Mental Health Services as part of Family Practice

Prof.(Dr.) Nimesh G. Desai
MD(Psych), MPH(USA), MRCPsych(UK)
Director, Institute of Human Behaviour & Allied Sciences (IHBAS), Delhi
IHBAS & Self

- Former Hospital for Mental Diseases (HMD), Shahdara, set up in 1966
- Became IHBAS in 1993—an autonomous body
- Joined in Dec 1998 as Prof & Head, Dept of Psychiatry (12 years)
- Been Medical Suptd, for over 10 years
- Director, IHBAS since April, 2010
- Earlier worked as faculty at NIMHANS, Bangalore (6 years) & AIIMS, Delhi (10 years)
Psychiatry/Mental Health Practice

• Popular Belief/Perception: Its all about
  “Mad” ---- “Sad”----- “Bad” guys

• “Mad”- Schizophrenia, other psychoses, Severe Mental Disorders (SMDs)
• “Sad”- Depressive Disorders/Anxiety Disorders & related problems
• “Bad”- Drug Abuse, Personality Disorders, Criminal Behaviour/Delinquency
Proportion of GBD from different groups of Health Problems 1998
(Source: WHR, 1999)

- Neuropsychiatric conditions: 9%
- Cardiovascular diseases: 10%
- Cancers: 5%
- Injuries: 16%
- Other diseases: 60%
One in Four

Data suggest that one in four persons carry the risk of diagnosable psychiatric Disorder in life time.

Look at three persons around you, and if they seem normal.......

Then, you should know!!!!!!!!
Depression as Public Health Problem

- More than one fourth, nearly half of the GBD linked to Mental Health problems is directly or indirectly due to Depression
- The impact of Depression related GBD is much higher for women
- The projected estimates for year 2020, place Depression at Number one or two slot, for GBD
Background and Need (Why?)

Range of Mental Health Problems

- Traditionally Psychiatry seen as dealing with “Lunatics”
- Post 2nd World War Period – included:
  Common Mental Disorders viz. Anxiety, Depression, Phobia, OCD & Panic Disorders
- Recently, the range broadened to: Substance Use Disorders, Adjustment Disorder, Psychological Aspects of Medical Illnesses, Violence & Aggression

Psychiatry → Mental health → Human Behavior
Nature and extent of Clinical Presentations

Varied Presentations: Specially in primary care general health practice

- Medical illnesses with psychological factors (difficult to differentiate)
  
  • Associated with medical illness
  
  • As a consequence of medical illness (Diabetes Mellitus)
  
  • Contributing to causation (Hypertension, Myocardial Infarction, Acid Peptic Disease)
Contd...

- Unexplained Physical Symptoms (no definite pattern, no sign or clinical/laboratory evidence of medical illness)

- Pain Syndromes (Tension Headache, Back Pain)

- Multiple Somatic Symptoms
Common Mental Disorders Presenting with Physical and/or Psychological Symptoms

• Anergia, Lassitude, Body Pains, Insomnia, Lack of Appetite

• Physical/Medical Complaints Associated with/due to Substance Use Disorders e.g.:
  Acid Peptic symptoms with Alcohol, tobacco, Liver Dysfunction with Alcohol, Peripheral Neuropathy with Alcohol, Respiratory Problems with tobacco Use
Contd...

• Physical Complaints Due to Stress

• e.g.: Frequent Infections, Chest Pain or Headache in Adults, Abdominal Pain in children, Back Pain in women

• Gross Abnormal Behavior (easy to identify)

• Isolated Symptoms like Insomnia
Overlap and co-morbidity of Medical and Psychiatry Problems

• About One third to Half
• Causation or Aetiology, often difficult to establish
• Some Medical Illnesses more commonly associated with psychological/psychiatry problems:
  
  earlier known as “Psychosomatic Illnesses”
  most notably Hypertension
  Diabetes
  Thyroid Dysfunction,
  Myocardial Infarction (Depressive and/or Anxiety Symptoms)
Prevalence of psychiatric disorder in different medical conditions

- Inflammatory bowel disease
- HIV/AIDS
- Stroke
- Parkinson's
- Rheumatoid arthritis
- Myocardial infarction
- Cancer
- Out-patients

Per cent
Frasure-Smith et al, 1993
Advantages and Disadvantages of Primary Vs Tertiary Specialist Care

**Merits of Primary Care:**

- Physician aware of:
  - background aspects
  - medical history
- Patients basic trust & confidence higher
- Geographical & logistic convenience
- Long term continuity of Care
- Less Stigma
Advantages and Disadvantages of Primary Vs Tertiary Specialist Care
contd...

**Demerits:**
- Range of Treatment options may be limited
- Inadequate Monitoring for Side Effects
- Toxic Effects
- Undue prolongation of treatment
- Time Constraints,
- Lack of counselling & other psychological treatment
- Possibly low level of perceived expertise
Indications for Tertiary Specialist Care

- Treatment Resistant
- Requiring Multidisciplinary Care
- Requiring Hospitalisation
- Long Term Management Plan
Indications for Primary Care Service Delivery

• Mild to Moderate Psychiatry Disorders
• Psychological Aspects of Medical Illnesses
• Functional Somatic Symptoms (FSS)
• Problems with good motivation
Current status of Treatment Options

_Treatment Option:_

- Referral/Identification
- Referral/Treatment with Referral as backup Resource
- Referral & other care/Joint Management
- Treatment with Specialist Consultation
Evidence for Primary Care being effective

- Interest & involvement of GPs increasing
- Training Programmes conducted at many places
- In UK, effectiveness in Diagnosis & Treatment tested & proven
Restricted availability and utilization of MH Services

• Significant treatment gap even in urban areas

• Lack of Trained Professionals

• Difficulties & Barriers in utilization
  - Stigma of Psychiatry/Mental Health Problem
    - Stigma of seeking help
    - Logistic problems
Difficulties & Barriers in utilization

Contd...

- Financial constraints
- Lack of Awareness of the Problem
- Lack of Awareness about services
- Myths about mental health services & psychiatry treatment
Scope of MH Service Delivery in Primary General Health care (What can be done?)

• GPs reaction to the range of Mental Health Problems
  - It is not “Medical”/my purview (Avoidance)
  - It is not in my competence
  - It is too difficult
  - Nothing can be done (Nihilism)
  - There are no services/ “good” specialists
  - I can do whatever “They” can do
Different levels of Service Delivery for various problems

Emergency Care: Suicidal persons

- Reassurance & support
- Offer Hope & Optimism
- Assessment of Risk
- Referral to specialist
Emergency Care: Excitement

- Ensure safety of all concerned
- Emergency sedation (Lorazepam /Haloperidol)
- Monitor for side effects
- Referral
Acute and short term care

-Mild forms of common mental disorders & Substance use disorders
-Psychological Aspect of Medical Illness

• Assessment
• Establishing Need for the treatment
• Initiate Pharmacological treatment
• Monitor for improvement & side effects
• Counselling, if required
• Referral, if required
Referral

- Severe Mental Illnesses
- Severe and chronic forms of Common Disorders
- Mental Disorders & Substance Use Disorders
- Personality disorders
- Mental sub-normality
After care: Schizophrenia, Mood disorders on prophylaxis

• Assessment & understanding the records
• Consult specialist /Hospital
• Follow up Prescriptions, if required
• Ensure compliance
• Monitor for Side Effects & Complications
• Help in Problem Solving
Advisory: Consultation, Family and Marital Issues, Interpersonal Issues

- Awareness of options & various services
  Maintain contact
  Avoid getting involved
Effectiveness of Training of GPs and Family Physicians in Mental Health (Desai et al, 2010)

Training Modules in Mental Health for GPs were developed under the ICMR task force project “Urban mental health problems and Service Needs”

Aim/Goal:
To enable General practitioners to Identify & Diagnose as well as Manage or Refer the commonly encountered Mental Health Disorders

Objective:
To test the effectiveness of the training imparted to GPs, in knowledge & attitude with a pre & post test questionnaire method
Knowledge and Skill Assessment Questionnaire (KSAQ) was used for pre and post assessments.

Pre mean and post mean comparison of KSAQ of all three centres
Paired Sample Statistics of Pre–Post-assessment KSAQ scores in all three Centres (N = 135)

<table>
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<th>S. No.</th>
<th>Session</th>
<th>Pre mean (SD)</th>
<th>Post mean (SD)</th>
<th>P value</th>
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<tbody>
<tr>
<td>1</td>
<td>All sessions combined</td>
<td>3.55 (1.71)</td>
<td>4.19 (1.74)</td>
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“Your prescription is cheaper if you buy it in bulk.”
Common FDCs in Treatment of Schizophrenia & other Psychoses (SMIs)

The “mad” tale of “XXXX Plus”

- **Trifluoperazine (TFP)** -- a piperazine side chain phenothiazine, high potency typical antipsychotic - Therapeutic Dose: 30-40 mgs/day

- **Trihexyphenidyl (THP)** – antiparkisonian agent, anticholinergic-commonly used for countering the parkinsonian side effects of typical antipsychotics like TFP & others- Dose required: 4-6 mgs/day

- “XXXX Plus”---- 5 mgs of TFP & 2 mgs of THP

- So, for 30-40 mgs of TFP, the person gets 12-16 mgs of THP, with all the anti cholinergic side effects!!!!!!!!
Rational Use of Drugs in Psychopharmacology

- Public health Enemy number One
- Benzodiazepines-their misuse & abuse
- From Diazapam & Nitrazepam to ALPRAZOLAM
- Significant prevalence with habituation
- Often Prescribed unduly, or extended by the physician or the patient
- Significant motor impairment
- Immunosuppression
- Sleep Promoters available
“I already diagnosed myself on the Internet. I’m only here for a second opinion.”
“DATE”

- Depression
- Alcoholism
- Tobacco
- Education
“DAI” Approach to Psychiatry for Family Physicians

- Depression (and Anxiety) Disorders
- Alcoholism
- Insomnia
Treatment of Depression by General practitioners - 3 Hour Training Module

Dr. Nimesh G. Desai, Dr. Deepak Kumar, Dr. Pallavi Dham

Institute of Human Behaviour & Allied Sciences, Dilshad garden, Delhi
DEPRESSION CLINIC

HAPPY HOURS
6-8 pm
Rationale of Pharmacotherapy for Alcoholism

- Social, economic as well as medical consequences
- Advances in Neurobiology
- Promising genetic research
- Availability of Animal models
- Development of drug therapy for other substances has motivated development in this field
Choosing a Pharmacological Agent based on Neurobiology

- Patients with good motivation and favourable prognosis: **Disulfiram**
- Patients with definite evidence/report of Craving & patients with Depression & patients with Type II Alcoholism (late onset, non familial): **SSRIs**
  
  **Fluoxetine, Citalopram, Sertraline**
Choosing a Pharmacological Agent based on Neurobiology

• Patients with Type I Alcoholism (early onset, familial type): **Ondansetron**
• Patients with frequent relapses: **Naltrexone**
• Patients in need of long term abstinence: **Acamprosate**
• Patients who are unable to maintain abstinence for initiation: **Topiramate**
Why Tobacco Cessation?

• Wide ranging strategies- but any sort of help for those who are addicted/dependent, is generally not thought of or mentioned.

• Modeling is one of the most common reasons for starting of tobacco use. Each successful treatment of addicted person also helps in prevention of tobacco use in “x” number of persons....may be 500, may be more!!!!!!!!!!!
Tobacco Cessation in India

• WHO/MOHFW Initiatives:
  A network of 20 Tobacco Cessation Centers & services set up across the country - 3 in Delhi

Private/Corporate Sector:
  – Max Hospital, Saket
  – Pulmonary/Respiratory Medicine specialists
Step Wise Management

TOBACCO CESSATION STEPS

Third Step

Second Step

First Step

Entry

You are here

Swarg Samayata Nuskh (Apani Mada Aap)
Self Help Tips

Brief Intervention

Intensive Treatment Program
Impact of Insomnia: Medical Conditions and Socioeconomic Impact

- Insomniacs are more prone to heart disease, diabetes, hypertension, chronic pain, and increased gastrointestinal, neurologic, urinary and breathing difficulties.

- Patients with multiple conditions are associated with chronic insomnia.

- Insomniacs have poorer quality of life, arising from depression, poor memory and work performance and reduced concentration.

- Insomnia has a detrimental effect on health-related quality of life to the same degree as chronic disorders.
Types of Insomnia

• Insomnia is classified into 3 categories:
  ➢ Transient (less than a week)
  ➢ Short-term (<30 days)
  ➢ Chronic (≥30 days)

• Chronic insomnia may be classified as:
  ➢ Primary insomnia (if insomnia is not associated with another condition)
  ➢ Comorbid or secondary insomnia (if insomnia is associated with another condition)

Am Fam Physician. 2007;76:517-26, 527-528.
Non-Pharmacologic and Pharmacologic Treatment Approach

• A range of non-pharmacologic and pharmacologic interventions have been shown to be efficacious for improving sleep.

• Non-pharmacologic Treatment
  – The most common therapy modalities include stimulus control, sleep restriction, cognitive, sleep hygiene and progressive muscle relaxation.

• Pharmacologic Treatment
  – Sleep promoting drugs such as benzodiazepines, non-benzodiazepine hypnotics of second generation, antidepressants, antipsychotics, antihistaminics or herbal and over the counter agents.
Pharmacologic Approach

- The most commonly prescribed hypnotic medications are the broad class of benzodiazepine receptor agonists.

  - Benzodiazepines (e.g.: flunitrazepam, and triazolam)
  - Non-benzodiazepines (e.g.: zolpidem, zaleplon, zopiclone and eszopiclone)

Non-benzodiazepines: Comparison with Benzodiazepines

• Non-benzodiazepines are more effective and safer than benzodiazepines:
  – Binds selectively to the $\alpha_1$ subunit of the GABA$_A$ receptor complex and are devoid of sedation
  – Reveals hypnotic efficacy with excellent safety profiles
  – Generally cause less disruption of normal sleep architecture
  – Rebound insomnia and withdrawal symptoms are less common with discontinuation
  – Safer in patients with respiratory disorders
Nonpharmacologic Approach

- Stimulus control therapy
- Sleep restriction therapy
- Relaxation-based interventions
- Cognitive therapy
- Sleep hygiene education
“Hello, and welcome to the mental health hotline....”

If you are obsessive compulsive, press 1 repeatedly

If you are co-dependent, please ask someone to press 2 for you.

If you have multiple personalities, press 3, 4, 5, and 6

If you are paranoid, we know who you are and what you want. Stay on the line,....so we can trace your call
If you are schizophrenic, listen carefully and a small voice will tell you which number to press.

If you are a depressive, it doesn’t matter which number you press, no one will answer.

If you have bi-polar disorder, please leave a message after the Beep or before the beep or after the beep. Please wait for the beep.
HELPLINE FOR MENTAL HEALTH 1-600-PSYCH

- If you have short-term memory loss, press 9.
- If you have short-term memory loss, press 9.
- If you have short-term memory loss, press 9.
- If you have short-term memory loss, press 9.
- If you have low self-esteem, please hang up. All operators are too busy to talk to you
“You’ve got a rare condition called ‘good health’. Frankly, we’re not sure how to treat it.”
THANK YOU
9810797933(text msgs pls)
ngd1955@rediffmail.com