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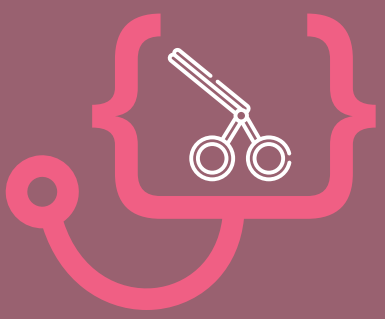

2019 Edition, Vol. I

STANDARD TREATMENT WORKFLOWS

of India

PARTNERS

national health authority

World Health Organization

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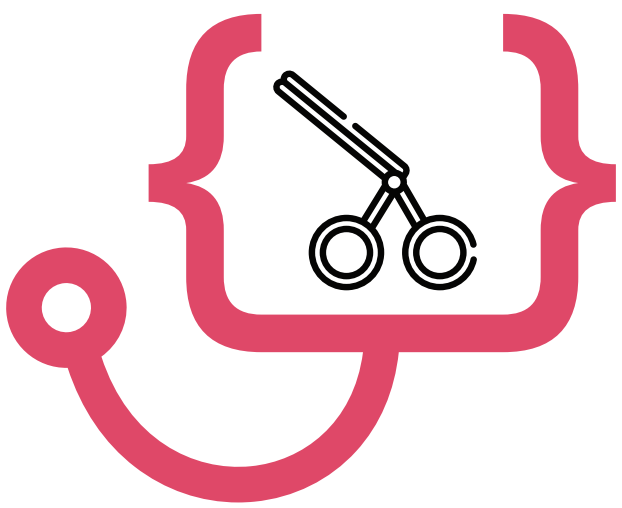

STANDARD TREATMENT WORKFLOWS of India

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INTRODUCTION

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GOAL

To empower the primary, secondary and tertiary care physicians/surgeons towards achieving the overall goal of Universal Health Coverage with disease management protocols and pre-defined referral mechanisms by decoding complex guidelines

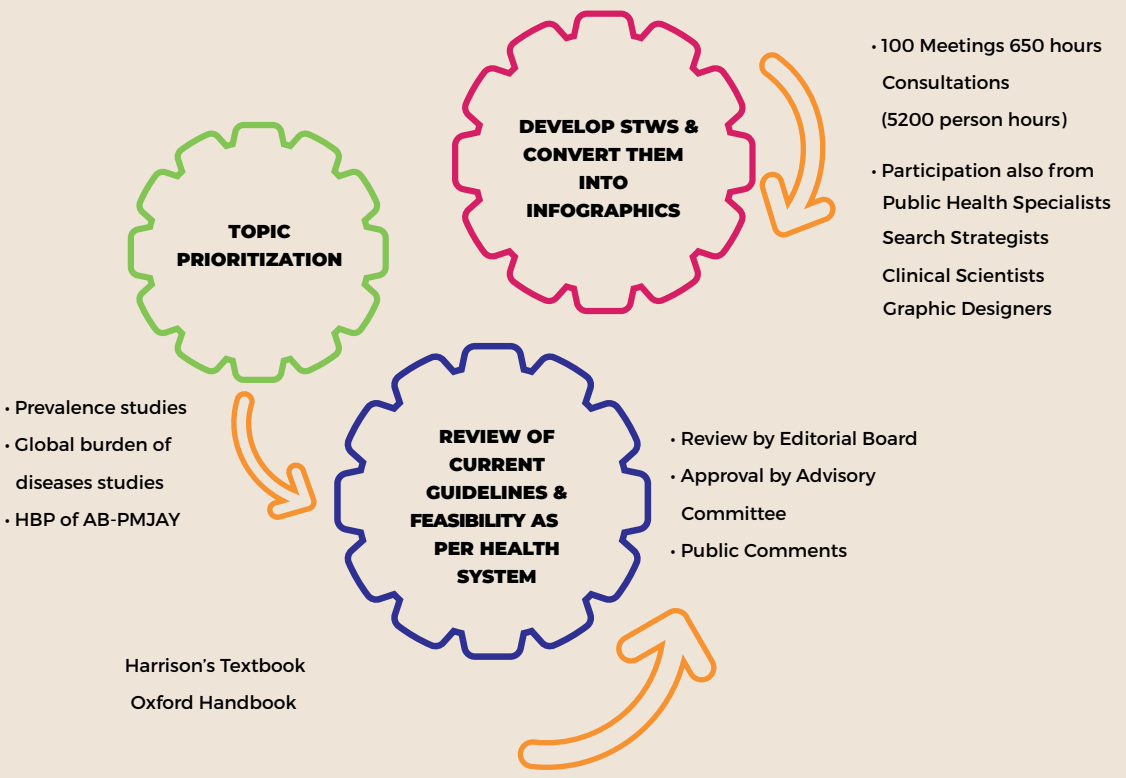
OBJECTIVES

Primary Objective:
To formulate clinical decision making protocols for common and serious medical/ surgical conditions for both OPD and IPD management at primary, secondary and tertiary levels of healthcare system for equitable access and delivery of health services which are locally contextual

Secondary Objective:
To facilitate PMJAY arm of Ayushman Bharat with secondary and tertiary level management of all surgical and medical conditions covered under the scheme.

METHODOLOGY

PROCESS OVERVIEW



PSYCHIATRY

October/ 2019

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Standard Treatment Workflow (STW) for the Management of ALCOHOL USE DISORDERS

ICD10-F10

Universal screening for every patient attending any healthcare facility

Special attention to: (AUDIT can be used for screening)

- H/ o head injury
- Appearing under influence of alcohol
- H/ o impaired social, occupational functioning
- Daily alcohol consumption
- Drinking in large quantities (men: 5 or more drinks/ day; women: 4 or more drinks/ day)

ASSESSMENT (DETAILED HISTORY)

- Age at initiation, quantity, frequency and progression (daily use and/or morning drinking)
- Time of last alcohol use and amount
- Binge drinking (men: 5 drinks over 2 hours; women: 4 drinks over 2 hours)
- Withdrawal state: insomnia, restlessness, anxiety, tremors. Use of alcohol (or benzodiazepines) to relieve or avoid withdrawal symptoms.
- Tolerance: increased doses of alcohol taken to achieve effects produced by earlier intake
- Craving
- Difficulty in controlling duration of drinking or amount of use
- Preoccupation with alcohol use with neglect of alternative pleasures or interests
- Increased time spent to obtain/ take alcohol/ recover from its effects
- Continued use despite patient being aware of evidence of harmful consequences that have occurred
- Abstinence and treatment attempts in past and reasons for relapse
- Co-morbid medical illness or psychiatric illness and their treatment
- Complications:
  - Physical- gastritis, peripheral neuropathy, hepatic dysfunction, accidents/injuries
  - Psychosocial - loss of work, fights at home, financial, legal problems

EXAMINATION

VITALS
- BP
- Pulse Rate
- Temperature

WITHDRAWAL SIGNS
- Tremor
- Sweating
- Tachycardia

SIGNS OF HEPATIC DYSFUNCTION
- Enlarged liver
- Icterus
- Abdominal swelling

NEUROLOGICAL SIGNS
- Cerebellar signs
- Peripheral neuropathy
- Confusion

DIAGNOSIS

Hazardous or Harmful use

- Involvement in risky behaviours such as binge drinking, driving under the influence of alcohol
- It should have resulted in harmful physical or psychosocial consequences

Alcohol dependence (three of the following six criteria to be present for at least one month)

1) A strong desire or sense of compulsion to take alcohol
2) Difficulty in controlling alcohol use
3) Withdrawal state when alcohol use has stopped or been reduced or use of the alcohol (or benzodiazepines) to relieve or avoid withdrawal symptoms
4) Evidence of tolerance
5) Preoccupation with alcohol use
6) Alcohol use persisting despite clear evidence of harmful consequences

INVESTIGATIONS

CBC | Liver function test | Blood sugar | Electrolytes | CT head (in case of seizure/ delirium tremens)

MANAGEMENT

PRIMARY CARE
- Alcohol Hazardous/ Harmful users - Brief Intervention* to reduce/stop consumption
- Alcohol Dependent users – Advice to stop use and motivate for treatment using Brief intervention*

REFER TO SECONDARY CARE IF
- H/ o withdrawal seizures/ hallucinations
- Additional psychiatric disorder
- Recurrent failed attempts at treatment

SECONDARY CARE
- Treatment of withdrawal symptoms
- Managment of withdrawal seizure
  - Inpatient management with benzodiazepines (diazepam or lorazepam)
  - Frequent titration of medication. Higher dosage may be required.
  - Closer monitoring and nursing care
- Treatment of additional psychiatric disorder or substance use disorder

REFER TO TERTIARY CARE IF
- H/ o delirium tremens
- Major medical problems
- Additional substance use

TERTIARY CARE
- Treatment of delirium tremens
  - R/ o head injury, hepatic encephalopathy, Wernicke's encephalopathy
  - R/ o other causes of delirium
  - Manage on similar lines as withdrawal seizures
  - Management in ICU setting when indicated
- Consult with other medical specialists (like gastroenterology or medicine for hematemesis).
- Management for suicidality or violence when emergent threat

*BRIEF INTERVENTION

Inquire using open ended questions in a non-judgmental manner. Help patient to evaluate the risks versus the perceived benefits and to arrive at a decision to reduce or stop alcohol use.

Includes (FRAMES) :
- **F**eedback about alcohol related problems
- **R**esponsibility – acknowledging that the patient is responsible for making the decision about their alcohol use
- **A**dvice regarding the harms associated with continued use
- **M**enu of alternative change options (includes identifying alternative activities such as hobbies, involving the family in treatment)
- **E**mpathetic attitude
- **S**elf efficacy - to encourage patients' confidence that they can make changes in their alcohol use and lifestyle

WITHDRAWAL MANAGEMENT

- Tab Diazepam (20-40mg/day in divided doses) based on severity of withdrawals.
- Monitor and titrate dose.
- If patient comfortable, reduce dose of medication by 10% to 20% per day, taper within 7 to 10 days
- Thiamine 100 mg OD
- Significant liver dysfunction: Lorazepam (2 mg Lorazepam equal to 5 mg Diazepam)

RELAPSE PREVENTION

(Long term goals- abstinence and socio-occupational integration)

- **Disulfiram (250 mg OD)**
  Pre-requisites:
  - Motivated patient
  - Patient's written consent
  - Under supervision of family members.
  - Inform patient and family about unpleasant, potentially serious reaction with even small amounts of alcohol (flushing, headache, vomiting, reduction of blood pressure, arrhythmias)
  - Ability of health personnel in the area to handle a potential reaction
- **Relapse prevention counselling:**
  - Identify cues leading to craving (like person, place, situation etc)
  - Develop strategies to deal with them effectively

INDICATIONS FOR ADMISSION

Failure of outpatient treatment | H/o withdrawal seizures/ delirium tremens | Co-morbid significant medical illness and/or psychiatric illness | Poly-substance use

KEEP A HIGH THRESHOLD FOR INVASIVE PROCEDURES

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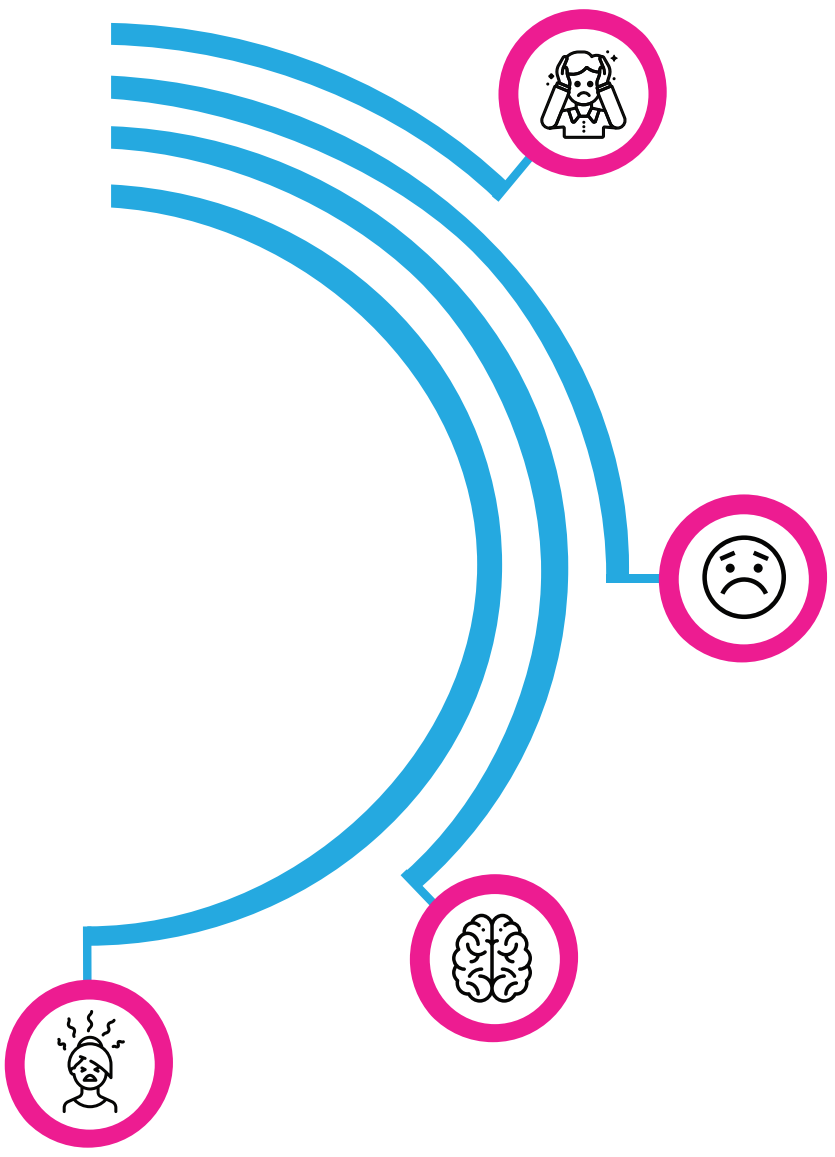
Standard Treatment Workflow (STW) for the Management of ANXIETY DISORDERS

ICD-10-F40-F42



- Tension, anxiety, apprehension, fear, worrying
- Sadness, lack of interest, uncontrolled negative thoughts
- Unexplained physical symptoms like chest pain, abdominal pain, muscular tension, headache, nausea
- Episodes of palpitations, difficulty in breathing, feelings of choking, light headededness, dizziness, fainting, trembling
- Attacks of fear, losing control or going "crazy", fear of dying
- Repetitive unwanted thoughts and behaviours

DIAGNOSIS

Generalized Anxiety Disorder (GAD): Chronic feeling of tension, apprehension, anxiety or worrying about a number of events or activities that involve every day routine life circumstances (e.g., work, school, health, finance, household chores etc.)

Agoraphobia: Fear of going out of home alone, being in enclosed spaces (e.g., malls, cinemas etc.), open spaces (e.g., bridges, vast playgrounds etc.), using public transportation (e.g., trains, buses, planes etc.)

Panic Disorder: Recurrent unexpected attacks of intense fear/ anxiety along with physical symptoms (palpitations, feelings of "choking", trembling, chest pain feeling dizzy/faint etc.)

Social Phobia: Marked fear and avoidance of social situations (e.g., interaction with strangers, meeting unfamiliar people, performing in front of others)

Obsessive-compulsive disorder (OCD): Recurrent and persistent unwanted thoughts (e.g., unwanted sexual and blasphemous thoughts, fear of harming self or others, fear of contamination, doubts about daily activities etc.) and repetitive behaviours (e.g., excessive washing / cleaning, checking, ordering etc.)

ASSESSMENT

- Duration of anxiety
- Degree of distress, and impairment of day-to-day functioning
- Symptoms of depression
- Substance and alcohol misuse
- Physical disorders: thyrotoxicosis, pheochromocytoma and hypoglycaemia
- Psychosocial factors: ongoing stress and other issues pertaining to work, family

MANAGEMENT

PRIMARY CARE LEVEL

Psychoeducation

- Reassurance
- Explain symptoms are of anxiety/ fear and mimic symptoms of physical illnesses (e.g., heart attack)
- Do not investigate excessively. Few investigations like ECG, ECHO maybe necessary in some patients
- Discourage doctor shopping
- Do not avoid triggers of panic attacks (e.g., physical exertion, agoraphobic situations) and fear (e.g., travelling by public transport).
- Emphasize avoidance maintains fears and phobias.
- OCD: Educate that the unwanted thoughts are a part of illness, and not a reflection of character or hidden intentions.

Pharmacological treatment

- Mild illness: Spending time, reassurance, and psychoeducation. May not need any medications.
- No improvement (few weeks): Escitalopram 5mg / day at night, with increase to 10 mg/d in a week. No satisfactory improvement in 4-6 weeks, may increase to 20 mg / day. If there is no significant improvement in another 4-6 weeks, refer to a specialist.
- Severe and unbearable anxiety: Diazepam (5 -10 mg) may be given at night. Do not continue for > 1 month. Taper and stop over 2 weeks. Long-term treatment with benzodiazepines to be avoided
- Escitalopram to be continued for at least 1-2 years after remission
- Side-effects (sexual dysfunction, sedation, weight gain) : monitor and address periodically

SECONDARY CARE LEVEL (DISTRICT HOSPITAL)

- Review diagnosis and treatment history if there is no improvement with a trial of Escitalopram.
- Check whether the patient has taken medication at prescribed dose and on a regular basis

- Second SSRI (either of them for about 2-3 months):
  - Sertraline upto 200 mg/day,
  - Fluoxetine upto 60 mg/day,
  - Paroxetine upto 50 mg/day,
  - Fluvoxamine upto 300 mg/day

- No response to second SSRI: cognitive behaviour therapy (CBT) if trained therapists available.
- Refer to tertiary centre if unsatisfactory response after second SSRI and / or addition of CBT.
- If referral to tertiary centre is not feasible, psychiatrists may try other strategies (other than Deep Brain Stimulation and surgery for OCD) mentioned under the "tertiary care" at the secondary level itself.

TERTIARY CENTRE (MEDICAL COLLEGE, REGIONAL MEDICAL CENTRE, PSYCHIATRIC HOSPITAL)

- Evaluate reasons for treatment resistance like
  - Wrong diagnosis
  - Inadequate drug treatment,
  - Poor adherence to treatment
  - Inadequate CBT,
  - Presence of comorbid conditions such as personality disorders and organicity
- **Panic disorder:** evaluate any medical conditions that mimic panic disorder (hyperthyroidism, hyperparathyroidism, pheochromocytoma, vestibular diseases, seizures, arrhythmias, etc.).
- **OCD:** Trial of third SSRI or clomipramine
- **Treatment resistant OCD:** inpatient treatment for intensive therapist-assisted daily CBT and for rationalization of medication regimen.
- **Other anxiety disorders:** Trial of non-SSRIs (e.g., venlafaxine, duloxetine, pregabalin etc.) and tricyclic antidepressants

- **If response to medications is poor or unsatisfactory:**
  - CBT is the preferred mode of treatment alone or in combination with medications.
  - Treat comorbid psychiatric disorders (e.g., personality disorders)
  - Pharmacological augmenting strategies if antidepressants and CBT do not provide relief.

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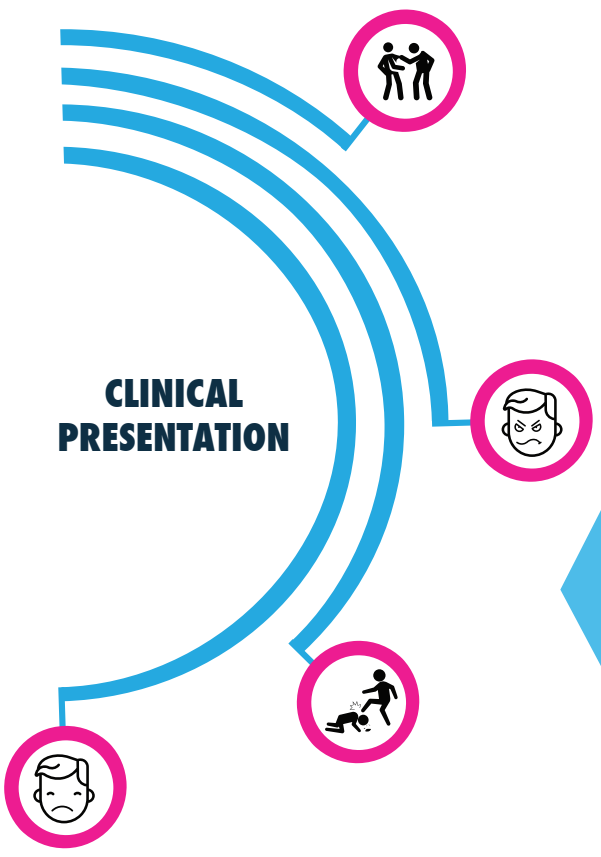
Standard Treatment Workflow (STW) for the Management of CHILDHOOD BEHAVIORAL DISORDERS

ICD10- F90-98

CLINICAL PRESENTATION



OPPOSITIONAL DEFIANT DISORDER (ODD)

- Doesn't obey or listen, back-answers, rude behaviors
- Demanding, stubborn, throws tantrums when demands are not met

CONDUCT DISORDER

- Aggressive – angry, abusive, fights, hits or hurts people, bullies other children, damages articles
- Stealing, lying, threatening or misbehaving with people, truant (keeps away from school without parents' knowledge), runs away from home, bad company, cruelty to animals

ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

- Restless, always on the move / running, can't sit in a place,talkative
- Can't focus attention on a task, poor concentration, gets easily distracted, disorganized, does not complete school work
- Too mischievous, can't be left alone, troubles people or damages things, or gets injured
- Impatient, always in a hurry, can't wait for his turn, does not care for danger, acts without thinking

ALL 3 DISORDERS

Poor or erratic school performance and / or complaints about behaviour from school

DIAGNOSIS

- Symptoms are present and persistent over several months
- Attempt further classification into ADHD, ODD and CD (ADHD may be present with or without ODD and CD

CAUTION

- Abrupt onset
- Recent onset (few weeks to few months)
- Sudden increase in severity (consider another psychiatric disorder such as bipolar affective disorder, hypomanic or manic episode -> follow the relevant STW)

ASSESSMENT (History From Multiple Sources)

PARENT INTERVIEW

- Symptoms- onset, duration, type(ODD, Conduct, ADHD-as above) and severity
- Developmental problems, emotional disturbances and stress
- Alcohol and substance use /misuse
- Impact on child and family

FAMILY SITUATION

- Health (including mental health) and wellbeing of family members
- Cohesion, mutual understanding and harmony in the family
- Parenting and childrearing practices: caring and disciplining, criticism, unfair comparison and physical punishments, mutual blaming of parents for child's problem

SCHOOLING

- Attendance
- Performance
- Learning problems,
- Classroom behaviors
- Recent changes in syllabus and/or school

CHILD INTERVIEW

- Develop rapport(discuss neutral topics; avoid direct tackling of misbehaviors)
- Observe:
  - Features of ADHD (restless, fidgety, easily distracted, attention keeps shifting)
  - Speech and language ability, intelligence, academic skills and mood
- Enquire about any stress or difficulties child is facing at home, school, and with peers and anger control

MANAGEMENT

WORK WITH FAMILY

- PSYCHOEDUCATION
  - Explain the child's behaviours are not intentional
  - Not child's fault, do not blame the child
  - Multifactorial causes-lack of self-regulation, and adverse environment
  - Can be improved with proper management
  - Parents can directly contribute to the child's improvement
- Help parents deal with their own worries and stress (listening, giving space to ventilate, validate and empathize their difficulties, reassure)
- Recognize and manage mental health problems such as depression and alcohol problem in parents
- Parent management training*

WORK WITH THE CHILD

- Avoid advice
- Anger management (count from 10 -1 backwards, move away from situation, deep breaths, relax, self-talk to cool down)
- Children with ADHD: "stop-think-act" or "halt and proceed" technique

WORK WITH THE SCHOOL

- Feedback to school regarding child's condition
- Teachers to give extra attention, help and support for the child
- Extra coaching, if needed in case of learning problems

*PARENT MANAGEMENT TRAINING

- Analyse the problem behaviors and understand patterns : time of occurance, triggers, duration and consequencies
- Engage with child in mutually enjoyable, pleasurable activities (playing games, discussing interesting things or doing activities together)
- Set clear do's and don'ts and explain to child in clear, simple, short instructions the consequencies (like withholding privileges following misbehavior; use star-charting (contingency management) and rewards based on number of stars earned
- In children with ADHD, develop clear daily routines, supervise activities and appreciate on completion of taks
- Limit screen time/ monitor use of electronic devices

• Dos
- Consistency in enforcing rules
- Catch the child being good and praise
- Ignore negative behaviours
- Child can be put in a boring place till he/ she becomes quiet for a few minutes (time-out)
- Encourage age appropriate responsibilities

• Don'ts
- Bribe
- False promises and threats
- Harsh punishments
- Excessive criticism and blaming especially in front of others
- Unfair comparison
- Yielding to unreasonable demands

MEDICATION (AVOID BEFORE 5 YEARS)

- **Severe and persistant aggression:**
  - **T. Risperidone** under close supervision (starting dose-0.25 mg, single daily morning dose after breakfast. Based on response, increase by 0.25 mg weekly up to 1 mg single daily dose).
    Not to exceed 1 mg/day
  - **Response + :** continue 3 months f/b slow taper
  - **Response - :** 4 weeks trial, then refer
  - Monitor adverse effects: weight gain, extra-pyramidal symptoms (EPS)
    [if EPS : add I mg Trihexyphenidyl OD morning]
- **Severe hyperactivity and impulsivety:**
  - T. Clonidine (starting dose-25 µg single daily dose before sleep, increase by 25 µg weekly up to100 µg per day in 2-3 divided doses
- Monitor BP and drowsiness
- Advise against sudden discontinuation

REASONS FOR REFERRAL

Severe, complicated presentation	Lack of response to treatment	Severe aggression	Highly dysfunctional family	Alcohol and substance abuse

SECONDARY CARE (DISTRICT HOSPITAL)

- Review and reassess diagnosis (clinical evaluation using Rutter's multi-axial system) and all the pointers given above
- If failed trial of Clonidine/ Moderate ADHD:
  T. Atomoxetine (starting dose-10 mg single daily morning dose after breakfast. Increase up to 1mg/ kg/day under close supervision).
  Monitor adverse effects and response
- Systematic parent management training / behavioral management and individual therapy (as given above)

TERTIARY CARE (MEDICAL COLLEGE / REGIONAL REFERRAL CENTRE)

- Evaluate and manage severe behavior disorders – severe ADHD, ODD, and CD, if necessary on short-term inpatient basis
- Multi-modal management with clear individualized plan
- Trial of Methylphenidate in moderate / severe ADHD under expert supervision
- Recognize and treat comorbid disorders such as bipolar disorder, substance use disorder, and internalizing disorders and manage
- Pharmacological management of older children / adolescents with severe aggression / impulsivity with Risperidone and/or Lithium
- Family therapy for dysfunctional / discordant families, contributing to child's condition
- Management of children in difficult circumstances with mental health issues (children in need of care and protection; children in conflict with law)

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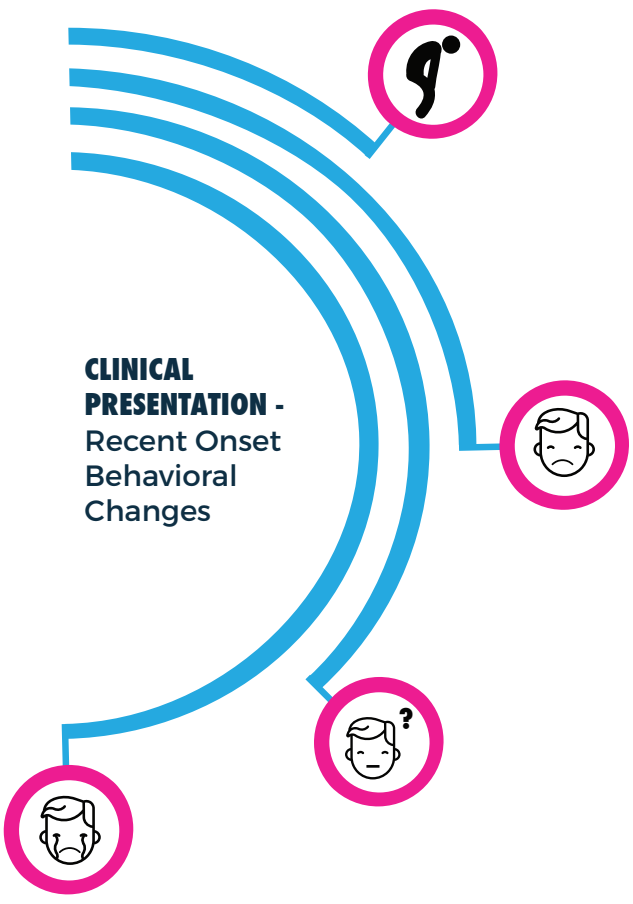

CLINICAL PRESENTATION - Recent Onset Behavioral Changes

SOMATIC (PHYSICALLY UNEXPLAINED) SYMPTOMS
- Weakness and tiredness
- Aches and pains
- Headache
- Non-epileptic attacks of fainting
- Chest pain and stomach pain
- Hyperventilation- often triggered by stress or distress

SYMPTOMS OF DEPRESSION
- Loss of interest in usual activities
- Recent deterioration in school performance
- Wanting to be alone, withdrawn, not interacting with people
- Looks unhappy, "off mood", crying for trivial or no reason, irritable, sensitive to any criticism
- Decreased sleep, loss of appetite and weight loss
- Talking about death and dying, self harm (eg. self-cutting) or suicidal attempt

SYMPTOMS OF ANXIETY
- Always worrying, tense
- Exam tension, performance anxiety, worries about marks and ranks
- Excessive fear and avoidance of some objects or situations (insects, animals, ghosts)
- Reluctance or refusal to go to school
- Very shy, avoids social situations, scared of talking or interacting with strangers,
- Clinging to mother, scared of being separated from mother

DIAGNOSIS
- Persistent symptoms of emotional disturbance for several weeks, significantly affecting the child's life
- Unexplained by medical condition such as hypothyroidism
- Depression and anxiety symptoms can co-occur
- Depression more common in adolescents, may have features similar to adult onset depression

CAUTION
- Assessment of suicidal risk and a plan of action is important in children with emotional disorders, especially depression (refer to appropriate STW)
- Elicit h/o hypomania/mania in children with moderate to severe depression (consider diagnosis of bipolar disorder)
- Physical conditions can cause similar symptoms (anemia and thyroid disturbance)

ASSESSMENT

PARENT INTERVIEW AND HISTORY TAKING
- Onset, duration, severity and full range of symptoms
- Home environment, family life and relationships, parenting practices and stressors
- Information (from paretns and school) about school performance, behavior, school refusal, bullying experiences, peer relations and any recent change

CHILD INTERVIEW
- Develop rapport
- Ask subjective distress (low mood, irritability, sadness, lack of enjoyment of activities, worries, fears, tensions, autonomic symptoms)
- Stressful events (loss, death in the family, separation, frightening experiences, traumatic abusive or shocking events, humiliating experiences, bullying in school, academic stress) and interpersonal difficulties
- Explore parent-child relations and interactions and any undue punishment or criticism

PHYSICAL EXAMINATION
(Rule out)
- Post-viral syndrome
- Recurrent attacks of malaria
- Chronic infections, chronic physical illness, anaemia, PCOD or thyroid disturbance

MANAGEMENT

WORK WITH PARENTS
- PSYCHOEDUCATION:
  - Child is emotionally disturbed and not able to function well
  - Not the child's fault
  - Avoid undue criticism, over expectation, unfair comparison, scolding and punishment
  - Parents' support, encouragement and understanding is important
- Counsel about suicidal risk in depression and to be alert to pointers to suicidality
- Evaluation and management of the mental health issues in parents
- Discuss about specific steps to reduce undue stress the child is facing

WORK WITH THE CHILD
- Psycho-education of the child- explain they are suffering from an emotional problem and it is not their fault and they will get better with proper treatment
- Anxiety management and emotional regulation skills
  - Muscle relaxation
  - Deep breathing exercises
  - Praanaayaama / yoga
  - Substituting distressing thoughts with more comforting thoughts
- Counsel the child to confide any distressing thoughts, including thoughts of death and dying
- Encourage the child to gradually return to the usual life and activities in a step-by step manner with parental support and encouragement

WORK WITH SCHOOL
- Give feedback to the school about child's condition and stress, need for support, encouragement and school's cooperation.
- If school refusal, graded return to school: encourage child to return to school gradually with the support of family and cooperation of school (e.g. initially for a few minutes in school compound, later for 1 period in school and moving on to longer duration

MEDICATION (MODERATE CASE OF DEPRESSION OR ANXIETY IN ADOLESCENTS)
- Tab Fluoxetine - start at 10 mg OD morning, increase to 20 mg OD after 2 weeks depending on response
- Inform adverse effects: behavioral activation (marked restlessness and irritability), onset of hypomanic symptoms, and worsening of suicidal ideas. Stop drug if they are troublesome
- Avoid benzodiazepines (except as temporary measure for few weeks in severe anxiety attacks or panic attacks - Clonazepam 0.25- 1 mg /day)

REASONS FOR REFERRAL
- Frequent expression of suicidal ideation/ attempted suicide / self-harm behavior such as self-cutting
- Severe symptoms
- Complicated picture, or features of obsessive compulsive disorder (OCD)
- No response to interventions in 4-6 weeks

SECONDARY CARE (DISTRICT HOSPITAL)
- Review and reassess diagnosis through detailed clinical examination using Rutter's multi-axial system
- Review the treatment received and plan multi-modal treatment.
- Reconsider medications, and augmentation strategies
- Review child's and family's awareness of the illness and do psycho-education
- Ascertain the presence of psychosocial factors : disturbed home environment, parent-child relationships and severe stressors
- Screen parents for mental health problems and manage accordingly
- **Individual therapy** focussing on identifying and challenging negative thoughts, anxiety management and coping with stress, helping them face difficult situations in small steps, improving interpersonal relationships
- **Parent counselling** to address family issues, communication and interaction patterns
- Collaborate with school wherever necessary (get school report; explain problem in simple terms, and suggest ways by which school can help)
- Recognize and manage less common problems such as obsessive compulsive disorder, psychoses and bipolar disorders
- Manage adolescents with mild / moderate suicidal risk

TERTIARY CARE (MEDICAL COLLEGE / REGIONAL REFERRAL CENTRE)
- Thorough diagnostic evaluation
- Manage severe mental disorders – psychoses, recurrent mood disorders, adolescents with severe depression, & treatment resistant cases, persistent suicidality, recurrent self-cutting, if necessary in inpatient setting
- Family therapy for dysfunctional / discordant families contributing to child's condition
- Cognitive behavior therapy for older children with severe OCD, depression, and anxiety disorders
- ECT on case to case basis (older adolescents with severe depression, mania, psychosis or catatonia unresponsive to adequate pharmacological management)
- Appropriate psycho-social steps if there is abuse, maltreatment or neglect
- Neurology referral in suspected cases of epilepsy and organicity

KEEP A HIGH THRESHOLD FOR INVASIVE PROCEDURES

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Standard Treatment Workflow (STW) for the Management of CHILDREN WITH DEVELOPMENTAL PROBLEMS

ICD10-F70-89

CLINICAL PRESENTATION

- Slow in development / delayed milestones of development
- Poor speech, self-care, learning and memory
- Less intelligent compared to other children

DIAGNOSIS

- Intellectual disability (mental retardation)* - global developmental delay + impairment compared to peers in intellectual functioning and adaptive skills
- Specific Learning Disorder (SLD)- Average intelligence with poor academic skills (reading, writing, spelling and maths inspite of adequate schooling)
- Specific speech delay – Only lagging in speech with normal intelligence, hearing and non-verbal communication
- Autism Spectrum Disorder (ASD) marked impairment in verbal and non-verbal social interactions (being solitary or "in his own world", poor response to name call and poor eye-to-eye contact) and stereotyped behaviors *in children under 5 years, avoid diagnosis of ID, name it as global developmental delay and start intervention

ASSESSMENT

DETAILED DEVELOPMENTAL ASSESSMENT:
- Assess if child is lagging behind in developmental attainments compared to same-age children
- Ask mother to estimate the mental age of child
- Ascertain if delay is global (all milestones) or restricted to one area (motor or speech)

PHYSICAL EXAMINATION:
- Height and weight,
- Head circumference,
- Vision and hearing
- Any noticeable physical anomalies (club-foot) or unusual facial appearance
- Motor abnormalities (stiffness / spasticity or weakness of limbs, unsteady gait)
- Any other problems (heart murmurs, organomegaly)

BEHAVIOURAL PROBLEMS:
- Hyperactive
- Impulsive behaviors
- Sleeping and feeding problems
- Aggression

EMOTIONAL PROBLEMS:
- Excessive crying
- Irritability
- Shyness and fears

OTHERS:
- Family situation
- Parents' awareness of the child's problems
- Quality of attention and care being given to the child,
- Past consultations and treatment educational history

MANAGEMENT

PSYCHO-EDUCATION OF PARENTS

- **Normal** – reassure parents
- **Mild delay** ("at risk") – early intervention and follow-up
- Explain causation due to some damage to brain before, during or after birth
- No medication can improve intelligence Teaching and training to improve skills and gaining independence
- Systematic, persistent and repetitive training as per the child's ability
- Treatment of associated problems (vitamin or mineral deficiency or epilepsy, ADHD, vision/ hearing issues,) – refer to appropriate STW
- Avoid overprotection, overindulgence and understimulation

EARLY INTERVENTION / SENSORY-MOTOR STIMULATION FOR YOUNG CHILDREN – UNDER 3 YEARS
- Create opportunities for the child to learn with interset and attention
- Engaging and spending time with child in activities
- Offer appreciation
- Engage the child to use eyes and ears (different types of sounds and sights), touch (eg., tickling, stroking, gentle massaging), movements (gentle movement of limbs, gentle bouncing, range of movement exercises) and improving hand functions (taking, holding, giving, pushing, pulling)
- Use play materials–rattles, paper balls, rubber balls, clay, soft dough, water play, soap bubbles, vegetables.
- Parallel vocalization to improve utterances (making the same sound as the child immediately).
- Improve conceptual skills by classifying, arranging, sorting, and recognizing and naming activities (for eg., vegetable sorting, grain sorting, arranging vessels by their size and shape)

HOME-BASED PARENT MEDIATED SKILLS TRAINING

- Develop and maintain regular, stimulating daily routines
- Teach parent to teach child : simple imitation, pointing, pretend-play; self-help skills (eating, toilet training, bathing, dressing), doing simple household chores (washing utensils, helping in cleaning house), social skills – skills of interaction, simple academic skills, simple vocational skills, helping in kitchen under supervision, self-protection
- Find current level of adaptive abilities of the child and choose a target skill
- Tell and show how to do things (modelling), make the tasks simpler, break activities in simple steps and teach one step at a time, notice and praise even minor efforts and improvements (rewarding or reinforcing), using hand-on-hand techniques (keeping your hand on the child's hand and making them do the activity)

EDUCATION AND TRAINING
- Liaise with schools and ensure child attends school that is most appropriate
- Assist in enrolment to special school
- Consider training in vocational skills (informal and formal) for older adolescents

SOCIAL WELFARE / LIAISON MEASURES
- IQ testing and certification for social welfare benefits
- Help parents to link with other agencies/ services that deal with such children such as CBR programs or parent associations

REASONS FOR REFERRAL

- Severe or multiple developmental problems
- History of regression (loss of acquired skills)
- Definite family history of developmental problems (h/o similar problem in the sibling)
- Co-occuring severe behavioral or emotional problems
- Suspected case of ASD
- Suspected SLD
- Genetic counselling
- Speech therapy or physiotherapy

SECONDARY CARE (DISTRICT HOSPITAL)

- Psychological testing for ID, SLD and diagnosis of ASD
- Basic management of ASD – home-based parent-mediated training in social, communicative, and self-help skills
- Appropriate management of behavior problems with medication / psychosocial or behavioral intervention (see relevant STW's)
- Help parents access relevant services such as District Early intervention centres (DEIC's), parent organizations, and benefits

TERTIARY CARE (MEDICAL COLLEGE / REGIONAL REFERRAL CENTRE)

- Evaluate and manage children with severe IDD, ASD, multiple disabilities, and those with severe comorbid disorders such as ADHD, aggression, bipolar disorder, and psychotic disorders through multi-disciplinary approach
- Investigate for the cause – review tests already done; imaging, genetic tests, metabolic tests (as per requirement) ;arrange for genetic counselling
- Manage treatable disorders (like hypothyroidism and inherited metabolic disorders)
- Manage comorbid physical health problems (like epilepsy, visual /hearing impairment, locomotor/ orthopaedic problems)
- Assessment and management for SLD – psychoeducation of the child and parents, liaison with school, teaching basic remediation techniques to parents, helping parents access relevant organizations, issue of exemption certificates, and decisions about further schooling such as open schooling

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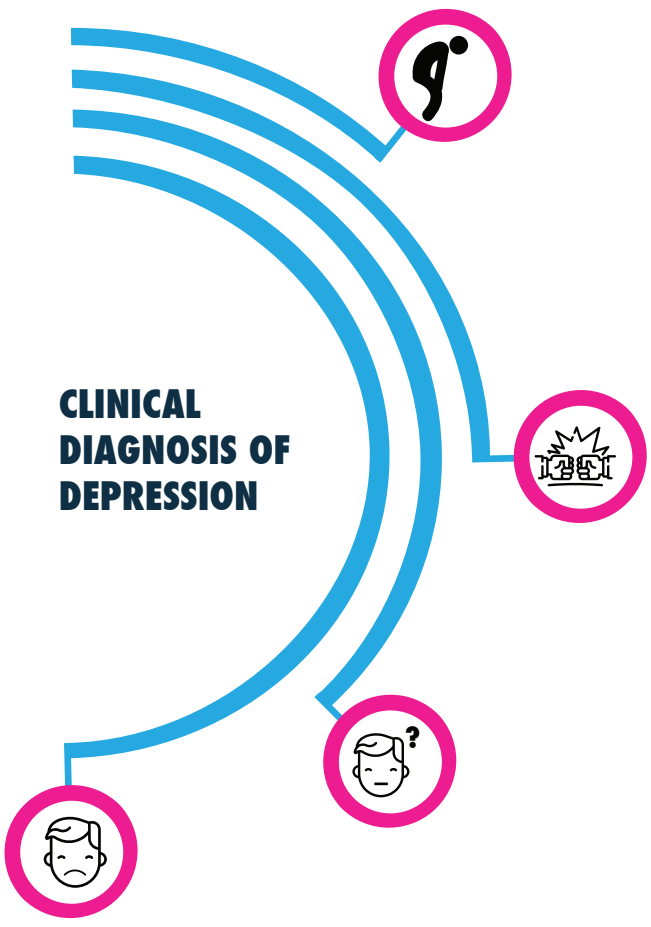
Standard Treatment Workflow (STW) for the Management of DEPRESSION

ICD10-F45



CORE SYMPTOMS

1. Depressed mood
2. Loss of interest and enjoyment
3. Easy fatigability/ diminished activity

ADDITIONAL SYMPTOMS

- Reduced concentration and attention
- Reduced self-esteem and self-confidence
- Ideas of guilt and unworthiness
- Bleak and pessimistic views of the future
- Ideas or acts of self-harm or suicide
- Disturbed sleep
- Diminished appetite

To make a diagnosis of depression, symptoms must present for at least 2 weeks.

Severity of depression	Core symptoms	Additional symptoms
Mild depression	2	2 or more
Moderate depression	2	3 or more
Severe depression	3	4 or more

Rule out Bipolar Disorder / Grief / Adjustment Disorder

CLINICAL ASSESSMENT

Cognition
- Hopelessness (about future)
- Helplessness (about others)
- Worthlessness (about self)

→ Assessment of Depressive Cognition

Assessment of Suicide Risk
- Suicidal thoughts
- Suicidal idea
- Suicidal intent
- Immediate risk for attempt

→ Assess friend and family support

INVESTIGATION

- Haemogram
- Thyroid function tests
- Electro Cardiogram
- Electrolytes (Sodium)
- Rule out secondary medical cause of depression like Hypothyroidism
- Rule out use of anticancer drugs (Cyclophoshamide) / anti retroviral drugs (Efavirenz, Zidovudine)/ Antibiotics (Dapsone , Ethambutol)/ Anabolic Steroids/ Propanolol
- Rule out associated comorbid medical condition – Diabetes, Stroke, Epilepsy, Cancer, Coronary Artery Disease and Auto Immune disorder

AT PRIMARY CARE

MILD DEPRESSION

- Advise Behavioral Activation to patients
- Practicing activity monitoring - write down your activities / rate your depression / schedule activities that make you feel good / make a to do list/ set clear and specific goals
- Focusing on your value categories – make time for your family / friends / set clear goals at work / contribute to community
- Reccomend yoga & mediatation
- Handling daily task - monitor sleep /diet and practice good personal hygiene
- Supportive psychotherapy / Brief Counselling
- Validate the problems and ensure frequent follow-up
- If no improvement in 4 to 6 weeks, consider pharmacotherapy

MODERATE / SEVERE DEPRESSION

- Tab Escitalopram 10 mg-20 mg /day or Cap. Fluoxetine 20mg -40mg /day
- Tab. Clonazepam 0.25mg – 0.5mg /day for sleep disturbance / anxiety symptoms and consider taper and stop after 2 weeks.
- If patient responds to SSRI in 2 to 4 weeks, then continue treatment for 6 to 9 months and taper and stop

REFERRAL TO SECONDARY CARE

- Difficulty in making diagnosis
- No improvement after 4 to 6 weeks of treatment with first line medications
- Depression in special population: Elderly / Pregnancy / Lactation / Children / Adolescents
- Comorbid medical illness / Substance use
- Suicidal risk assessment

BROAD MANAGEMENT PLANS

- Selective Serotonin Reuptake Inhibiters (SSRI) are usually first choice (watch for GI bleed and drug interaction)
- Improvement starts in in 2nd week and expect adequate response by 6 weeks
- Duration of treatment typically lasts 6-9 months and Gradual tapering of medication advised for first episode
- Restart SSRI , In case of resurgence and recurrence of depressive symptoms
- Observe for switch / activation with Antidepressants
- Watch for risk of overdose with TCA (Amitriptyline / Imipramine) and Mirtazapine

AT SECONDARY CARE

- Confirm Diagnosis and Suicide risk assessment
- Assess for other Medical Comorbidities
- Investigations – Haemoglobin,Thyroid Function Test, Electrocardiogram
- Non Responder - Switch over to SNRI (Venlafaxine 75 – 150 mg, Mirtazapine 30 mg) or TCA (Amitriptyline 75 - 225mg / Imipramine 75 -225mg)
- Cognitive Behavioral Therapy / Problem Solving Therapy
- Add on Yoga Therapy / Meditation

REFERRAL TO TERTIARY CARE

- No improvement in 2nd line treatment
- Immediate risk for suicidal attempt / thought
- Needing intense counselling/ psychotherapy
- Co Morbid Substance - Cannabis / Poly substance

SPECIAL POPULATION

- Pregnancy / Lactation period - Pre Conception counselling and preferred drug is Tab. Sertraline 50 mg – use lowest possible dose
- Elderly - Tab. Escitalopram 10 -20 mg or Tab. Sertraline 100 mg (monitor for hyponatremia)
- Avoid TCAs like Amitriptyline / Imipramine in Elderly (due to anticholinergic side effects)
- Adolescents- Cap. Fluoxetine 20 -40 mg /day (observe for switch / activation/ suicidality)

AT TERTIARY CARE

- Reconfirm Diagnosis
- Assess other psychiatric comorbidities
- Partial Responder - Optimise the SNRI /TCA or Augment with Tab. Lithium 300 to 600mg /per day or Tab. Thyroxine 25 - 50 ug per day.
- Non Responder – Add Tab. Sertraline 100mg or Tab. Bupropion 300mg to existing Venlafaxine 150mg / Tab. Mirtazapine 30mg / Amitriptyline 225mg / Imipramine 225mg.
- Add on Electro Convulsive Therapy for Catatonia / Suicidality
- Add on Cognitive Behavioural Therapy/ Inter Personal Therapy / Problem Solving Therapy
- Add on low dose antipsychotic treatment (Risperidone 2 -4 mg / Tab. Olanzapine 5 – 10 mg) for psychotic symptoms

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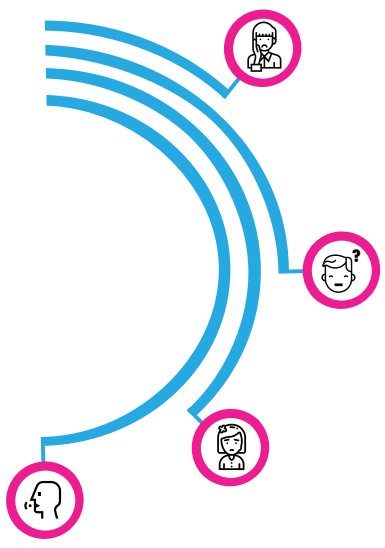
Standard Treatment Workflow (STW) for the Management of PSYCHOSIS

ICD10-F20-29



DIAGNOSIS

- Presence of delusions (suspiciousness and fear without obvious explanation)
- Hallucinations (talking, smiling or laughing to self)
- Disorganized behaviour & poor self-care
- Social and occupational dysfunction

PRIMARY CARE LEVEL

WELLNESS CENTERS

Identify, educate and refer to PHC

If immediate threat to self/ others, refer to Taluk / District center

FOLLOW-UP AND REHABILITATION:

- Monitor & manage challenges in treatment continuation
- If unsatisfactory outcome despite regular treatment:
  - Liaise with higher centers for optimal outcome
  - Liaise with social welfare department for disability certification & welfare benefits if continued poor outcomes

PHC

INITIATE TREATMENT:

- T. Risperidone 2mg HSx1 week f/b 3 – 4 mg HS + Trihexyphenidyl (THP) 2mg(morning)
- Psychoeducation:
  - medical model of psychosis
  - address misconceptions & build hope
  - inform about possible adverse effects of medications

FOLLOW UP:

- 2 weeks after initial contact: Check for changes in symptoms and adverse effects (excess sleep, extrapyramidal symptoms (EPS), tiredness) adjust the dose of risperidone and THP accordingly; address questions if any; advise gradual return to work/school; give specific follow-up date; liaise with wellness center for ensuring continuity of care
- Once in 1 – 2 months: Check for symptoms, functioning and adverse effects (EPS, weight-gain, menstrual/sexual dysfunction); adjust the dose of Risperidone (range: 2 – 8 mg/day) and THP (range 2 – 6 mg/day); liaise with wellness center for ensuring continuity of care

REASONS FOR REFERRAL TO TALUK / DISTRICT LEVEL:

- Diagnostic confusion / suspicion of organic condition
- Substantial risk of harm to self or others and catatonic symptoms
- Comorbid substance use, depression/anxiety, intellectual disability
- Poor symptom-control or functioning despite regular treatment or poor treatment adherence
- Significant adverse effects: weight-gain, metabolic adverse effects, tardive dyskinesia
- Questions regarding marriage, pregnancy, sexual dysfunction

SECONDARY CARE (TALUK/DISTRICT HOSPITALS)

INDICATION FOR REFERRAL FROM PHC	Diagnostic confusion	Poor response to Risperidone	Intolerance to Risperidone	Poor adherence to treatment	Comorbid conditions	Challenging situations	Rehabilitation needs	Pregnancy
MANAGEMENT #Encourage follow up in primary care after addressing referral issues * Watch for adverse effects as SSRIs may increase serum levels of antipsychotics	Clarify diagnosis; neuroimaging if organicity is suspected	Positive symptoms: Follow algorithm Negative symptoms: • Rule out or manage depression/ anxiety and extrapyramidal symptoms; • Family counseling if understimulated/ over-protected • Consider less-sedating antipsychotics and adding SSRIs*	Follow algorithm	• Assessment of factors causing poor adherence & specific manage-ment • Consider depot anti-psychotics • Liaise with primary care for assertive follow up	• Depression/ anxiety: Brief psychological intervention; consider SSRIs* • Substance use: Detoxification and brief interventions (see SUD module) • Developmental disabilities: Behavioral	• Suicidality: -Inpatient care, -Crisis management, -Management of comorbidity; -Consider ECT • Violence: -Verbal de-escalation -IV sedation, -Brief inpatient care	• Assess disability & counsel about welfare benefits • Rehabilitation counseling - Family intervention for expressed emotions and attitudes & behaviors interfering with functioning - Brief interventions for cognitive & social-skill deficits - Address vocational/ educational challenges involving governmental/ non-governmental	• Proactively address sexual and endocrine problems when relevant • Educate about risk of obstetric outcomes, risk of relapse & risk of psychosis in the offspring

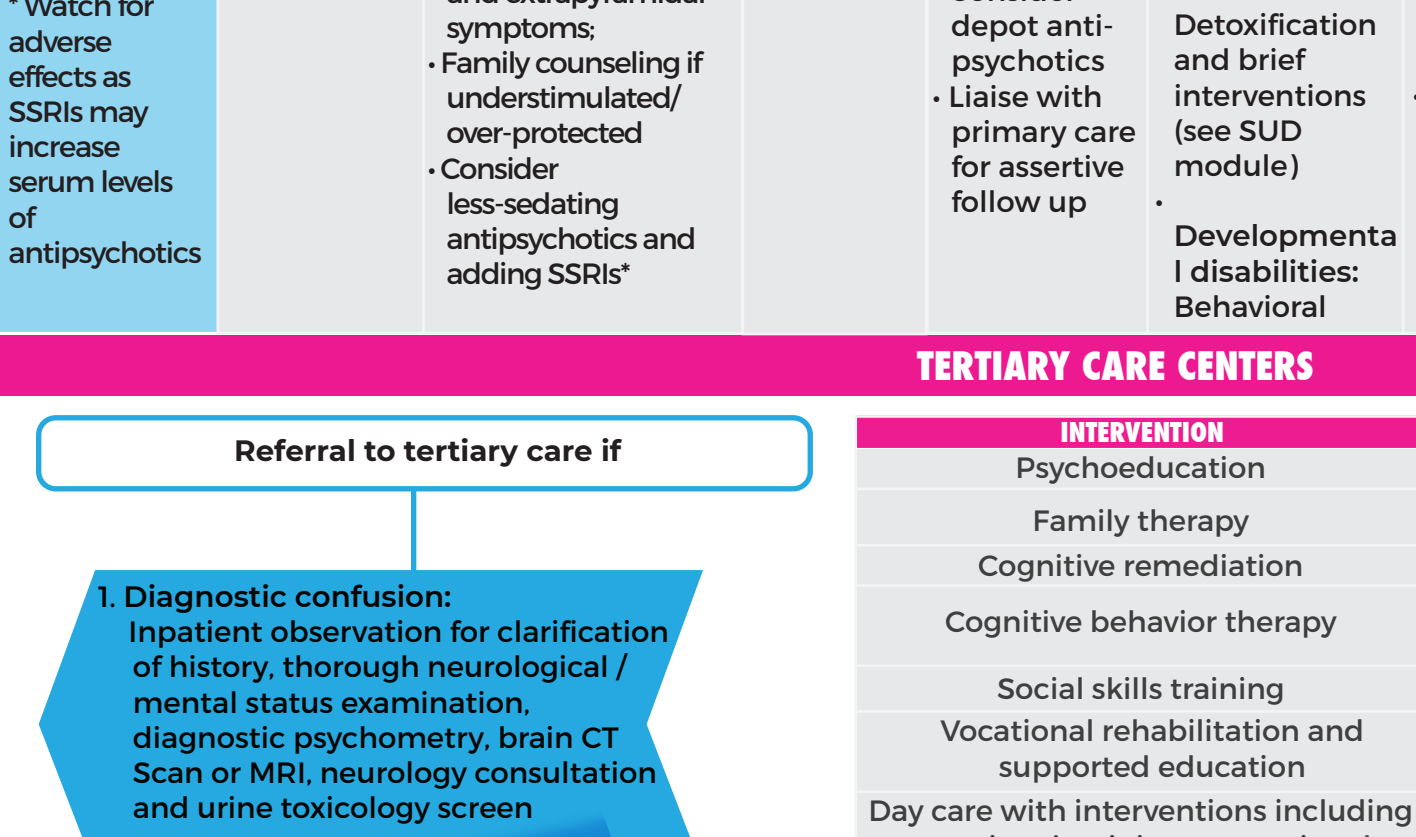
TERTIARY CARE CENTERS

Referral to tertiary care if

1. Diagnostic confusion:
   Inpatient observation for clarification of history, thorough neurological / mental status examination, diagnostic psychometry, brain CT Scan or MRI, neurology consultation and urine toxicology screen
2. Poor outcome:
   +Following psychosocial interventions may be offered in isolation or in combination depending on the context in inpatient, outpatient or day-boarding settings

INTERVENTION	CONTEXT IN WHICH USEFUL
Psychoeducation	Poor adherence; high family expressed emotions
Family therapy	High family expressed emotions; family discord
Cognitive remediation	Poor neuro and social cognitive functions
Cognitive behavior therapy	Depression, anxiety, obsessions, persistent psychotic symptoms
Social skills training	Poor social skills
Vocational rehabilitation and supported education	Poor occupational functioning, challenges in studying or getting / pursuing gainful occupation
Day care with interventions including vocational training, recreational activities, living-skill training, etc.	Negative symptoms, poor socio-occupational functioning, combination of other symptoms listed in the table
Interventions for substance-use	Hazardous use of substance or substance use disorder
Pregnancy – puerperium services	Pre-pregnancy, pregnancy and post-partum advise and interventions Pre-pregnancy, pregnancy and post-partum advise and interventions

ALGORITHM FOR CHOOSING ANTIPSYCHOTIC MEDICATION (AP) FOR TREATMENT OF SCHIZOPHRENIA



At any point, consider electroconvulsive therapy if:
1. Serious suicidal risk
2. Catatonia not responding to Lorazepam
3. Refusal of food / fluids
4. Severe aggression / violence
5. Refractory / intolerance to clozapine

* Treat with adequate dose as shown in table-1 for 6 – 8 weeks to assess efficacy
#While choosing alternative AP, consider adverse effect profile and cost
^ At any point, if there is medication non-adherence, consider long-acting preparations in addition to other measures for managing non-adherence

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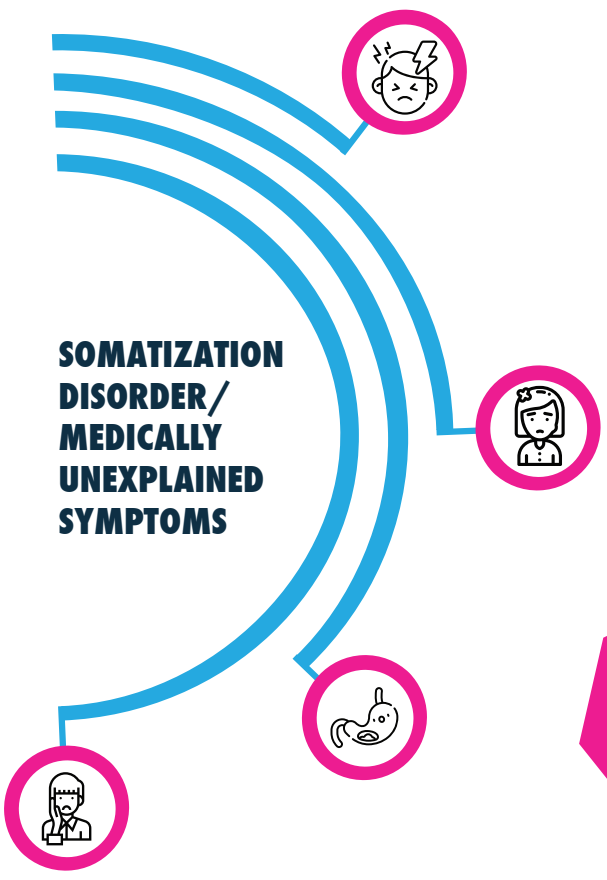
Standard Treatment Workflow (STW) for the Management of SOMATOFORM DISORDER (SD)

ICD10-F45



Repeated subjective experience of physical symptoms which are not explained by any recognizable physical disease

Bodily complaints are often the most common reason for consultation with health professionals

CHALLENGES FACED BY THE DOCTOR

- Repeated request for investigations – despite negative findings and reassurance
- Doctor shopping and not satisfied with repeated reassurance

PRESENTION TO A DOCTOR

- Pain at multiple sites
- Fatigue and exhaustion
- Significant distress and impairment
- Functional disturbance of different organ systems
- Focus of patient is on symptom relief rather than cause of illness

DIAGNOSTIC CRITERIA

INITIAL ASSESSMENT

- Detailed clinical examination – to rule out any medical illnesses which might explain the symptoms
- Complete history of the onset of all symptoms, exacerbating and relieving factors
- Assessment for any other psychiatric illness such as depression or anxiety disorders

PSYCHOSOCIAL ASSESSMENT

- Encourage to talk about psychosocial stressors if any
- Individual factors – poor copying skills, anxiety, life events, health anxiety, medical illnesses
- Family related factors – Substance use in family, interpersonal relationship with family, financial status
- Environmental factors – support system, peer relationship, work environment

DIAGNOSTIC CRITERIA

A. One or more somatic symptoms that are distressing or result in significant disruption of daily life.
B. Excessive thoughts, feelings, or behaviours related to the somatic symptoms or associated health concerns as manifested by at least one of the following:
   1. Disproportionate and persistent thoughts about the seriousness of one's symptoms
   2. Persistently high level of anxiety about health or symptoms
   3. Excessive time and energy devoted to these symptoms or health concerns
C. Although only one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months)
A persistent course is characterized by severe symptoms, marked impairment, and long duration (more than 6 months)

Severity:
Mild – only one of the symptoms specified in criterion B is fulfilled
Moderate – Two or more of the symptoms specified in criterion B is fulfilled
Severe – Two or more of the symptoms specified in criterion B are fulfilled, plus there are multiple somatic symptoms (or one very severe somatic symptom)

Following list include 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)
3. Abnormal skin sensations (itching, burning, tingling, numbness, soreness) and blotchiness
4. Sexual and menstrual complaints (ejaculatory or erectile dysfunction, hyperemesis of pregnancy, irregular menses, menorrhagia, sexual indifference) are also common

MANAGEMENT

PRIMARY CARE

- Detailed physical examination
- Management of anemia and nutritional deficiencies
- Avoid irrational use of pain medications
- Low dose of antidepressant medications – Amitriptyline 12.5 mg to 50 mg (max) night dose
- Explain that onset of medication effect will take 2-3 weeks
- Validate the somatic symptoms
- Advise to engage in routine activities, physical exercise and relaxation techniques like deep breathing
- Discuss with family members that the symptom, distress and disability are genuine
- Strengthen supports
- Regular follow up

REFER TO SECONDARY CARE IF

1. Difficulty in making diagnosis
2. No improvement after 4 weeks of treatment with first line medications
3. Comorbid medical illness
4. Suicidal risk
5. Comorbid psychiatric illness

SECONDARY CARE

- Investigations – to rule out any medical illnesses that might explain the symptoms
- Complete history with behavioural observation
- Use 2nd line medications – SSRIs (Escitalopram 10-20 mg, Sertraline 50-100 mg, Fluoxetine 20 mg) and SNRIs (Venlafaxine 75 – 150 mg, Duloxetine 30- 60 mg)
- Combination of two psychotropic medications (might be required if poor response to single medication)
- Brief counselling
- Psycho education – focusing on relationship between stress and physical symptoms
- Relaxation training, regular exercise, yoga and meditation

REFER TO TERTIARY CARE IF

1. No improvement in 2nd line treatment
2. High suicidal risk
3. Needing intense counselling/ psychotherapy
4. Difficult patients

TERTIARY CARE

- Inpatient care if needed
- Combination of two psychotropic medications (when required)
- Add on second and third line medications – Duloxetine, Mirtazapine, anticonvulsants (Lamotrigine, Pregabalin). Use of Gabapentin, Carbamazepine if chronic pain symptom predominates
- Structured Cognitive Behavioural Therapy, Cognitive restructuring, Mindfulness and acceptance based approach
- Use of alternative medicine approach – Yoga
- Collaborative approach – involve Physician, Neurology team and Pain Clinic referral (where indicated)
- Vocational rehabilitation if needed
- Physical therapies – guided exercise and physiotherapy

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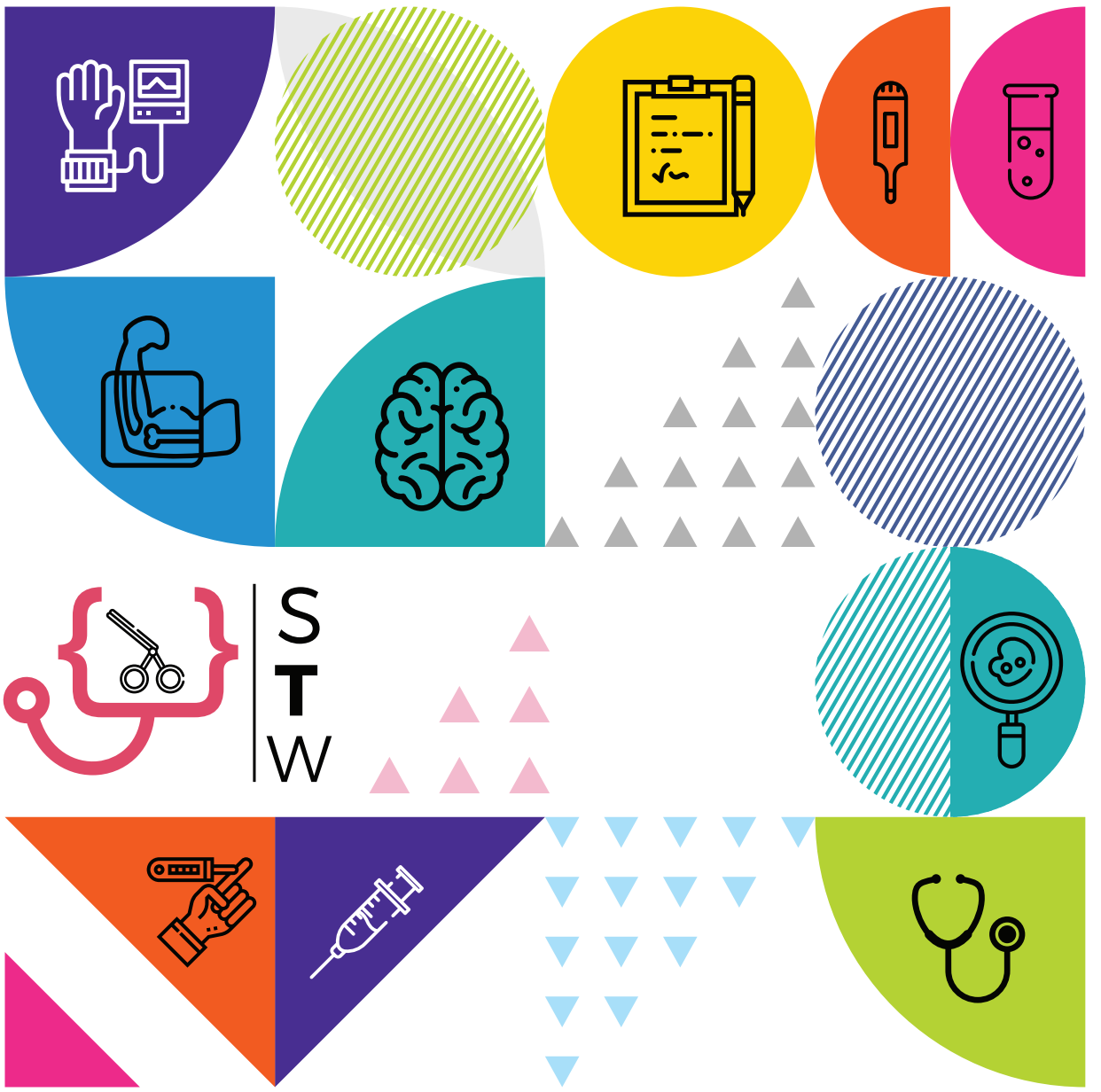

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