diagnosed based on criteria established by the DSM-5, which include the cessation or reduction of heavy alcohol use, the presence of at least two specific withdrawal symptoms within hours to days of stopping or reducing alcohol use, and the symptoms causing significant distress or impairment in social, occupational, or other areas of functioning.

The symptoms of AWS typically begin within 4-12 hours of stopping alcohol use and peak during the second day, improving by the fourth or fifth day. However, some symptoms, such as anxiety, insomnia, and autonomic dysfunction, may persist for up to 3-6 months.

Presenting Symptoms	The usual time of appearance after stopping alcohol use
Withdrawal symptoms: **Headache, anxiety, insomnia, tremulousness, gastrointestinal disturbance, palpitations, alcoholic hallucinosis: visual, auditory, or tactile hallucinations**	12 to 24 hours
Withdrawal seizures: Generalized tonic-clonic seizures	24 to 48 hours
Alcohol withdrawal delirium (delirium tremens): hallucinations (predominately visual), disorientation, tachycardia, hypertension, low-grade fever, agitation, diaphoresis	48 to 72 hours

Only less than 10% of people in withdrawal ever experience delirium or withdrawal seizures.

When to suspect other causes of Seizures (Independent Seizure disorder)?	
1.	Seizures are focal or Complex partial seizures.
2.	No definite history of recent abstinence from drinking.
3.	Seizures occur more than 48 hours after the patient's last drink.
4.	The patient has a history of fever or trauma.

<u>Alcohol Withdrawal Delirium or Delirium Tremens:</u>

It is a severe complication of AWS characterised by clouding of consciousness and disorientation.

Alcohol withdrawal delirium, or delirium tremens, is characterized by clouding of consciousness and disorientation. Untreated delirium tremens has a mortality rate of 1 to 5 percent.

Identification and Management of Alcohol Withdrawal Syndrome (AWS) for Primary Care Doctors:

History: Critical historical data to be collected include:

1. Quantity of daily alcohol intake (30ml of 40% alcohol equals 1 unit of alcohol), duration of alcohol use, time since last drink, episodes, and symptoms of previous alcohol withdrawals, concurrent medical or psychiatric conditions, abuse of any other agents.

2. The physical examination should assess the withdrawal symptoms and also possible complicating medical conditions, including arrhythmias, congestive heart failure, coronary artery disease, gastrointestinal bleeding, infections, liver disease, nervous system impairment, and pancreatitis.

3. It is essential to check a patient's vitals, hydration status, any external injuries, and hepatomegaly and perform a complete neurological examination.

4. Basic laboratory investigations must include a complete blood count, blood sugar levels, liver function tests, and renal function tests.

Differential Diagnosis:

It is important to keep in mind the possibility of other medical conditions like CNS infections, haemorrhage, head injury, electrolyte imbalance or withdrawal from other sedatives, mimicking or co-existing with alcohol withdrawal syndrome, especially in cases where the history of a pattern of use or last use is unclear.

Management:

The management of alcohol withdrawal syndrome involves both supportive care and pharmacologic treatment.

Supportive care: This includes correcting dehydration and abnormalities in electrolyte levels, providing multivitamins and thiamine (100 mg per day) to prevent Wernicke's encephalopathy, and monitoring for any complications or co-occurring medical or psychiatric conditions.

If intravenous fluids are administered, thiamine (100 mg intravenously) should be given before glucose is administered to prevent the precipitation of Wernicke's encephalopathy.

Choice of treatment setting:

The choice of treatment setting depends on the severity of withdrawal symptoms. Mild to moderate withdrawal symptoms can be managed on an outpatient basis, while severe withdrawal symptoms require inpatient detoxification.

WHEN TO REFER:

If an individual has features such as:
• Any co-morbid serious medical issue E.g.- uncontrolled hypertension, diabetes, etc
• Seizures (Fits)
• Episodes of unconsciousness
• Confusion
• Memory problems
• Fever, headache
• Vomiting of blood
• Using injectable drugs
• Abnormal behaviour / violence

The above symptoms are indicative that the person has serious medical problems, which may even lead to death if left untreated.

Note: 90% of the cases can be managed at the PHC level. Only 10% have complications which need referral.

Pharmacological treatment:

Benzodiazepines are the medication of choice for the treatment of alcohol withdrawal syndrome (Detoxification). The choice of benzodiazepine depends on the pharmacokinetics of the drug and the patient's individual needs.

Diazepam is a long-acting agent that provide a smoother withdrawal, while lorazepam and oxazepam are intermediate-acting agents that are preferable in patients who have cirrhosis /liver dysfunction or abnormal liver function tests.

Regimen:

A fixed-dose regimen involves administering doses of benzodiazepine at specific intervals,

Note: For every 30ml of hard liquor, half a bottle of beer (350ml), the benzodiazepine equivalent to Diazepam 5mg.

Below is the benzodiazepine equivalent to Diazepam 5mg for the commonly available drugs at the PHC level:

Name	Approx. dose equivalent to 5mg diazepam
Lorazepam	0.5 - 1mg
Oxazepam	10 mg

E.g.- 1. Tab Diazepam 10 mg 1-1-2 x 2 days

0-1-2 x 2 days

0-0-2 x 2 days

Then STOP

Follow-up:

After the initial detoxification, it is essential to follow up with treatment for alcohol dependence, which may include both pharmacologic and non-pharmacologic interventions such as anti-craving medications, deterrents, and behavioural therapies such as Motivational Enhancement Therapy (MET) and Relapse Prevention Therapy (RPT).

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Alcohol use disorder

Chapter 6.3 Medications to prevent relapse (Anti-craving agents)

Alcoholism is a relapsing and remitting chronic condition that imposes a significant social and medical burden on society. Relapse in an alcoholic patient can occur for a variety of reasons, including psychosocial issues, cravings, and more.

The FDA has approved four medications to treat alcoholism: Disulfiram, Naltrexone (oral and long-acting injectable formulations), and Acamprosate.

Disulfiram:

Disulfiram was the first agent to be approved for preventing relapse in alcoholic patients in 1948. It works by inhibiting the enzyme aldehyde dehydrogenase and increasing the concentration of acetaldehyde in the blood, leading to unpleasant symptoms when alcohol is consumed.

- It is used as a deterrent and should be taken under supervision.
- Starting dose - 250 mg in the morning, once a day.
- Start only after one week of complete stoppage of alcohol.
- Consent- Take written consent from the patient before starting.
- Disulfiram card – A special identification card which states that patient is on disulfiram and the serious side effects possible when alcohol is consumed.
- Common side - drowsiness, headache, fatigue, allergic dermatitis, and gastrointestinal upset.
- Duration of treatment – one year
- Contraindications - Cardiovascular disorder, Psychosis, pregnancy. Instruct to avoid the use of Alcohol and alcohol-containing products (aftershave, alcohol-containing cough syrup, certain homoeopathic and ayurvedic medications, etc.) as it can cause a reaction (Disulfiram Ethanol reaction).

Symptoms	Management
- **Sweating, flushing** - **Hyperventilation, Dyspnoea** - **Nausea, Vomiting, Abdominal pain** - **Chest pain, palpitations, hypotension, tachycardia** - **Agitation** - **Seizures, Coma**	- Supportive management with IV fluids - Airway management - Sedation if required - Fomepizole can be used in severe cases

Naltrexone:

Naltrexone works by blocking the effects of opioids on the brain and reducing cravings for alcohol. It is available in oral and long-acting injectable formulations. The oral form can be taken once daily.

Indications for Naltrexone

- Wish to reduce heavy drinking or Pursue abstinence
- Do not have significant hepatic insufficiency
- Not taking or consuming opioids

Dosage- 50 mg/day once daily in the morning with food

It can be started at 25mg/day once daily in morning and increased to 50mg/day after a week.

It can be used in combination with counselling and should be avoided in patients with current opioid dependence. It can be for as long as patient wants to maintain abstinence.

Naltrexone may cause adverse reactions such as nausea, vomiting, headache, fatigue, insomnia, nervousness, irritability, and injection site reactions. It is essential to monitor the liver function test (LFT) before starting the medication and then at one month and annually. It is partially contraindicated for patients with liver functions that are 3-4 times normal and is contraindicated in patients with liver failure or acute hepatitis.

Suitable Patients for Naltrexone:

Naltrexone may be suitable for patients with high levels of craving, a positive family history of alcoholism, who want to reduce heavier drinking behaviour without the goal of abstinence, or on days when drinking is anticipated. It can be used in combination with psychotherapy and support, and patients should be closely monitored for potential side effects and potential interactions with other medications.

Acamprosate:

Acamprosate works by modulating the balance of neurotransmitters in the brain and reducing cravings for alcohol. It is taken three times a day and should be used in combination with psychotherapy. It should be avoided in patients with kidney impairment.

Dosage- Patients > 60 kg should receive 333 mg 2-2-2

Patients <60 kg should receive 333 mg 1-1-2

No titration is required while starting and stopping; it can be started early in abstinence.

Acamprosate may cause adverse reactions such as headaches, diarrhoea, nausea, vomiting, abdominal pain, and pruritus. It is important to note that patients with mild to moderate renal impairment may require a dose reduction. In contrast, patients with severe renal impairment (creatinine clearance of ≤30 mL/min) should avoid the medication. It should also be avoided in patients with hypercalcemia (total >10.3, ionized >5.4 mg/dl). Patients should be monitored for depressive symptoms and suicidal ideation.

Appropriate Patients for Acamprosate:

Acamprosate may be appropriate for patients who, at treatment onset, are motivated for complete abstinence and who have started the treatment after a period of sobriety. It may also be beneficial for patients with harmful emotional state cravings and protracted alcohol withdrawal symptoms such as sleep difficulties. Patients on Opioid Agonist Therapy (OAT) for pain management and patients with multiple medical issues and taking many other medications may also benefit from acamprosate treatment. It should be used in combination with counselling and support, and patients should be closely monitored for potential side effects and potential interactions with other medications.

Other agents that have been found to help prevent relapse include Topiramate, Baclofen, and SSRIs. It is important to note that these medications should be used in combination with psychotherapy and support for best results

It is important to note that, even with proper treatment, relapses are common in patients with alcohol use disorder, and multiple treatment attempts may be needed. Medications can be an effective tool in preventing relapse, but they should be used in combination with other support, such as counseling and support groups.

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Click on the topic or scan QR code below to learn more about alcohol use disorder:

Alcohol use disorder

Chapter 6.4: Tobacco use and management

Introduction:

Tobacco dependence poses serious health risks to individuals and society. Smoking, the leading cause of preventable deaths globally, results in over 7 million fatalities annually. This chapter outlines the prevalence, features, and treatment strategies for nicotine dependence.

Prevalence and Significance:

With an estimated 28.6% of Indian adults using tobacco in some form, the prevalence of tobacco use remains high. Nicotine dependence is characterized by a compulsion to use tobacco, difficulty in control, withdrawal symptoms, tolerance, neglect of activities, and continued use despite consequences.

Nicotine Withdrawal and Treatment:

Nicotine withdrawal symptoms, occurring within the first week of quitting, encompass both affective and physical aspects. These include irritability, anxiety, depressed mood, insomnia, fatigue, and constipation. Treatment involves a comprehensive approach.

Pharmacological Treatment:

Varenicline:

- Acts as a partial agonist on nicotinic receptors, reducing pleasurable effects.
- Adverse effects: nausea, insomnia, nightmares, mood changes.
- Dosage: Gradual increase to 1mg twice daily.
- Duration: 3-6 months.

Bupropion:

- Enhances CNS neurotransmitter release.
- Initiate a week before quitting at 150mg daily.
- The dose should be increased to 150mg twice daily after three days.

Nicotine Replacement Therapy (NRT):

- NRTs alleviate withdrawal symptoms by providing controlled nicotine doses.
- Forms: gum, patch, lozenge, inhaler, nasal spray.
- Dosages and durations vary depending on smoking habits.
- Side effects: insomnia, rash, nightmares, allergies.

Gum, Lozenges, Inhalers, Sublingual Tablets:

- Taken every 1-2 hours while awake.
- Proper gum usage: chew slowly, "park" between cheek and gums.

- Dosages: 2mg for 25 cigs or less, 4mg for >25 cigs.
- Maximum: 24 gums/day.
- Side effects: mouth soreness, dyspepsia.
- Duration: 12 weeks, with gradual dosage reduction.

Method of Chew and Park:

First, they should chew the gum very slowly until they notice a minty taste or tingling feeling, then "park" the gum between the cheek and gums for 1 to 2 minutes to allow nicotine to pass through the gum tissue and be absorbed. Patients should gradually resume chewing until a tingling or minty taste returns after two minutes or after the tingling stops, and then "park" the gum in a different location on the gums. Instruct patients to use the "chew and park" technique once more until there is no longer any taste or tingle (around 30 minutes).

Side effects of this method include headaches, a painful, dry mouth, dyspepsia, nausea, and jaw pain.

How nicotine gums help:

- Effective in controlling withdrawal symptoms.
- Tobacco use concurrently doesn't lead to any significant issues.
- It can begin without completely quitting cigarette consumption.
- Nicotine dosage is user-controllable.

Pharmacotherapy	Precautions, contraindications	Adverse effects	Dosage	Duration of treatment
Varenicline	Significant Kidney Disease	Nausea, Insomnia, Nightmares, Depressed mood, and psychiatric symptoms	0.5mg/day for 3 days then 0.5mg twice/day for 4 days then 1mg twice/day	3-6 months
Nicotine Patch		Local skin irritation, Insomnia	21mg/day 14mg/day 7mg/day Depends on the number of cigarettes used per day	12 weeks Tapering to a lower dose can be done after 2-6 weeks and then at 4-8 weeks

Nicotine Gum		Mouth Soreness, Dyspepsia	25 cigs= 2mg every 1-2 hourly > 25 cigs = 4mg every 1-2 hourly (Maximum: 24 gums/day)	12 weeks Week 1-6:1 piece every 1-2 h Week 7-9: 1 piece every 2-4 h Week 10-12: 1 piece every 4-8 h

Non-Pharmacological Interventions:

Five Ds technique for managing Craving:

Delay: Wait until urge passes.

Distract: Shift focus to a different activity.

Drink water: Reduces craving and withdrawal effects.

Deep breathing: Relaxation technique.

Discuss: Talk to supportive individuals or groups.

5As Approach for Motivating to address Tobacco use:

Assess: Identify tobacco use and motivation to quit.

Advise: Offer clear advice to quit.

Agree: Collaboratively set a quit date.

Assist: Provide support, medications, and resources.

Arrange: Schedule follow-up and ongoing support.

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Click on the topic Scan QR code below to watch a video on Nicotine use and management:

Nicotine use and management

7 | SEVERE MENTAL DISORDERS

Chapter 7.1 Schizophrenia and Psychotic Disorders

Schizophrenia is a severe mental disorder that affects a person's thinking, perception, self-experience, cognition, volition, affect, and behaviour.

It is considered an illness that causes severe functional impairment and significantly limits one's major life activities. The term schizophrenia is derived from two Greek terms meaning "to split" and "mind," literally meaning "a split of mind."

The prevalence of schizophrenia in India is around 0.8% in the general population and affects males and females equally. The prevalence in the primary health care settings is also around 0.8 %.

Symptoms of schizophrenia are first recognizable in late adolescence or early twenties.

Individuals with schizophrenia are two to three times more likely to die earlier than the general population, with suicide being the leading cause of death.

The natural course of schizophrenia is variable, and some patients experience exacerbation and remission of symptoms periodically throughout their lives.

Symptom domains	Example of symptoms
Positive symptoms	Delusions, Hallucinations, Extreme aggression/agitation, Disorganised speech
Negative symptoms	Flattened affect, Avolition (reduced motivation), asociality (social isolation), Anhedonia (lack of pleasure), Alogia (poverty of speech) Mutism; posturing; rigidity
Psychomotor Symptoms	Mutism, Posturing, Rigidity, Mannerisms
Cognitive Symptoms	Poor memory and comprehension, poor attention and concentration, disorganised thinking

Different symptom domains have different courses and outcomes. Positive symptoms respond well to antipsychotics, while negative symptoms may worsen with antipsychotics.

According to the Clinical Schedule for Primary Care Psychiatry (CSP), psychosis can be subtyped as :

1. Acute onset: Acute Transient Psychotic Disorder
2. Episodic Course: Bipolar Affective Disorder
3. Continuous Course: Schizophrenia

Clinical Features of schizophrenia

For ease of understanding and relevance of use in primary care practices, we have described the most common symptoms of psychosis in detail in this chapter. These include delusions, hallucinations, and aggression. Other symptoms include disorganized thoughts, the delusion of control, and catatonia. Before diagnosing schizophrenia, it is essential to rule out any organic cause using the CSP questionnaire.

Hallucinations:

False sensory perceptions (visual, auditory, tactile, olfactory, gustatory) that occur without external stimuli. Usually experienced as originating from the outside world and not from within the person's mind as imagination.

Delusions:

Delusions are false, firm beliefs that are held with extraordinary convictions even when evidence to the contrary is given. These beliefs are usually not shared by others in society. Based on the content of the delusions, there can be different types of delusions.

Delusion of reference	A delusional belief that people are referring to the patient in their action
Delusion of persecution	A delusional belief that people are plotting against the patient

Disorganized behaviours:

These refer to actions that are erratic, unpredictable, and lack a clear purpose or structure. It can manifest as difficulties in organizing daily activities, maintaining personal hygiene, or adhering to social norms.

E.g.: A person experiencing disorganized behaviour due to psychosis may exhibit difficulties in completing simple tasks. For instance, they might attempt to brush their teeth with a hairbrush or wear mismatched shoes without realizing the error. Their actions may appear confusing and unrelated to the task at hand, reflecting the disorganization of thought processes associated with psychosis.

Catatonia

This is a condition which is characterised by a range of movement abnormalities such as stupor (prolonged immobility and unresponsiveness), agitation, posturing (assuming unusual or rigid

body positions), mutism (limited or absence of speech) and , staring for long periods without blinking.

Assessment of a patient with probable psychotic disorder:

Whenever a patient is brought to the PHC with behavioural symptoms, the doctor should screen the patient as per the Clinical Schedule for Primary care clinicians (CSP) screening questions.

General screening questions as per CSP

- How was your sleep for the last few weeks?
- How has your appetite been for the last few weeks?
- How is your interest in doing your daily work?

If any of the general questions are answered as "disturbed," it is likely that the patient is suffering from some psychiatric illness. In such cases, the remaining eighteen questions should be asked. The penultimate four questions should be asked in all cases suspected to have psychotic illnesses (i.e., question number 17 - 20).

Screening questions for psychotic disorders as per CSP

- In the past few weeks, have they talked or smiled to themselves/Hallucinations?
- Have they had poor self-care/wandering in the past few weeks?
- In the past few weeks, have they had suspiciousness/talking big/delusions?
- In the past few weeks, have they been talking excessively/ sleeping less/hyperactive?

If the attendant of the patient responds positively to any of the above questions, further details of the illness, e.g., onset, duration, and progress of the illness, should be enquired. Usually, the onset is gradual in schizophrenia.

When to refer to a Psychiatrist?

• If the patient is actively suicidal
• If the patient is very aggressive
• When the diagnosis is not clear
• When the diagnosis is clear, but there is confusion over the treatment plan
• If the patient has shown no improvement after taking medicine for a month
• If the patient has developed severe side effects with medication
• If the patient is not taking medicine regularly and needs a depot injection
• If the family members or patient want a second opinion
• If there is any organic cause suspected

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Click on the topic or scan the QR code below to learn more about Schizophrenia:

Schizophrenia

Chapter 7.2 Antipsychotics - Olanzapine and Risperidone

Antipsychotics are a group of drugs used to treat schizophrenia and other psychotic disorders. Schizophrenia is one of the most severe psychiatric illnesses with high morbidity

The dopamine hypothesis of schizophrenia is a commonly accepted explanatory model. It states that hyperactivity of the mesolimbic dopamine pathway causes the positive symptoms of schizophrenia, such as delusions and hallucinations. This is supported by the fact that D2 receptor blockers, which reduce dopamine activity, effectively reduce these symptoms.

Antipsychotics are broadly classified into two groups: typical and atypical antipsychotics.

Atypical antipsychotics or second-generation antipsychotics have a different mechanism of action than typical antipsychotics. They act as dopamine receptor D2 and serotonin receptor 5-HT2A antagonists. This action in the mesolimbic pathway causes fewer extrapyramidal symptoms. Additionally, atypical antipsychotics have been found to have a lower risk of developing tardive dyskinesia. They also have better efficacy in treating negative symptoms, cognitive impairment, and affective symptoms of schizophrenia. Some atypical antipsychotics have also been used to treat other psychiatric disorders, such as bipolar disorder, major depressive disorder, and even as adjunctive therapy in treatment-resistant depression.

S.NO.	TYPICAL ANTIPSYCHOTICS	ATYPICAL ANTIPSYCHOTICS
1	Haloperidol	Olanzapine 10mg
2	Fluphenazine (Depot Injection) 25mg fortnightly	Risperidone 4mg

OLANZAPINE

Dose:

It is prescribed from a starting dose of 5mg/day and can be increased by 5 mg/d every 5 days up to 20mg/day, based on tolerability and response.

Timing Of Medication:

It can be given as once daily dose at night.

Side Effects:

Weight gain, increased appetite, diabetes, and dyslipidemia. It also causes sedation, orthostatic hypotension, and constipation. Less frequently, it can cause akathisia and tremors.

RISPERIDONE

Dose:

Risperidone is prescribed from a starting dose of 2 mg/day, increased by 2 mg every 3 days up to a maximum dose of 8 mg/day.

Formulations:

Risperidone is available as an oral tablet formulation of strength 0.5mg, 1mg, 2mg, 3mg, and 4mg, oral liquid or syrup formulation (1 mg/ml).

Timing Of Medication:

It is given once daily at night.

Side Effects:

The extrapyramidal side effects of risperidone are usually dose related. Risperidone can also cause other side effects, such as weight gain and serum prolactin elevation.

HALOPERIDOL

Dose:

Haloperidol is prescribed from a starting dose of 0.5 mg/day, increased by
2 mg every 3 days up to a maximum dose of 10 mg/day.

Formulations:
Haloperidol is available as an oral tablet formulation of strengths 0.5 mg, 1 mg, 1.5 mg, 2 mg, 2.5 mg, and 5 mg.

An injection form of Haloperidol 5mg/1ml is available, which can be used for sedation of agitated patients. It should be used along with Lorazepam 2 mg or 4 mg IV.

Timing Of Medication:
It is given once daily at night
Side Effects:

The side effects of haloperidol include drowsiness, nausea, vomiting, constipation, tremors, etc.

LONG-ACTING FLUPHENAZINE

Usually long-acting fluphenazine is given when the patient doesn't take medications regularly and is prescribed by a psychiatrist.

At the primary health care level, it is vital to know the side effects and dosage of long acting fluphenazine for follow-up.

An injection form of fluphenazine 25mg/1ml is available and is usually given twice a month, 15 days apart.

Side effects

The side effects include drowsiness, nausea, vomiting, constipation, tremors, etc.

Side Effects Of Antipsychotic Medications

These are the extrapyramidal side effects, metabolic side effects, ECG changes in the form of QTc prolongation, and hyperprolactinemia.

Extrapyramidal Symptoms:

- **Parkinsonism** is characterized by stiffness, slowness of movements, tremors, drooling of saliva, slurring of speech, short-stepping gait, reduced blink rate, and diminished facial expressions. It typically occurs 5-7 days after starting the medication and can be managed by reducing the dose of the antipsychotic and/or adding anticholinergic medicines such as trihexyphenidyl.
- **Acute dystonia** is characterized by sudden twisting of the neck, tongue protrusion, abnormal posturing of limbs, trunk, and blepharospasm starting within a few hours to days of starting the antipsychotic medication. ***As a treatment, Inj Promethazine 25-50mg only IM can be given.***
- **Akathisia** is characterized by a subjective feeling of restlessness, objective signs of restlessness, or both. It is associated with anxiety, inability to remain still, and pacing or rocking movements. It can be treated with beta-blockers such as propranolol and benzodiazepines and managed by reducing the dose of the antipsychotic or changing the antipsychotic.
- It's important to note that **tardive dyskinesia** is a potentially irreversible condition, and it is essential to monitor patients receiving antipsychotics for signs of tardive dyskinesia and to discontinue treatment if the symptoms appear. The risk of developing tardive dyskinesia is highest in older adults and those who have been taking antipsychotics for a prolonged period of time.
    - NMS is a life-threatening adverse event that can occur at any time after starting antipsychotic medication. The symptoms include muscular rigidity, dystonia, agitation, hyperthermia, excessive sweating, tachycardia, and elevated blood pressure. Patients with NMS should be referred to higher centres for management.

CONSIDER REFERRAL TO A HIGHER CENTRE
• Neuroleptic malignant syndrome (NMS)
• Hypersensitivity to antipsychotics
• Treatment resistance

Good Clinical Practice Guidelines

- Check weight, blood sugar levels, and family history of DM before starting antipsychotics.
- Start at a lower dose and increase based on tolerability
- Prescribe a single antipsychotic. Polypharmacy should be avoided.
- Switch to another antipsychotic if there is no improvement after an adequate dose (minimum dose mentioned in CSP) and duration of treatment(the duration mentioned in CSP)
- Monitor for side effects during every follow-up consultation
- When stopping the medication, slowly reduce the dose over weeks to months.(25% of dose every 3 months)

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Click on the topic or scan QR code below to learn more about antipsychotics:

Antipsychotics

Chapter 7.3: Bipolar Disorder and Management at Primary Health Centre

Introduction:

Bipolar Affective Disorder is a type of severe mental illness. It is grouped under "Mood disorder." It is also known by various names, such as, 'bipolar disorder", "bipolar affective disorder (BPAD)", and "manic-depressive illness". It is characterized by episodes of depression, hypomania/mania, and mixed episodes; between the episodes, the recovery is usually good.

According to the National Mental Health Survey (NMHS), 0.3%-0.5% of the population, i.e., Around 4-5 million individuals, have a bipolar illness, and the treatment gap is 70%, which implies that roughly 30-35 lakh people do not receive any treatment for the illness.

It usually starts in the adolescent/early adult age group and impacts the patient and caregivers if timely and adequate intervention is not provided. Also, patients with BPAD face various problems, including the risk of suicide.

Clinical Presentation:

Mania:

Diagnosed when a patient exhibits the following for a continuous period of 7 days of more -

- Elevated or irritable mood
- Increased psychomotor activity – patient has increased movements and does all actions at faster pace
- Decreased need for sleep – patient feels energetic even after sleeping for only a few hours
- Pressured speech – patient speaks continuously and cannot be interrupted
- Racing thoughts
- Grandiose beliefs
- Impulsivity, and high-risk behaviours
- Severe cases may require hospitalization

Depression:

Diagnosed when a patient exhibits the following for a continuous period of 14 days of more -

- Low energy levels
- Low/Sad mood
- Decreased activity and interest in previously pleasurable activities
- Difficulty concentrating
- Disrupted sleep and appetite
- Low self-esteem
- Feelings of guilt, worthlessness ,hopelessness, or helplessness
- Thoughts of suicide or other suicidal behaviours

Antidepressant-Induced Switch:

Some individuals may experience manic or hypomanic episodes triggered by antidepressant medications.

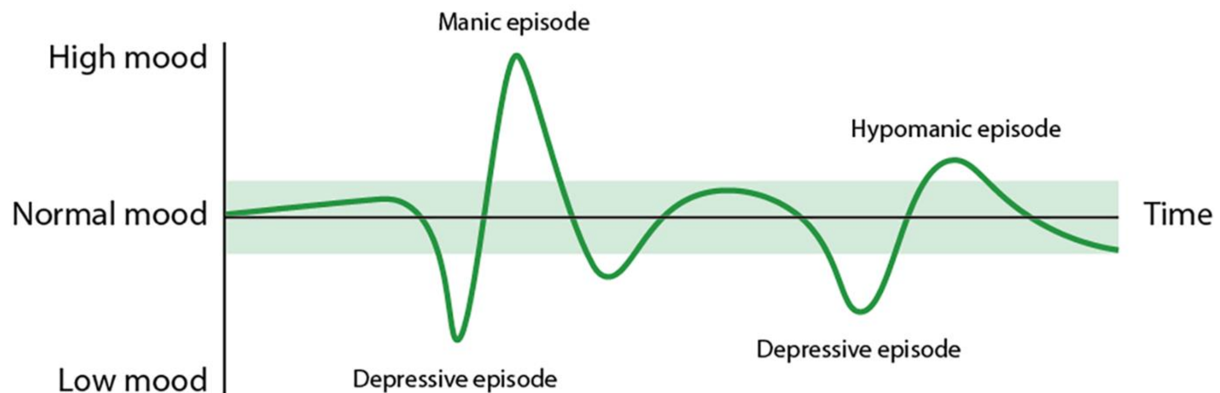

Figure - Course of Bipolar disorder

Heritability and Comorbidity:

Heritability: Bipolar disorder has a genetic component. If one parent is affected, the risk is 8-16%, increasing to 32-35% if both parents are affected. The risk further rises to 20-40% for non-identical twin siblings and as high as 60-80% for identical twin siblings.

Comorbidity: Bipolar disorder frequently coexists with other conditions. Substance use disorders, anxiety disorders, OCD, ADHD, and personality disorders are common comorbidities.

Initial Assessment:

- **Age of Onset and Polarity**: Determine when the disorder began and whether depressive or manic episodes predominate can aid diagnosis and treatment planning.
- **Episode Severity:** Assess the severity of episodes, identifying risk factors like suicidal or aggressive behaviours.
- **Treatment Response and Side Effects**: Evaluate past treatment experiences, including responses and potential side effects.

Baseline Investigations To Be Done:

- **Detailed General Physical Examination – Height, weight, BMI, Waist circumference**
- **Complete hemogram**
- **Liver function test**
- **Renal function test**
- **Thyroid function test**
- **ECG**

Management and Treatment:

Pharmacological Treatment

Mood stabilizers: Mood stabilizers are the mainstay of treatment for BPAD.

- Divalproex/ Valproate
- Carbamazepine/ Oxcarbazepine

Lithium, a common mood stabilizer, is not discussed here as it is not recommended for prescription in primary care settings. This is due to its potential interactions with many common drugs and the necessity for vigilant monitoring due to the risk of toxicity and side effects. Kindly refer to a psychiatrist if a patient is on Lithium.

Antipsychotics medications: mainly used during acute episodes.

- Risperidone
- Olanzapine

Valproate:

Indications: Acute Mania, Prophylactic treatment of BPAD

Dose: 20-30 mg/kg body weight BD dose

Valproate can be started at 15mg/kg body weight BD dose and gradually up titrated by 250mg/d every week to a target dose of 20-30 mg/kg body weight

Precautions: Consider the teratogenic effects in women of childbearing age. Common side effects include gastric irritation, weight gain, and tremors.

Valproate Toxicity: Symptoms include altered mental status, CNS depression, coarse tremors, and multi-system involvementteev2 Stop the drug immediately, monitor vitals, and send CBC, LFT, RFT, serum electrolytes, and ammonia levels. Refer to a higher centre if needed.

Carbamazepine / Oxcarbazepine:

Indications: Acute Mania (2nd line), Maintenance phase (2nd line)

Dose: Start with 100 mg to 200 mg, gradually increasing (200mg every week) to 400 mg BD. Be cautious with Clozapine co-administration due to the risk of blood dyscrasia.

Side Effects: Common side effects include drowsiness, headache, nausea, and dry mouth. Be vigilant for erythematous rashes, hyponatremia, and altered liver function tests.

Carbamazepine Toxicity: Symptoms include diplopia, ataxia, confusion, agitation, vomiting, and abdominal pain. Stop the drug immediately, monitor vitals, and serum levels, and refer if necessary.

Antipsychotic Drugs:

Antipsychotics are mainly used in acute phases for symptom control. Once stabilized on mood stabilizers, consider withdrawal. Risperidone and Olanzapine are suitable for acute mania or hypomania episodes, often alongside Benzodiazepines.

Duration of Treatment:

The duration varies based on the number of episodes and family history. Lifelong medication may be necessary for recurrent episodes.

However, below is a guideline that will help you in managing patients with bipolar disorders:

- If the patient presents with first-episode mania, the treatment consists of two parts:
    - Acute treatment, which would last for around 3 months and
    - Maintenance phase, which would last for about 6 months.
- Hence for the first episode, the total duration of treatment would be 9 months.
- If there are 2-3 episodes, then the duration of treatment would be 5 years.
- And for more than 4 episodes, the treatment would be lifelong.

Aggression Management:

In acute episodes with aggression, oral or intramuscular medications like Lorazepam, Promethazine, and Haloperidol may be used.

Agitation and acute episodes of bipolar disorder can be challenging to manage in primary care settings. Below are guidelines for managing these situations effectively.

Adults:

Lorazepam (1 to 2 mg) or Promethazine (25 to 50 mg) can be administered orally or intramuscularly. If benzodiazepines are inappropriate, consider using Promethazine.

Alternatively, Haloperidol (2 to 5 mg) with Promethazine (25 to 50 mg) can be considered.

Consider In-Patient care or refer to a higher centre if the patient has the following features:
• **Recent Suicidal attempt**
• **Severe agitation or violence**
• **Severe episodes**
• **Risk of harm to others**

• **Not able to take care of themselves**
• **Catatonic features present**
• **Co-morbid medical illness where Out patient monitoring is difficult**

Psychoeducation:

- Assess patients' and caregivers' understanding of aetiology, treatment, and prognosis.
- Discuss the symptoms of depression, mania, hypomania, and mixed episodes.
- Provide information about available treatment options, their durations, efficacy, and potential side effects.
- Emphasize the importance of compliance and supervised medication.
- Explain the possible course of the disorder and its long-term outcomes.
- Discuss maintaining a regular sleep-wake cycle and practicing good sleep hygiene.
- Address potential issues related to substance use.

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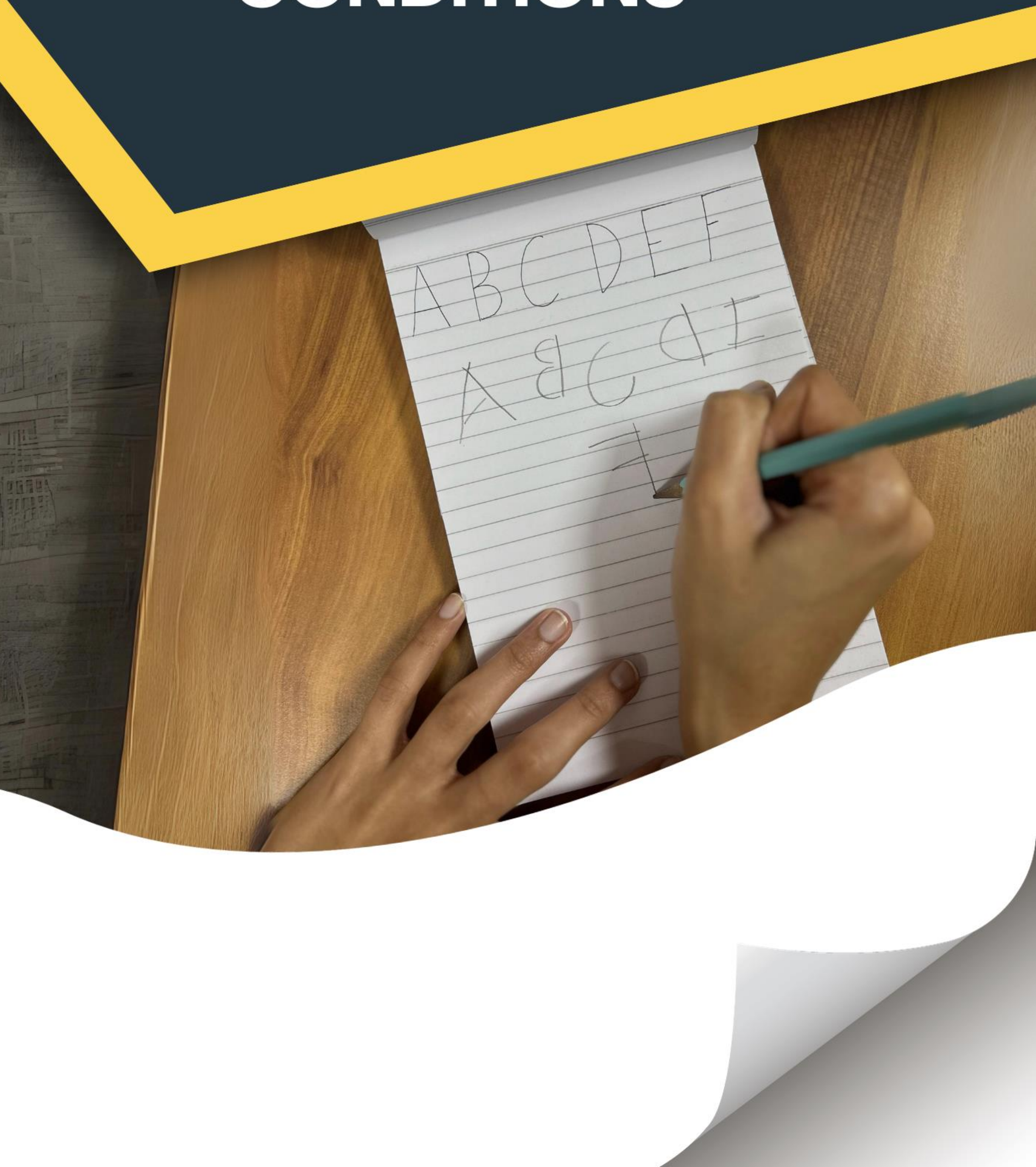
Click on the topic or scan QR code below to learn more about the management of Bipolar Disorder:

Bipolar Disorder

8| SPECIAL CONDITIONS



Chapter 8.1: Emotional and Behavioural Disorders of the Elderly

ROLE OF A PRIMARY CARE DOCTOR:

There is a growing need to integrate geriatric mental health into the existing primary care system, as it may reduce the treatment gap significantly through early diagnosis and interventions, thereby reducing morbidity and mortality. Common mental health conditions seen in the elderly are depression, dementia, delirium, anxiety, insomnia, psychotic illness, and substance use.

HOW TO APPROACH AN ELDERLY PERSON:

I. INTERVIEW WITH PATIENT AND FAMILY:

Begin by asking the name and place of the patient

-What are their chief complaints?
-Follow by asking three basic questions:
a) How is your sleep?
b) How is your appetite?
c) Are you able to do your daily routine work (eating, bathing, brushing)?
If the answer is "no" or "disturbed" for any of the above, proceed as below:

1. Delirium:

PATIENT	FAMILY/DOCTORS
Orientation to time, place, and person: **1. What is the approximate time now (is it morning/afternoon/evening)** **2. Where are you currently?** **3. Who has come with you now?**	1. When did the confusion start? 2. Sleep-wake cycle reversal (does he sleep during the day and wake at night) 3. Is there any abnormally confused behaviour

Management:

- Detailed investigations to be done: Blood tests- Kidney functions, Complete blood count, electrolytes, sugars
- Refer to a higher centre for evaluating the cause
- Brief pharmacological management: ONLY IF AGITATED/DISRUPTIVE-
T. Risperidone 0.5mg 0-0-1 to 1-0-1 or T. Haloperidol 0.5-1mg 0-0-1

2. Depression:

PATIENT	FAMILY
Follow CSP screener	

Management:

- Relevant blood investigations to be carried out: CBC, RFT, sugars, electrolytes
- Start T. Escitalopram 5mg for 2 weeks, then increase to 10mg 0-0-1

OR T. Fluoxetine 10mg for 2 weeks, then 20mg 1-0-0

If sleep disturbance: T. Clonazepam 0.25mg 0-0-1

- If there is a high suicidal risk or decline in personal care- refer to a higher centre

3. **Anxiety:**

- Introduction- one of the most common symptoms in the elderly, especially fear of falls, health anxiety, worries related to death

a) **Health anxiety:**

✓ Health anxiety disorders (e.g., hypochondriasis) are prevalent, and have a late age onset.

✓ Typically arises following stress, serious illness, significant loss, or following exposure to disease-related stimuli.

b) **Fear of falling:**

✓ Consists of moderate to severe fear with avoidance of multiple situations and activities (approximately 3 %).

✓ The fear of falling is also impairing, limiting mobility, and contributing to functional decline and institutionalization.

- Medical conditions to keep in mind for anxiety in the elderly- Stroke, Parkinson's disease, Angina, Arrhythmia, Asthma, Irritable Bowel Syndrome, metabolic abnormalities, and vitamin deficiency states.

Management:

Pharmacological-

✓ SSRI- fluoxetine, escitalopram

Non-pharmacological-

- Lifestyle modifications: Sleep, diet, exercise, socialization, Structured daily activities

Patients should be referred if:

- Comorbid severe depression (and, at times, suicidality) is present.
- Anxiety disorder is severe and treatment-resistant. e.g., OCD.
- Concurrent serious medical illnesses and treatment need evaluation and management.

4. **PSYCHOSIS:**

PATIENT	FAMILY
Follow CSP screener	

- **Management:**

- To do investigations

- Start. T Risperidone 0.5 to 2mg 0-0-1 in 2-4 weeks, depending on symptoms OR T. Olanzapine 2.5mg to 5mg 0-0-1 in 2 weeks.
- If the risk of harm to self or others is, unmanageable- refer to a higher centre.

5. INSOMNIA:

Sleep disturbances are common in the elderly. Any change in routine, medical, or psychological problems may worsen sleep.

Causes: physical (pain, frequent urination, breathing difficulty), psychiatric, environmental causes (light, sound, uncomfortable bedding), medications

Interventions:

Nonpharmacological techniques- Sleep problems are pretty common; before considering medications, explain sleep hygiene techniques, as illustrated in previous chapters

Pharmacological treatment:

Agents such as lorazepam, clonazepam, or diazepam may be used with caution**.**

T. Lorazepam 1mg 0-0-1 OR. T clonazepam 0.25 to 0.5mg 0-0-1.

Discourage continuation after one month.

6. Dementia:

Ask for the duration of symptoms and dysfunction because of the problems.

PATIENT	FAMILY
1. Do you feel you have forgotten things recently? **2. Do you misplace things in the house?** **3. Are you able to do your previous activities well- cooking, shopping, household chores, dressing, and using the phone (if applicable) ?**	1. Does he/she appear distracted? 2. Is there slow decline in their higher mental functions especially memory? 3. Does he/she forget ways/get lost in the house? 4. Are there any changes noticed in their speech- naming difficulty, asking questions repeatedly? 5. Is he/she able to do ADL themselves? 6. Any behavioural disturbance- insomnia, irritability, aggression, etc.

ADL: Activities of Daily Living, e.g., sleeping, eating, bathing, toileting

Management:

- Relevant blood investigations to be carried out: CBC, RFT, sugars, and electrolytes to rule out other causes.
- Refer to a higher centre for a detailed evaluation of dementia

II. INTERVENTIONS AND TIPS FOR THE CAREGIVERS:

- ✓ Empathetic listening towards the caregivers' account of their feelings and what they are concerned about disturbed behaviours.
- ✓ Reassure the families that these behaviour problems are common during old age.
- ✓ Ensuring dignity and privacy (especially during activities such as dressing and bathing).
- ✓ Establishing a daily routine.
- ✓ Safety: Keeping a chair to sit while bathing, a mat to prevent slipping, etc
- ✓ Speak slowly and clearly; if the person has not understood, try to say things using simpler words and shorter sentences. Minimise background noise.
  - ✓ Use of identification bracelet/necklace in case of a history of wandering behaviour and getting lost.
  - ✓ Locking doors in the night- in case of wandering.
  - ✓ Use clothes that can be easily removed.
  - ✓ Limiting water intake in the evening and night.
  - ✓ Use of bed-pan if needed.
  - ✓ Try and identify the triggers for anger and avoid it. Identify activities that soothe them: e.g., music/ walking.
  - ✓ Use memory aids such as labelling doors to the bathroom or a writing board in the room on which today's day and date are written every day.

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Chapter 8.2: Neuro-Developmental Disorders, Behavioural & Emotional Disorders of Childhood

The central nervous system of a child develops in five domains, namely fine motor, gross motor, language, social, and cognitive domains called developmental milestones. These domains correspond to a certain group of neuronal connections and areas of the brain. Damage to all or a few of these connections and brain areas during their development from birth leads to Neurodevelopmental disorders. These disorders, which can be identified by parents, teachers, and doctors, are generally overseen, leading to a missed diagnosis.

Behavioural disorders are disturbances or changes in the behaviour of a child causing significant distress in themselves, at home, or in other social circumstances, including school. It includes any of the following: inability to concentrate, being easily distracted, not being able to control urges, not obeying parents, teachers, or other elders, being involved in fights, lying, stealing, or other such notorious behaviours. It could be a result of various factors interplaying with each other, including parenting styles, the conflict between parents or family members, etc.

Emotional disorders are disorders in which children experience excessive and prolonged sadness and fear while facing stressful situations in their lives. This shall impact their performance at school and behaviour at home, which shall reduce or increase based on their in-born abilities and available family support.

As children are still learning about emotions and mastering them, they tend to have difficulty in expressing internal emotional states/feelings verbally; symptoms usually manifest as behavioural/physical symptoms. Hence, the majority of the parents do not recognize the needs of their children and respond to them in a harsh and punitive manner which leads to children, in turn, reacting with more unmanageable acts and emotions, making it a vicious cycle. Moreover, all these disorders can coexist and can be potential risk factors for each other. Also, NDD can have medical comorbidities like seizures, cerebral palsy, congenital heart disease, genetic syndromes, and metabolic and endocrine abnormalities, which can interfere with the natural growth trajectory of the child.

SUB-TYPES

Types of Neurodevelopmental disorders:

1. Specific Learning Disorder (SLD)

2. Intellectual Developmental Disorder(IDD)

3. Autism Spectrum Disorder (ASD)

4. Specific disorders of language development

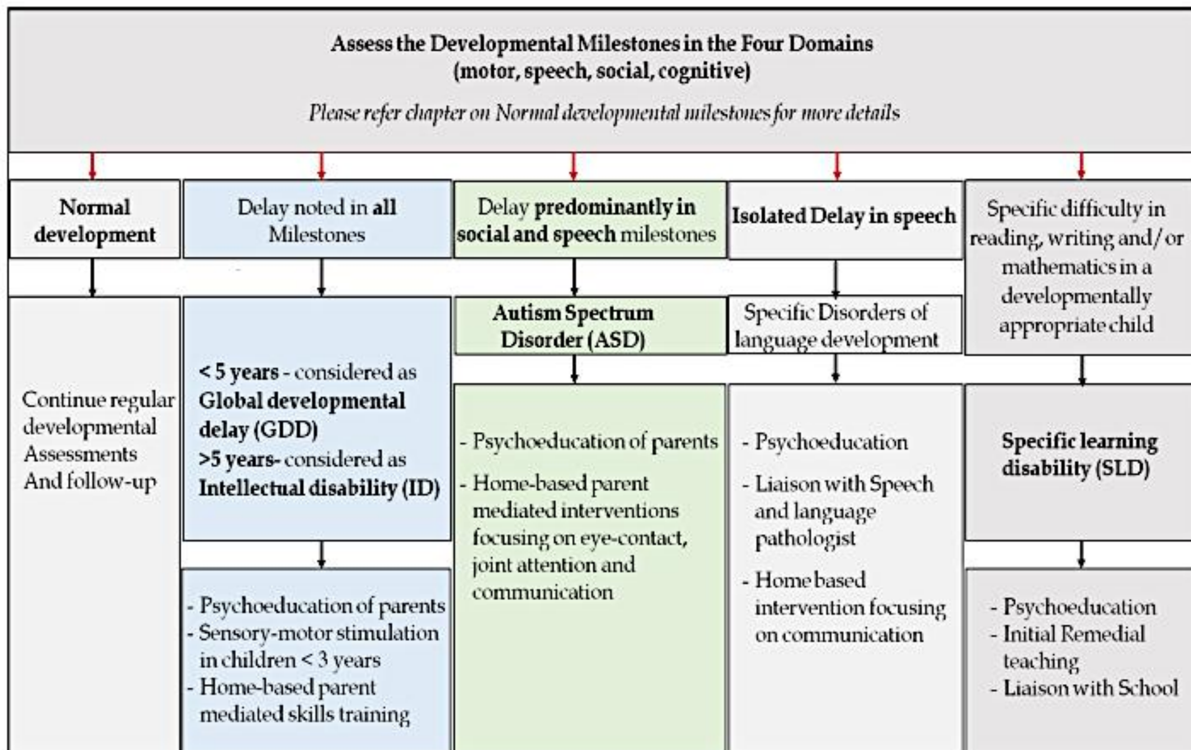


Figure: Steps to assess & manage neurodevelopmental disorders

Types of Behavioural Disorders:

1. Attention Deficit Hyperactivity Disorder (ADHD)

- Inattention:
  - Difficulty in paying attention while talking or doing a task
  - Difficulty in concentrating on studies
  - Often misplacing or forgetting items
  - Easily distracted
- Hyperactivity:
  - Talking excessively, interrupting while others are talking
  - Not able to sit in a place (Always 'on the go')
  - Feeling fidgety when controlled
- Impulsivity
  - Not able to wait for his/her turn in games
  - Doing things without thinking about the consequences
- Poor planning and organization of routine and academic responsibilities
- All these symptoms are present at home and school

2. Oppositional Defiant Disorder (ODD)

- Irritable and angry mood or becoming easily annoyed
- Argumentative (talking back) on parents, deliberately annoys them
- Wanting to hurt somebody without good reason (vindictive)
- But NO lying, stealing, or being involved in bullying or fights
- NO causing cruelty to other children or animals seen

3. Conduct Disorder (CD)

- Involving in fights and bullying with peers
- Not following rules
- Lying, stealing, causing damage to properties
- Causing cruelty to animals or other children
- Disobedient and throwing temper-tantrums

Types of Emotional Disorders:

1. Depression: crying, irritability, dull appearance, less interaction and spending time alone, poor study performance, disturbed appetite and sleep, suicidal thoughts
2. Anxiety: anxious about daily activities (studies, the health of oneself & parents, etc.), not wanting to sleep alone or go to school, avoiding anxiety-provoking situations
3. Conversion Disorder – unresponsive episodes, abnormal movements, hyperventilation episodes

RISK FACTORS

Risk factors for Neuro-Developmental Disorders:

- History of premature birth
- Low birth weight
- Birth asphyxia
- Postnatal infection
- History of seizures or neonatal ICU admission

Risk Factors for Behavioural & Emotional Disorders :

- Biological: History of Depressive disorder/anxiety disorder in one or both parents
- Child (individual) characteristics: inferiority complex, stubborn thinking, sensitivity to criticism
- Parenting and family factors: Harsh, over-controlling, or over-protective parenting, critical nature of communication, physical disciplining, excessive social and academic demands, and expectations
- Social factors: peer rejection, neglect by teachers, bullying experiences
- Stressors/Negative life events: death of loved ones, parental divorce, fights or job loss, adverse events in school like poor academic performance

LIFETIME CONSEQUENCES

Lifetime impact if not identified and treated:

Area	**Impact**
Educational achievement	Lower attainment; higher rates of school dropout
Occupational adjustment	Higher unemployment; frequent job changes
Marital adjustment	Higher rates of separation, divorce
Social adjustment	Less contact with relatives, friends
Physical health	Higher rates of hospitalization, mortality in non-communicable diseases
Mental health	Higher rates of psychiatric disorders in adulthood
Conflict with the law (Behavioural disorders)	Arrests, rates of driving while intoxicated
Substance use	Smoking tobacco, cannabis, consuming alcohol
Inter-generational	More children with similar problems

GUIDELINES FOR BRIEF MANAGEMENT

A. Addressing the distress of Parents:

Do's for Addressing Parents' Distress	**Don'ts for Addressing Parents' Distress**
Provide a Safe Space - **Create a safe environment for parents by using counselling skills described before**	Avoid Blame Important to address any guilt or self-blame which parents might have about the child's condition
Prioritize Parental Mental Health – **Provide parents with resources to local support groups. Regularly check mental health of parents and help them to seek help in case of any issues.**	Discourage Expression – Let the parents express their concerns freely in the consultation by creating a non-judgement atmosphere
Offer Practical Solutions –	Disregard Self-Care - It is important to ensure that the parents have healthy self-care practices like regular

Help them to learn problem solving coping strategies as described in the chapter on LIPI	exercise, sufficient sleep and balanced nutrition
Encourage Open Discussions. – **Help parents to have open communication between each other, without engaging in fights or blaming each other**	Ignore Practicality – It is important to help parents set realistic expectations for their child and have practical solutions for the problems they are facing

B. Educating the Parents on Neurodevelopmental Disorders (working through stigma)

Educating Parents on Neurodevelopmental Disorders (NDD) and Overcoming Stigma
About NDD and Management
- NDD stems from brain damage before, during, or after birth; no cure via medicine/surgery.
- Train children for daily self-care and independence, despite longer learning times.
- Consult specialists for medical/psychiatric aspects like seizures or ADHD.
- Balance discipline, set limits, avoid overprotection/permissiveness.
- Identify and encourage child's strengths and interests
Working Through Stigma
- Clear misconceptions about NDD.
- Stress NDD isn't child/parents' fault.
- Foster open discussions for reduced stigma and better understanding.
- Share success stories to inspire hope.
- Advocate inclusivity at home and in the community.
- Connect parents with support

C. Educating the Parents on Behavioural & Emotional Disorders (working through stigma)

- As children grow, they can feel stressed from school, friends, and family. How parents act matters—being supportive helps a lot.
- Talk openly with children about feelings, and be patient.
- Understand that children grow differently.
- Symptoms are real but they may have psychological roots
- Help children face challenges step by step.
- Explain to children it's okay to feel good about themselves, not just when they do well in school.
- If a child talks about hurting themselves or feeling really down, teach them to ask for help.
- If things stay tough, a Psychiatrist can help.

- Remind children to have routines, get enough sleep, relax, and have fun hobbies.

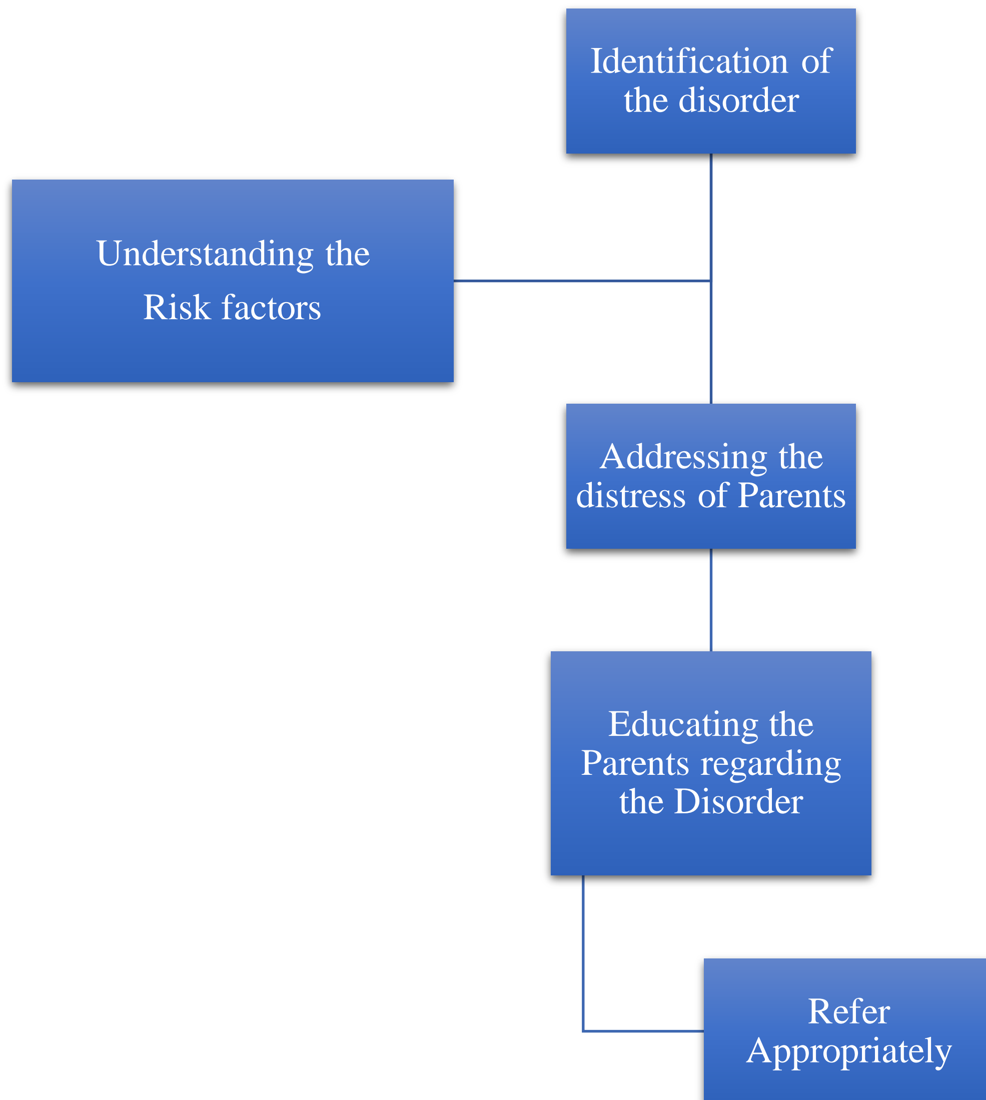
REFERRAL

How to refer children' 'at risk' for neuro-developmental disorders?

- Assess for the delay in developmental milestones
- DO NOT advise, 'Let's wait and watch.'
- Do Brief Management with Parents
- Refer the child to a Psychiatrist for further intervention
- If confident, can refer to Speech and/or Occupational therapist directly
- If necessary, refer the child to Paediatrician in case of comorbid physical ailments
- Arrange a follow-up if interested.

How to refer children 'at risk' for Behavioural & Emotional Disorders?

- Identify symptoms and assess for risk factors
- DO NOT advise, 'Let's wait and watch.'
- Do Brief Management with Parents
- Refer the child to a Psychiatrist or a Clinical Psychologist for further intervention.
- If necessary, refer the child to Paediatrician in case of comorbid physical ailments.
- Arrange a follow-up if interested.



Flowchart 1: Overview of the Approach to Children with Psychiatric Disorders

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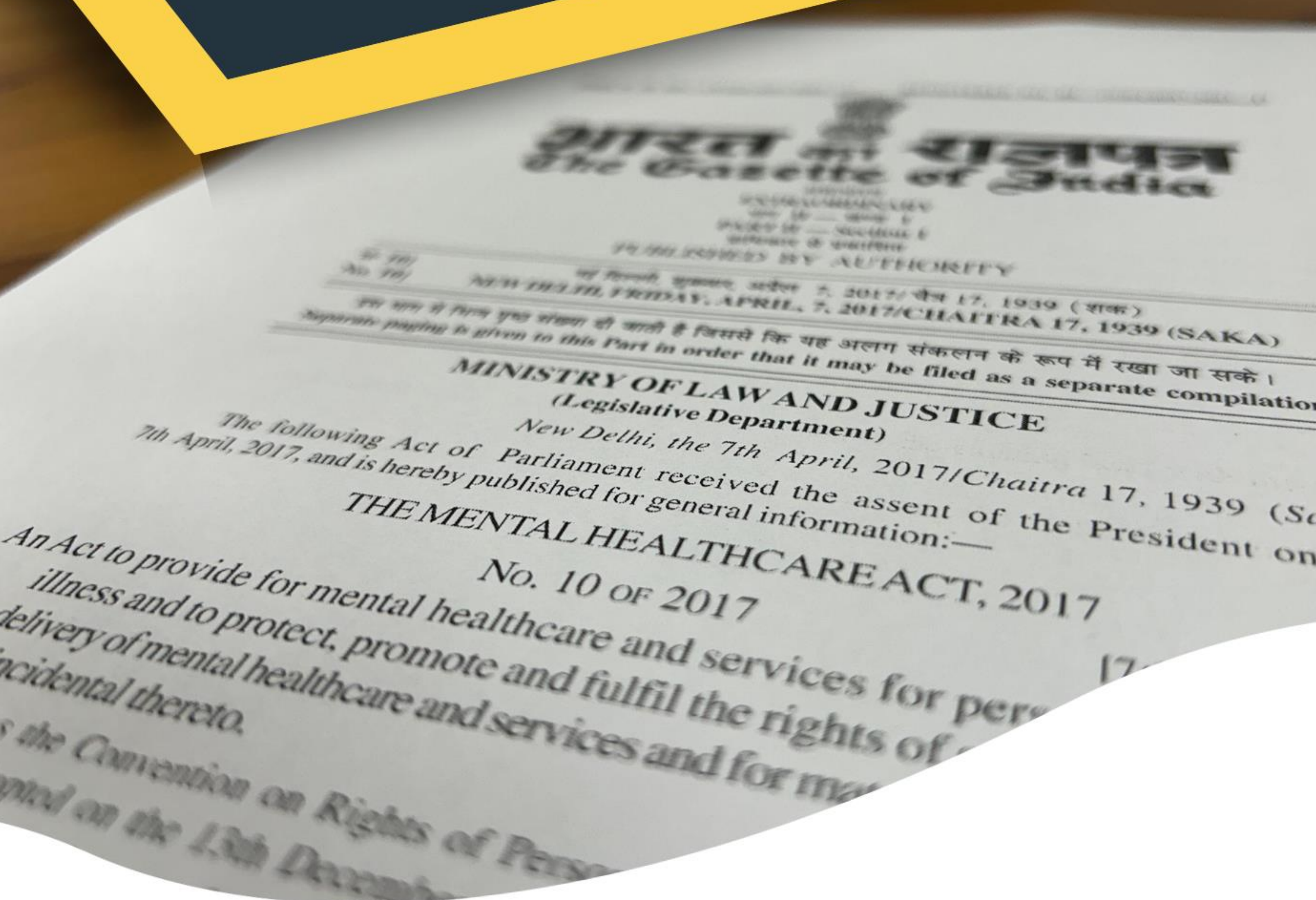
9| APPLICABILITY OF MENTAL HEALTH CARE ACT 2017 AT PRIMARY HEALTH CARE



Applicability Of Mental Health Care Act (2017) in the Primary Health Care

MHCA, 2017 was passed by the Parliament of India on April 7, 2017. It has been in force since 29 May 2018; hence this chapter is written keeping in mind the challenges and opportunities encountered by a PHC doctor in the application of MHCA, 2017 at the grassroots level.

No individual can be treated against his or her wish unless there is an emergency or a life-threatening situation. The right to refuse medical treatment is a fundamental right. Article 21, Right to Life and Liberty, lays down that no person shall be deprived of his life or personal liberty. The restrictions may be imposed on the fundamental rights only in pursuance of law, and limitations must not be arbitrary, unfair, or unreasonable. Deprivation of Article 21 (Right to life and personal liberty) can only be practised under the 'procedure established by law. This procedural law is the Mental Healthcare Act 2017 which has laid down the procedures for the registration of Mental Health Professionals (MHP), registration of Mental Health Establishments (MHE), admission and discharge, and Rights of Persons with Mental Illness. The preamble of the Mental Healthcare Act 2017 says, "It is an act to provide mental healthcare and services for persons with mental illness and to promote and fulfil the rights of such persons during delivery of mental healthcare and services.

Application Of MHCA in Primary Health Care

1. Emergency Treatment For The Mentally Ill (SECTION 94)

Any Medical Officer can **treat** a person with Mental Illness (PMI) in any place, including the community. Emergency treatment is initiated where it is immediately necessary to prevent—

(a) Death or irreversible harm to the health of the person; or

(b) The person inflicting serious harm to himself or others; or

(c) The person causing serious damage to property belonging to himself or to others where such behaviour is believed to flow directly from the person's mental illness.

Emergency treatment is limited to 72 hours or till the time the patient reaches the Mental Health Establishment, whichever is earlier. This time of 72 hours also includes time for transportation of the person with mental illness to the nearest Mental Health Establishment. If a Medical Officer needs to admit the patient, PHC should be registered as a Mental Health Establishment. If PHC is unregistered as a Mental Health Establishment, a referral for admission needs to be made to the nearest MHE after providing emergency care. However, MHCA does not bar treatment in PHC, the community, and camps.

In an emergency, the patient can be sedated with an I.M./I.V. Injection of haloperidol (5-10 mg) or an I.M./I.V. injection of lorazepam(2-4 mg)

2. Role of PHC Doctor During Admission

A. Voluntary Admission

As per section 86 of the MHCA,2017, a PHC doctor alone can authorize voluntary admission of a person with mental illness (PMI) but only in a PHC registered as a mental establishment.

B. Involuntary Admission

As per sections 89 and 90 of the MHCA,2017, in case of involuntary admission, a PHC doctor alone cannot authorize the admission of a PMI.

3. Follow-Up Care

Patients can be seen by a doctor at PHC or referred to a Mental Health Establishment for follow-up care. Home visits can be done to provide follow-up care. Under section 18, subsection 10, PHC needs to maintain a stock of Essential drugs to be made available to all persons with mental illness free of cost (Appendix II).

4. Rights Of Persons With Mental Illness (Section 18- 28)

- **Section 18: Right to Access Mental Healthcare**
  Ensure mental health services are affordable, high-quality, abundant, and accessible to all, without discrimination based on various factors such as gender, sex, sexual orientation, religion, culture, caste, social or political beliefs, class, disability or any other basis. Delivery should be acceptable to individuals with mental illness, their families, and caregivers.

- **Section 19: Right to Community Living**
  A PMI (Person with Mental Illness) cannot be restricted to an MHE (Mental Health Evaluation) just because he is homeless, abandoned by family, or due to a lack of community-based facilities. The government shall provide for less restrictive community-based establishments like halfway homes, group homes, etc. The government would provide support and legal aid for facilitating the right to the family home and living in the family home.

- **Section 21: Right to Equality and Non-Discrimination**
  Emergency and ambulance services must be provided at par with those provided to patients with physical illnesses. Insurers need to provide insurance for mental illness on the same basis as is available for physical illness.

- **Section 22: Right to Information**
  PMI and the relative (Nominated Representative) have the right to information about the mental illness, proposed treatment, and the side effects in the language they understand.

- **Section 23: Right to Confidentiality**

A PMI has the right to confidentiality in respect of mental illness and treatment. Exceptions can be made when information is needed by a relative for making treatment decisions, when there is a threat to the life of the patient or others, or when information needs to be shared with other MHPs or health professionals for treatment purposes. Only such information as is necessary should be released.

- **Section 24: Restriction on The Release of Information in Respect Of Mental Illness**
  No photograph or any other information, including that stored in digital format, shall be released to media without the consent of the patient.
- **Section 25: Right to Access Medical Records**
  All doctors working at PHC need to maintain minimum basic records even if the patient is seen in an emergency or on an OPD basis. The patient has the right to access basic medical records.
- **Section 27: Right to Legal Aid**
  A person with mental illness shall be entitled to receive free legal services to exercise any of his rights under this Act.

5. Wandering Mentally Ill (Section 100)

A wandering Mentally Ill person shall be taken under the protection of the officer-in-charge of the area police station and be brought to the public health establishment for assessment within 24 hours. Such a person cannot be detained in lock-up or prison under any circumstances. The medical officer at PHC will be responsible for arranging the assessment of the person. Further treatment - Emergency or, if admission is needed, may be provided by the PHC doctor as per the provisions of the act as discussed above.

It is the duty of the police officer in charge to trace the family members and inform them about the whereabouts of the PMI. For a homeless PMI, once treatment is completed, it is the duty of the officer-in-charge to take the person to a government establishment for homeless persons.

7. SUICIDE (SECTION 115)

A person with an attempt to suicide will be presumed to be suffering from severe mental stress. The appropriate Government shall have a duty to provide care, treatment, and rehabilitation to a person who has severe stress and who attempted suicide to reduce the risk of recurrence of the attempt to commit suicide.

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Click on the topic or scan QR code below to learn more about MHCA 2017:

MHCA 2017

10 | TELE MANAS 14416

Collaborative Care – Tele MANAS

The term 'Primary Care' means the provision of essential healthcare made universally accessible to individuals and acceptable to them. It involves the community's full participation and should be affordable at every stage of development. Mental health conditions are often underdiagnosed in primary care despite their higher prevalence (30-40%). Among the mental health conditions, Common Mental Disorders (CMDs) are found to be comorbid with many medical disorders (Hypertension, Diabetes Mellitus, etc.), and their prompt recognition and treatment are imperative for the overall well-being of the patient.

The innovations in the training of primary health officers continue to evolve, with current examples being the use of telepsychiatry services to train doctors in real-time in their clinics. This model of digital training of primary care doctors is being successfully organized in various states like Karnataka, Chhattisgarh, Bihar, Uttarakhand, Punjab, etc.,

The COVID-19 pandemic resulted in an increase in mental health issues in the country. However, it also resulted in the acceptability of tele-mental health services. To deal with the increasing mental health problems and provide quality mental health services, the government of India conceptualized providing digital mental health services through Tele MANAS.

National Tele Mental Health Programme of India; Tele Mental Health Assistance and Networking Across States (Tele MANAS):

Tele MANAS is a digital arm of the NMHP. It was announced as an extension to the service delivery framework of the existing NMHP in the Union Budget in February 2022. It aims to provide universal access to equitable, accessible, affordable, and quality mental healthcare through 24/7 tele-mental health counselling services as a digital component of the National Mental Health Programme (and its operational arm, DMHP) across all Indian States and UTs with assured linkages.

Objectives of Tele MANAS:

1. To exponentially scale up the reach of mental health services to anybody who reaches out across India, any time, by setting up a 24x7 tele-mental health facility in each of the States and UTs of the country.
2. To implement a fully-fledged mental health service network that, in addition to counselling, provides integrated medical and psychosocial interventions, including video consultations with mental health specialists, e-prescriptions, follow-up services, and linkages to in-person services.
3. To extend services to vulnerable groups of the population and difficult-to-reach populations.

Workforce and components:

Workforce/human resources under Tele MANAS is divided into two tiers based on the level of the services provided (counselling, psychiatric consultation, along with pharmacotherapy/ psychotherapy) and the expertise. Tier-1 will comprise the State Tele MANAS cells, which include trained counsellors and mental health specialists. Tier 2 will comprise specialists at DMHP/Medical College resources for physical consultation and/or e-Sanjeevani for audio-visual consultation.

Tele-Mental health services include providing advice, counseling, connecting with a mental health professional for telepsychiatry services, and enabling people to seek help when it is not possible for them to come physically to a hospital or a help centre.

Beneficiaries of Tele MANAS:

Any individual with mental health issues can reach out to Tele MANAS services for help.

Primary healthcare providers such as MBBS primary care doctors (PCD), AYUSH healthcare providers, nurses, and grass root healthcare providers/community health providers, i.e., Accredited Social Health Activists (ASHAs) may al reach out to Tele MANAS, wherein collaborative care shall be provided to the individual.

Relevance to Primary Care Doctors:

Convenience: Receiving care in a primary care setting may be more convenient for some individuals, as it may be easier to access than a specialized psychiatric clinic.

Continuity of care: By receiving care from a primary care psychiatrist, individuals can establish a long-term treatment relationship and receive care that is coordinated with their other medical care.

Early intervention: By identifying and treating mental health conditions early on, primary care psychiatrists can help prevent more serious mental health issues from developing.

Integration with physical health care: Primary care psychiatry allows for the integration of mental and physical health care, as the primary care psychiatrist can work closely with the individual's primary care physician to ensure that all of their health needs are met.

Cost: Receiving care in a primary care setting may be less expensive than receiving care in a specialized psychiatric clinic.

If, at any time, the PCD feels like they might need support in managing a person with a probable mental health condition, they can seek Tele MANAS services and do collaborative consultations with a mental health professional.

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Click on the topic or scan QR code below to learn more about Tele-MANAS:

Tele-MANAS

APPENDIX I

CLINICAL SCHEDULES FOR PRIMARY CARE PSYCHIATRY (CSP v2.4)

Clinical Schedules for Primary Care Psychiatry: Version 2.4

(September 2023)

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Clinical Schedules for Primary Care Psychiatry: Version 2.4

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- ✓ *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 → 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

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 hours of the last drink.

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

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

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

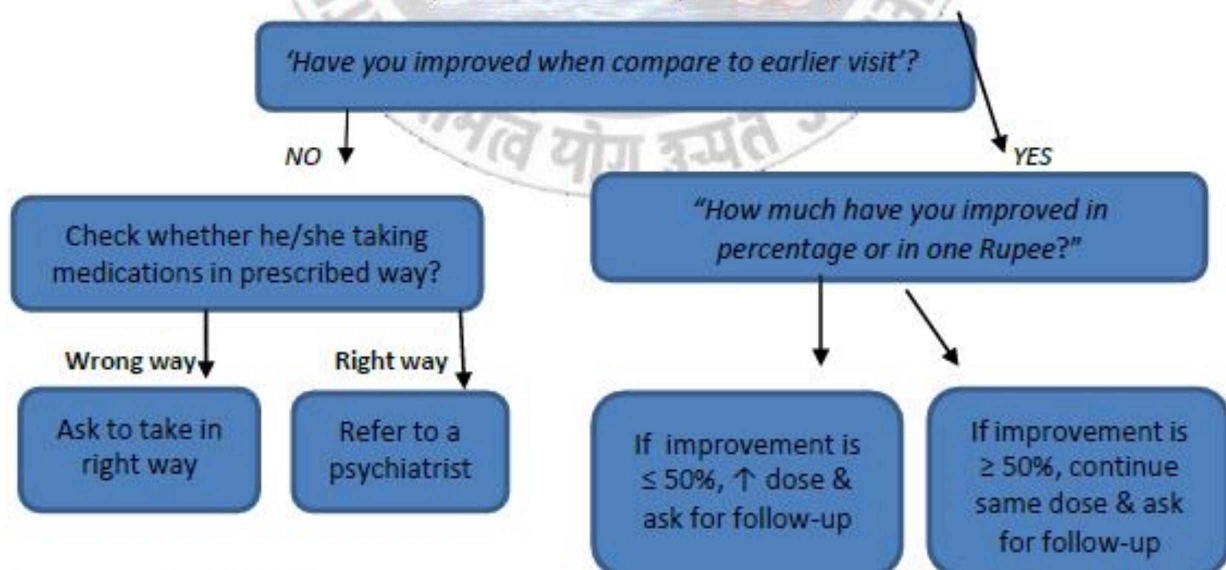
- ✓ *Psychiatric disorders can be present in patients with diabetes mellitus, essential hypertension, ischaemic heart disease, stroke, cancers, etc.*
- ✓ *Avoid poly-pharmacy.*
- ✓ *Begin low (dose), go slow (for escalation of dose)*
- ✓ *However, the medicines and dose mentioned in this point-of-care 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

PRESCRIPTION MODULE (Cont.)

- *Rx for Alcohol Addiction*

<table>
<tr>
<td>

1. Inj. **OPTINEURON FORTE** (containing thiamine 100mg) 1 ampule 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.

</td>
<td>

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)

</td>
</tr>
<tr>
<td>Counselling: Please refer to page 7 of this manual.
Follow up after 10 days.</td>
<td>The course of Rx with anti-craving medicines is 9 -12 months.</td>
</tr>
</table>

- **Rx for Tobacco Addiction**

<table>
<tr><td colspan="2">Tab. Bupropion XL 150mg 1-0-0 X 5 days
2-0-0 (continue)</td></tr>
<tr><td>Counselling: Please refer to page 7 of this manual.</td><td>Treatment course is 4-6 months.</td></tr>
<tr><td colspan="2">Follow up once every 30 days.</td></tr>
</table>

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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:

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APPENDIX II

ESSENTIAL DRUG LIST

F.No. T.20013/40/2017-NCD/PH-I
Government of India
Ministry of Health and Family Welfare

Nirman Bhawan, New Delhi – 110108
Dated 8 May, 2018

To.

1. The Principal Secretaries (HFW) of all States/UTs
2. The Mission Directors (NHM) of all States/UTs
3. The State Nodal Officers (NMHP) of all States/UTs

Subject: List of Psychotherapeutic Drugs/Medicines that should be available at District Hospital/CHC/PHC levels.

Sir,

I am directed to refer to the guidelines for implementation of district level activities under the National Mental Health Programme, circulated vide letter dated 24.06.2015, containing, inter-alia, list of drugs that should be available at District Hospital/CHC/PHC levels and to state that the revised indicative list of drugs for various mental health conditions that should be available at District Hospital/CHC/PHC levels is as under:

1. List of Psychotherapeutic Drugs/Medicines that should be available at District Hospital Level

S.No.	Mental Health conditions	Psychotherapeutic drugs/medicines
1	Psychotic Disorders	Tab Haloperidol 5mg
		Tab Risperidone 2 mg
		Tab Olanzapine 5 mg
		Inj Fluphenazine 25 mg
		Inj Haloperidol
		Inj Risperidone*
2	Depressive Disorders	Tab Imipramine 25 mg
		Tab Escitalopram 10 mg
		Cap Fluoxetine 20mg
3	Bipolar Disorders	Tab Lithium Carbonate 300 mg
		Tab Carbamazepine 200 mg
		Tab Sodium Valproate 500 mg
		Tab Olanzapine 5 mg
		Inj Risperidone*
4	Generalized Anxiety and Sleep Disorders	Tab Zolpidem 10 mg
		Inj Promethazine 50 mg
		Tab Clonazepam 0.5 mg
		Tab Lorazepam 1 mg
		Inj Lorazepam
5	Obsessive Compulsive Disorders and Panic Attacks	Cap Fluoxetine 20 mg
6	Epilepsy	Tab Sodium Valproate 500 mg

S.No.	Mental Health conditions	Psychotherapeutic drugs/medicines
		Tab Phenobarbitone 30 mg and 60 mg
		Tab Diphenylhydantoin 100 mg
		Tab Carbamazepine 200 mg
		Inj Lorazepam
7	Miscellaneous	
	a) Extra pyramidal symptoms	Tab Trihexyphenidyl 2 mg
		Inj Promethazine 50 mg

* to be administered under supervision of Psychiatrist

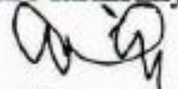
2. At CHC/PHC level

S.No.	Mental Health conditions	Psychotherapeutic drugs/medicines
1	Psychotic Disorders	Tab Haloperidol 5mg
		Tab Risperidone 2 mg
		Tab Olanzapine 5 mg
		Inj Fluphenazine 25 mg
2	Depressive Disorders	Tab Imipramine 25 mg
		Tab Escitalopram 10 mg
3	Bipolar Disorders	Tab Olanzapine 5 mg
4	Generalized Anxiety and Sleep Disorders	Inj Promethazine 50 mg
		Tab Clonazepam 0.5 mg
		Tab Lorazepam 1 mg
		Inj Lorazepam
5	Obsessive Compulsive Disorders and Panic Attacks	Cap Fluoxetine 20 mg
6	Epilepsy	Tab Phenobarbitone 30 mg and 60 mg
		Tab Diphenylhydantoin 100 mg
		Inj Lorazepam
7	Miscellaneous	
	a) Extra pyramidal symptoms	Tab Trihexyphenidyl 2 mg
		Inj Promethazine 50 mg

This issues with the approval of the Secretary, Ministry of Health and Family Welfare.

Yours faithfully,

(Ajaya Kumar KP)
Under Secretary to the Govt. of India
Telefax: 011-23061342



APPENDIX III

SAD PERSONS SCALE

SAD PERSONS SCALE

The 'sad persons scale' is an attempt to assist non-psychiatrists in assessing suicide risk. It may help as a guide regarding the need for referral or admission.

- **S** Sex Male
- **A** Age <19 Or >45
- **D** Depression
- **P** Previous Attempt
- **E** Ethanol
- **R** Rational Thinking Loss
- **S** Social Supports Lacking
- **O** Organised Plan
- **N** No Partner
- **S** Sickness

Score one point for each factor. The total score ranges from 0 (very little risk) to 10 (very high risk).

Guidelines for Action with the scale:

Total points	**Proposed clinical action**
0-2	Send home with appropriate follow-up
3-4	Close follow-up; Consider hospitalisation
5-6	Strongly consider hospitalisation depending on confidence in follow-up arrangement
7-10	Admit to hospital

NB. This is a guide only and should not be used to replace clinical judgement.

APPENDIX IV

TELEMANAS POSTER

Ministry of Health & Family Welfare
Government of India

NATIONAL TELE MENTAL HEALTH PROGRAMME OF INDIA

Tele Mental Health Assistance and Networking Across States

Digital Arm of District Mental Health Programme

Tele MANAS

A Government of India Initiative to provide comprehensive digital mental health counselling & care services across the country

TOLL FREE NUMBER

TRANSFORMING MENTAL HEALTH THROUGH TECHNOLOGY..

APPENDIX V

ADDITIONAL RESOURCES

For more information, scan the QR code to explore additional manuals published by NIMHANS Digital Academy, addressing various topics relevant to primary care doctors, including Suicide Prevention, Child and Adolescent Health, and more.

FEEDBACK

"As an Assistant Professor, Department of Community Medicine and Family Medicine, AIIMS Kalyani, I work at the Community Mental Health and Deaddiction Centre in Urban Primary Health Care Centre. This manual will enable us to cater to the mental health needs of those in need and reduce the treatment gap in the community." **- Dr Ashish Pundhir (Batch 35), Diploma in Community Mental Health for Doctors**

"This manual is a treasure for life as it will serve as a resource we can keep going back to easily, as and when required, to revise and consolidate our concepts in basic mental healthcare."- **Dr Deepali Goel (Batch 38), Diploma in Community Mental Health For Doctors**

"The manual is written in a crisp and precise manner. Topics of relevance, such as depression, anxiety, and insomnia, that are commonly encountered in primary care practice are covered in depth. This will be an invaluable resource for all primary care doctors." - **Dr. Rini Raveendran (Batch 31), Diploma in Community Mental Health For Doctors**

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BENGLURU, KARNATAKA - 5600029