PRIMARY CARE PSYCHIATRY PROGRAM

TELE MEDICINE CENTRE

NIMHANS DIGITAL ACADEMY, DEPARTMENT OF PSYCHIATRY

NATIONAL INSTITUTE OF MENTAL HEALTH AND NEURO SCIENCES

(AN INSTITUTION OF NATIONAL IMPORTANCE)

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Clinical Schedules For Primary Care Psychiatry: Version 2.2

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- ✓ *This schedule is prepared for the clinical use of **Primary Care Physicians** (PCPs).*
- ✓ *In India, PCPs are also referred to as 'General Practitioners' (GPs), 'Family Physicians/Doctors' (FPs/FDs), 'General Doctors' (GDs)etc.*
- ✓ *This contains guidelines for screening, referral, early diagnosis, first line treatment and routine follow-up of an **ADULT** patients with psychiatric disorders at routine **OUT-PATIENT** primary health care or GPs clinics.*
- ✓ *The contents of this schedules are an adopted version of psychiatric classification, diagnostic criterias, & treatment guidelines for wider utilization by GPs of India.*

WHAT ARE THE EXPECTATIONS FROM GPs/PCPs?

A. In first contact/ new patients

- ✓ *GPs should be able to do rapid screening in all adult patients for possible psychiatric disorders.*
- ✓ *GPs should be able diagnose & provide a first line of treatment that consists of medication and brief counselling.*
- ✓ *If patient shows improvement with treatment in 3 - 4 weeks, consider following them up under their own care.*
- ✓ *If case diagnosis is unclear, consider referral to a psychiatrist.*

B. In stable patients referred by a psychiatrist for routine follow-up

- ✓ *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, consider referring them back to psychiatrists.*
- ✓ *Consider referral to a psychiatrist for second opinion whenever patients/families concern about 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 who are likely to get **repeated prescriptions** from GPs for the following medication has higher probability of having psychiatric disorders. These medications are*

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 shall pro-actively search for psychiatric disorders in these kinds of patients in their routine clinical practice.

Part I: SCREENER / CASE RECORD FORM

Hospital No: ..... **Date**: ..... **Aadhaar No:**
Name: ..... **Age**: ..... years, **Gender**: .....
Postal address with parent/Guardian name:

Presenting complaints with its duration:

1. ..... 2. .....
3. ..... 4. .....
5. ..... 6. .....

Physical examination findings: .....

Can you explain above symptoms and signs with known medical illness?

YES / NO

Please proceed with your diagnosis & your Rx	If illness is ***< 2 weeks,*** *reassure & ask patient to follow-up if symptoms persists*	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, are you drinking alcohol heavily or regularly?*	*YES / NO*	If YES to any, 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 getting tensed/stressed 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 these similar physical symptoms?*	*YES / NO*	
17	*In the past few weeks, does he/she have talking or smiling to self / hallucination*	*YES / NO*	If YES to any, check for ***Psychotic Disorder***
18	*In the past few weeks, does he/she have poor self-care / wondering aimlessly*	*YES / NO*	
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 behaviour*	*YES / NO*	$ *PFA & Refer*

Note: *Items 1-15 for patients, 18-20 for family & friends, 16, 17 & 21 for clinical interpretation of doctors*
$ Provide ***Psychological First Aid*** & refer to a psychiatrist

Behavioural observation/s: .....

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*
5	**Other**.....

Treatment plan:
1. ***Prescription***
2. **Brief counselling provided: YES / NO**
3. **Follow-up date:**
4. **Follow-up notes**

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Part II: MANAGEMENT GUIDELINES

I. DIAGNOSTIC GUIDELINES

- ✓ The diagnoses of psychiatric disorders are based on cluster of symptoms and signs described below.
- ✓ Many medical illnesses in clinical practice can present as typical psychiatric disorders. Hence, it is advisable to ***rule out these medical conditions*** based on clinical symptoms and signs of medical illness, if present.
- ✓ Thyroid and cardiac dysfunctions are common medical conditions which can mimic psychiatric disorders.
- ✓ If medical illness is found, priority to be given on treatment of this medical 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 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 these anxiety /tension/worries/nervous 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 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 / 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 attack of severe anxiety or fear **(panic attack)** 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, 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 SOMATIZATION 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, 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)

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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

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 medical conditions which can explain psychiatric symptoms
- ✓ Serum thyroid stimulating hormone (TSH), & Electrocardiogram (ECG) are commonly used investigations
- ✓ CT/MRI of Brain are rarely used in routine clinical psychiatry.

III. TREATMENT GUIDELINES

A. General Treatment Guidelines of psychiatric medications

- ✓ ***Onset of action*** *is slow, i.e., around 2 to 3 weeks and takes 4 to 6 weeks for full action.*
- ✓ ***Longer course of medications:*** *Once improvement occur with any medication, there is a need to continue medication at* ***same dose*** *for at least 6 months.*
- ✓ ***DO NOT stop 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 + Counselling	SSRI for 9 -12 months BZDs for initial 2-4 weeks
B	Predominantly Anxiety Disorder	SSRI + BZDs + Counselling	
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 modality practiced by all doctors in their everyday practice, often without their knowledge.
- ✓ Similarly, same thing shall be offered for patients with psychiatric disorders also.
- ✓ *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 benefit from medication, how long to continue, and need for repeated follow up.
- ✓ Please provide practical tips to handle stressor 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 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 at 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	
Burpropion	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	++	++	++	++	
Dotheipin				+++	+++	++	++	Relatively Cardio safe
Clomipramine	25	75	300	++	++	++	++	
Nortryptyline	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 **manic switch** (< 5%) with antidepressants (TCA > SSRI); to be managed by stopping antidepressants and refer to a psychiatrist.*

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				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 to be begin under 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	Every2 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 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 GPs

*

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 *STAT* & then begin tab. Trihexyphenidyl 2-4 mg for 2 to 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 often added as prophylactic agent

* *after of 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

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, advice always 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.*
4. Encourage their friends & family to cooperate and help patient for multiple treatment attempts.

Alcohol Disorders

Alcohol harmful use (Infrequent type)- Counselling includes benefits of stopping and loss (short term and long term) of continued use**.** You may prescribe thiamine supplementation. Advise for regular follow up.

Alcohol harmful use (Frequent type)- SOS use of Naltrexone 25 mg ½ an hour before every drinking session (Sinclair method). This method gradually reduces the harm by reducing the quantity of alcohol and eventually helps to stop alcohol completely.

Alcohol Addiction*:*

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

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

***Disulfiram** is an 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.*

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 that nicotine gum has poor acceptability and unpredictable effects, i.e., may not get desired effects.
2. **Bupropion** is available in 150 & 300 mg tablets. To be given preferably in morning; begin 150 mg for first 5 days & then 300 mg for 3 to 6 months.
3. **Varenicline** is expensive. Days 1-3: 0.5 mg OD, days 4-7: 0.5 mg BD, then 1 mg BD for 3 to 6 months.

G. MANAGEMENT OF PSYCHIATRIC DISORDERS IN COMORBID MEDICAL ILLNESS

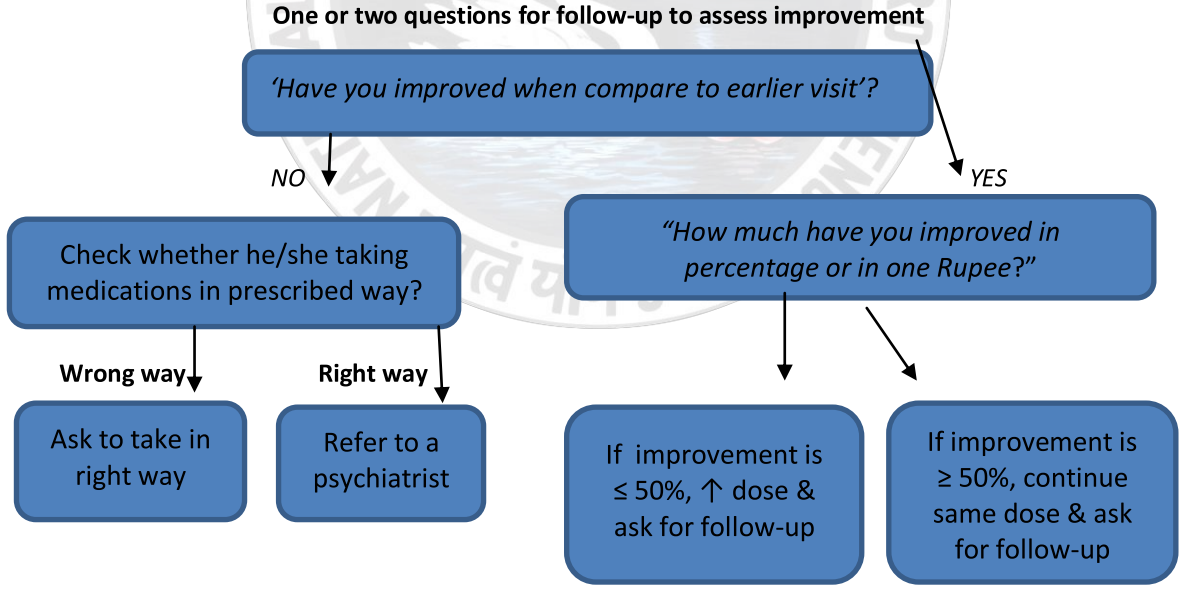
- ✓ *Psychiatric disorders can be present in patients of diabetes mellitus, essential hypertension, ischaemic heart disease, stroke, cancers, etc.*
- ✓ *Avoid poly-pharmacy.*
- ✓ *Begin low (dose), go slow (for escalation of dose)*
- ✓ *However, this schedule contains reasonably safe medications which to be prescribed at lower dose which is considered in safe always.*
- ✓ *If doubt, refer to a psychiatrist.*

H. TREATMENT OF PSYCHIATRIC DISORDERS IN PREGNANCY AND LACTATION

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

IV. FOLLOW UP 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 psychiatrist, in case person goes back for repeated drinking episode despite on adequate dose of anti-craving Rx*

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1.Rx for Depressive & Anxiety Disorders

1. Tab. FLUOXETINE 20mg, 1-0-0 2. Tab. CLONAZEPAM 0.25mg ***OR*** Tab. DIAZEPAM 5mg, 0-0-1 X 10days & then **STOP**	**OR**	1. Tab. ESCITALOPRAM 10mg, 0-0-1 2. Tab. CLONAZEPAM 0.25mg ***OR*** Tab. DIAZEPAM 5mg, 0-0-1 X 10days & then **STOP**	**OR**	Tab. AMITRYPTILINE 25mg, 0-0-1/2 X 4days 0-0-1 X 4days 0-0-2 (continue)
Counselling to include, Begin its action: 2-3 weeks, Full action: 4-6 weeks & Course of treatment: 6-9 Months				
Follow up @ 1 Month	**If improvement, follow-up yourself.**		**If NO improvement, Refer to Psychiatrist.**	

2. Rx for Somatization Disorder

Tab. AMITRYPTILINE (25mg) 0-0-1/2 X 4days 0-0-1 X 4day 0-0-2 (continue)	**Counselling to include,** Begin its action: 2-3 weeks, Full action: 4-6 weeks & Course of treatment: 2 years.	
Follow up @ 1 Month	**If improvement, follow-up yourself.**	**If NO improvement, Refer to Psychiatrist.**

3. Rx for Psychotic disorders

1. Tab. RISPERIDONE 2mg,0-0-1 X 4days 0-0-2 (Continue) 2. Tab. THP 2mg, 1-0-0	**OR**	Tab. OLANZAPINE 5mg,0-0-1 X 4days 0-0-2 (Continue)
Counselling to include, Begin its action:2-3 weeks, Full action:4-6 weeks &Course of treatment:6-9 months		
Follow up @ 1 Month	**If improvement, follow-up yourself.**	**If NO improvement, Refer to Psychiatrist.**

Prepared by Department of Psychiatry, NIMHANS, Bengaluru
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4. Rx for Alcohol Addiction

1. Inj. OPTINEURON FORTE (containing thiamine 33mg) 1 ampule deep IM once a day for 5days. 2. Tab. DIAZEPAM 10mg,1-1-2 X 2days 0-1-2 X 2days 0-0-2 X 2days 0-0-1 X 2days then **STOP** 3. B-Complex tablet containing a high dose of THIAMINE (100mg/day) 0-0-1 for 3months.	4. Tab. BACLOFEN 10mg, 0-0-1 X 1day 1-0-1 X 1day 1-1-1 X 1day 1-1-2 (Continue) **OR** Tab. TOPIRAMATE 25mg, 0-0-1 X 2days 1-0-1 X 2days 1-0-2 X 2days 2-0-2 (continue)
Counselling: Please refer to page-7 of CSP. **Follow up after 10 days.**	**Treatment course with anti-craving medicines for 9months to 1year.**

5. Rx for Tobacco Addiction

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

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DIPLOMA IN PRIMARY CARE PSYCHIATRY

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

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 while working at your 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. *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.
   c. *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.
   d. *Videoconference based Continuing Skill Development (V-CSD):* 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.
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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