STANDARD TREATMENT GUIDELINE FOR PSYCHIATRY

WHAT ARE THE EXPECTATIONS FROM MEDICAL OFFICERS?

In first contacts new patients (for possible psychiatric disorders)

1. Medical officer should be able to do rapid screening in all adult patients.
2. Medical officers should be able diagnose & provide a first line of medication and brief counseling.
3. If patient shows improvement on treatment in 4 weeks, follow them up.
4. If case diagnosis is unclear, refer to a psychiatrist.

In follow up patient on every visit, (Follow up of patients seen first time, improving, and stable patients referred by a psychiatrist).

1. Along with patients, family/friends are a reliable source of information
2. Enquire about clinical condition, check for common side effects, prescribe same medications when condition is same
3. If any patient does not improve, worsens, does not take regular medication, has severe side effects, becomes suicidal or aggressive, refer them to psychiatrists
4. Referral to a psychiatrist for second opinion whenever patients /families express concern about how long the medication should continue?.

WHAT KIND OF PATIENTS MEDICAL OFFICERS ARE LIKELY TO HAVE PSYCHIATRIC DISORDERS?

Any patient, who gets repeated prescriptions from medical officers for the following medications, has higher probability of having psychiatric disorders. These medications are

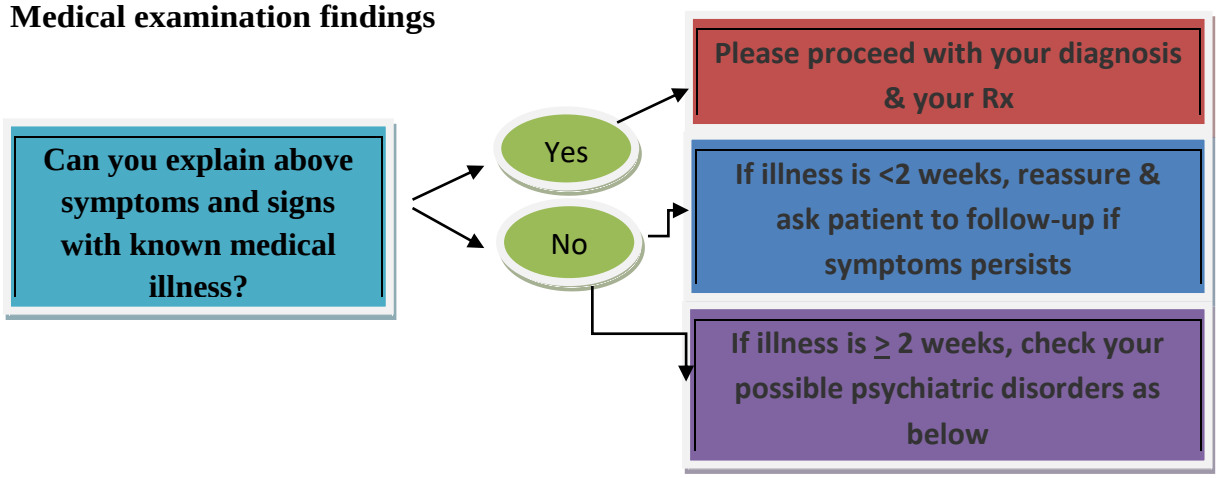
1. Analgesics/Pain killers (Diclofenac, Ibuprofen, Nimesulide)
2. Multivitamins in tablets/capsules/tonic bottle forms
3. Tonic seekers & Energy syrups
4. Antacid / H2 Blockers / Proton Pump Inhibitors (Ranitidine, Omeprazole, Pantoprazole)
5. Benzodiazepines (Alprazolam / Diazepam / Chlordiazepoxide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

It suggested that, medical officers should pro-actively search for psychiatric disorders in these kinds of patients

Part I: CASE RECORD FORM

Name of health facility:…… **Name:…… Age ……** **Gender : Male/ Female/ Other** **Postal address with parent/Guardian name:** **……**	**Date:**	**Aadhaar No:**
Presenting complaints with its duration……..		
Remark, if any……		

Medical examination findings



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, are you drinking alcohol heavily or regularly?	Yes /No	If YES, check for Alcohol Disorder
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 getting up from bed in the early morning?	Yes /No	If YES, check for Tobacco Addiction
8	In the past few weeks, did you get sudden attack 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, are you often being tens / stress up with no reason or for small trivial reasons?	Yes /No	If YES to any, check for Generalized Anxiety Disorder(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 regular 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) which 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, does this patient shown the signs of doctor shopping (repeatedly consulting you or other doctors) for the similar physical symptoms?	Yes /No	
17	In the past few weeks, does he/she have talking or smiling to self/ hallucination	Yes /No	

18	In the past few weeks, does he/she have poor self-care / wondering aimlessly	Yes /No	If YES to any, check for Psychotic Disorder
19	In the past few weeks, does he/she have suspiciousness/ big claims/ delusion	Yes /No	
20	In the past few weeks, does he/she talking excessively/ sleeping less/hyperactive	Yes /No	
21	In the past few days, did he/she have suicidal, self-harm or aggressive behavior	Yes /No	Provide Psychological First Aid & refer to a psychiatrist

Note: Items 1-15 for patients, 18-20 for family & friends, 16, 17 & 21 for clinical interpretation of doctors

Behavioral observations, ………

Diagnosis: (Tick appropriate)

1	**Alcohol Disorder:** Harmful use (Frequent type / 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
5	Other, if any, ……

Treatment plan:

1. Prescription:……
2. Brief counseling provided: YES /NO
3. Follow-update:……
4. Follow-up notes:…….....

DIAGNOSTIC CRITERIA OF DEPRESSIVE DISORDER

Core symptoms

1. Depressed mood
2. Decrease Energy level or increases fatigue/tiredness
3. Loss of interest or pleasure in activities that were usually pleasurable earlier

Additional symptoms

1. Disturbed sleep
2. Disturbed appetite
3. Decrease Concentration & Attention
4. Decrease Activity/thinking level

5. Decrease Sexual interest
6. Decrease 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

Note - Presence of at least 2 of above core symptoms and at least 3 of 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 / nervous with no obvious or trivial reasons for many months (often for > 6 months)

The characteristics of anxiety/tension/worries/nervous are

1. Generalized in nature (involving several aspects of life involving family, health, finances, work, such as family tragedy, ill health, job loss or accidents even when there are no obvious signs of trouble).
2. Persistently (present throughout 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 cause/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/ Motortension -** (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 attack of severe anxiety or fear (panic attack) as follows

1. Repetitive (more than one attack)
2. Spontaneous (sudden onset without any reasons)
3. Unpredictable These panic attacks are usually associated with
    a. Sudden onset of palpitations, chest pain, difficulty breathing/choking sensations, dizziness, dry mouth, and feelings of unreality are common.
    b. There is also a secondary fear of dying, losing control, or going mad.
    c. Having a fear of 'anticipatory attack' leading to avoidance of certain situations where these attacks occurred.
    d. These attacks begin abruptly, reach a peak in minutes and resolution occurs in 10-20 minutes.

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

DIAGNOSTIC CRITERIA OF SOMATIZATIN DISORDER

These patients presents with various physical complaints without a physical explanation determined by a full history and physical examination. These symptoms may be single, multiple and 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) is often present.
2. Gastrointestinal sensations (pain, belching, regurgitation, vomiting, nausea etc.),
3. Abnormal skin sensations (itching, burning, tingling, numbness and 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 definite diagnosis of somatization disorder

1. For many months (at least 6 months) of symptoms of illness explained above
2. Doctor shopping (repeated visit 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 plainly false, e. g. patient is related to 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 for 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 of withdrawal symptoms whenever he/she reduces or stop alcohol such as tremors, sleep disturbance, sweating, palpitation etc

TOBACCO ADDICTION

Person uses any tobacco products regularly and/or heavily and unable to control its quantity

I. INVESTIGATIONS

1. Laboratory or radiological investigations are not used routinely in psychiatric disorders
2. The need for investigations depends on clinical findings to exclude other medical conditions which can explain psychiatric symptoms
3. Serum thyroid stimulating hormone (TSH), & Electrocardiogram (ECG) are commonly used investigations
4. CT/MRI of brain are rarely used in routine clinical psychiatry

II. TREATMENT

A. General Treatment Guidelines of psychiatric medications

1. Onset of action is slow, i.e., around 2 to 3 weeks and takes 4 to 6 weeks for full action.
2. Longer course of medications: Once improvement occurs with any medication, there is a need to continue medication at same dose for at least d months.
3. Don't stop psychiatric medications abruptly until & unless it is an emergency such as severe side effects, etc

No		Diagnosis	First line Rx	Probable duration of Rx
1		**CMDs**		
	a	Predominantly Depressive Disorder	SSRI + BZDs + Counseling	SSRI for 9 - 12 months BZDs for initial 2-4 weeks
	b	Predominantly Anxiety Disorder	SSRI + BZDs + Counseling	
	c	Predominantly Somatization Disorder	TCA + Counseling	2 year
	d	Mixed Disorder (Depressive, Anxiety/Somatic symptoms)	TCA > SSRI + Counseling	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 — Infrequent type	Counseling + BI vitamin	Follow up advised
	b	Alcohol Harmful use — Frequent type	SOS Naltrexone 25 mg /c hour before every drinking session	
	c	Alcohol Addiction	Anti-craving medications + BI vitamin + BZDs detoxification	9-12 months
4		**Tobacco Addiction**	NRT / Bupropion	3- 6 months

B. Counseling

1. It shall be brief (to be completed in < 5 minutes).
2. It is one of the non-medication treatment modality practiced byall medical officer in their every day practice, often without realizing.
3. Something shall be offered for patients with psychiatric disorders also.
4. Counseling include same education about illness,
5. Setting realistic expectations from treatment – counseling on when to expect benefit from medication, how long to continue, and need for repeated follow up
6. Please provide practical tips to handle stressor when present.
7. Please do not confuse counseling with psychotherapy that psychiatrists practice.
8. Psychotherapy (talk therapy) is specialized form of counseling aim to relieve symptom, which take multiple sessions of 40-60 minutes each.

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 at primary care.
- 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 recommended for General Practitioners.
- There is a risk of manic switch (< 5%) with antidepressants (TCA > SSRI); to be managed by stopping antidepressants and refer to a psychiatrist.

Name	Initial dose	Max dose (MO)	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
Sertraline	50	100	200	±	±	0	Delayed ejaculation	Safe in old patients & medical comorbiditi es
Newer antidepressants								
Mirtazapine	7.5	15	45	+++	+	+	Very less	
Tri Cvclic Antidepressants								
Imipramine	25	75	300	++	++	++	+ +	
Dotheipin				+++	+++	++	+ +	Relatively Cardio safe

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 (MO)	Max dose (Psy)	Common side effects (Mostly dose dependent)					Remarks
				Sedation	Hypotension	EPS	Weight gain	↑ Prolactin	
Atypical Antipsychotics (Safer than typical antipsychotics)									
Risperidone	2	4	8	+	++	+	++	+++	
Olanzapine	5	10	30	++	+	±	+++	+	
Clozapine*	25	100	600	+++	+++	0	+++	0	Seizure risk above 600 mg, Agranulocytosis (at any dose), cardiomyopathy
Typical Antipsychotics									
Haloperidol	2	10	20	+	+	+++	0	++	Anticholinergic side effects
Chlorpromazine	25	100	600	+++	+++	+	++	++	Anticholinergic side effects

*EPSE (Extrapyramidal side effects) – graded as 0 = Absent; ± = Probable/Very little; + = Mild; ++ = Moderate; +++ = Severe. Increased prolactin leads to amenorrhea, galactorrhoea and other sexual side effects

* **Clozapine to be begin under supervision of a psychiatrist**

MOOD STABILIZERS

Name	Initial dose	Max dose (MO)	Max dose (Psy)	Common side effects	Remarks
Lithium	300	900	1200	Tremor, Polyuria, Polydipsia, Hypothyroidism	Narrow therapeutic index
Carbamazepine	200	600	1200	Ataxia, Sedation, Skin rash, Steven Johnson syndrome,	
Valproate	250	1000	1500	Hair loss, Weight gain, GI disturbance	

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. Haloperidol Decanoate	IM	25 to 100	Every 4 weeks
3	Inj. Risperidone Consta	IM	25-50	Every 2 weeks

To be given only for patients who does not take medicine regularly leading relapses. These depot injections preferable to begin by a psychiatrist and follow up may be done with their medical officer.

D. **EXTRA-PYRAMIDAL SIDE EFFECTS (EPS)** ***INCLUDES***

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

* After administration of antipsychotics

E. BENZODIAZEPINES tablets

No	Name	Type	Dose/day	Addiction potential	Schedule
1	**Clonazepam**	Long active	0.5-6 mg	±	OD/BD
2	**Diazepam**	Long active	5-30 mg	+++	OD/BD
3	**Chlordiazepoxide**	Long active	10-100 mg	++	OD/BD
4	**Lorazepam**	Short acting	0.5-2 mg	++	BD/TDS

A general guideline

1. Please do remember patients with alcohol & tobacco addiction need many treatment attempts as several relapses (may be 3 — 4 times) are common and relapses are rule than exception (even with proper treatment) for complete stopping.
2. For any kind of alcohol & tobacco disorders always advice to stop completely. If willing for Rx, follow below guidelines
3. **If patient's not willing to stop,**
    a. Never force any patient/s to begin treatment,
    b. Inform about availability of medications to stop,
    c. Counsel about benefits of abstinence and damages of continued use,
    d. Always ask them to come whenever they wish to stop. These steps build up better doctor-patient relationship for long-term treatment for addiction Rx.

Encourage their friends & family to cooperate and help patient for multiple treatment attempts

F. ALCOHOL AND TOBACCO DISORDERS

Alcohol Disorders

1. Alcohol harmful use (Infrequent type)- Counseling includes benefits of stopping and loss (short term and long term) of continued use. You may prescribe thiamine supplementation. Advise for regular follow up.
2. Alcohol harmful use (Frequent type) - SOS use of Naltrexone 25 mg /can hour before every drinking session (Sinclair method). This method gradually reduces the harm by reducing the quantity of alcohol and eventually helps to stop alcohol completely.
3. Alcohol Addiction-
    a. Detoxification with BZDs only if there are withdrawal symptoms (Diazepam preferred up to 40 mg/day on 1" & 2"‘ day, 30 mg/day for 3" & 4‘ day, 20 mg/day for 5‘ & 6‘ day, 10 mg/day for 7 & 8‘ day, then stop).
    b. Thiamine supplement up to 300 mg/day for 3 months.
    c. Anti-crowing medications (gradual hike is advised) such as Topiramate up to 100 mg/day, Baclofen up to 40 mg/day, Acamprosate up to 999 mg/day (333 mg TDS) may be used for 9 months to 1 year.

These anti-craving medications can be given from first day of Rx. They reduce craving, reduce quantity of alcohol even if person drinks alcohol on it. Hence, anti-craving medications can also be given even if person has continued to drink alcohol; this reduces/prevents withdrawal symptoms / hangover / craving of next morning.

DISULFIRAM is on aversive drug (not an anti-craving) not advisable for use at primary care level. In case GPs prefer, please use with caution preferably after informed consent from patients and supervision by a family member. Start ONLY after 5 days of completely stopped alcohol. Dose is 250 mg OD preferably in the morning.

Note – This guideline is adopted from NIMHANS guideline for Primary Care Psychiatry Program.

*** THE END ***