

## Standards of Practice



### SCARF Tele-psychiatry in Puddukottai (STEP) project



Schizophrenia Research  
Foundation

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## Standards of practice

### SCARF Tele-psychiatry in Puddukottai (STEP) project

#### Introduction

This document sets out the guiding principles for care of psychiatric patients being seen at PDKT. The clinician will have to improvise (also be to justify such decisions and preferably clear it with their supervisors) whenever the SOP is inadequate in any way.

Please keep in mind the following :

1. In most cases, we do not see patients face to face.
2. Whenever required, patients must be referred to the nearby GP/ HOSPITAL for examination. This is specially so with children, pregnant women and the elderly and those with substance abuse problems and those who have remained untreated for a long time ( > 5 years).
3. Although the field staff do have a good rapport with patients and families, they are not trained mental health professionals and hence cannot administer PSR interventions.
4. We do not have facilities to closely monitor side effects.

Standards pertaining to the following are covered in this document

1. The first visit
2. Review visits
3. Standards pertaining to treatment prescriptions
4. Treating aged patients (>65 yrs)
5. Surreptitious Treatment

Other issues covered under the sections listed above are

- When only patients are seen
- When only caregivers are seen
- Field visits by staff
- Referral patients
- Field visits by psychiatrists

## 1. The First Visit

One of the primary objectives of the tele-psychiatry program is to reach the untreated but the desire to provide MH services to these deserving individuals must be balanced against the risks and safety considerations.

As a general rule the patient must be accompanied by a Care Giver (defined as a first degree relative or spouse) during the first consult and preferably for all further consultations.

If the first contact/ consult is solely with the CG a prescription can be issued only for a maximum period of 1 week.

No further prescription to be issued if the patient is not brought for an evaluation on the scheduled date (1 week later) as required.

However under the following circumstances the prescription can be extended by a week

- (1) The patient was not brought for consultation as he was unwilling to come
- (2) It was logistically impossible to bring the patient due to their condition

Any further prescription (after 2 weeks) is issued only after a home visit is made by the community worker and a detailed assessment completed using the **Home Visit Assessment Schedule**. The home visit and assessment should be made before the next scheduled visit (week 3). The need for a home visit is decided by the treating psychiatrist who should communicate the need for the same to the community staff.

In circumstances where a home visit by the community staff proves inconclusive the patient should be visited by a trained MH professional (psychiatric social worker/psychologist). Following their evaluation and in consultation with the treating psychiatrist a prescription can be issued. However the patient can receive treatment only for a maximum period of 2 months without being seen by a psychiatrist. For continuing treatment beyond 2 months, the patient must either be brought to the tele-psychiatry clinic for an evaluation or be assessed by a psychiatrist during field visits.

It is very likely that the patient would receive surreptitious treatment at this stage. See section dealing with "Surreptitious Treatment" for protocol dealing with the same.

Protocols to be followed in specific conditions such as in the treatment of aged pts (>65yrs), etc, are spelled out in subsequent sections of this document dealing with the same.

In circumstances where patients have come alone and there is concern about accidental overdosage or suicide the prescription should be only for a week. Patients should be advised to come for review with a caregiver. There will be situations where the care giver is contacted to provide info/ support etc. Home visit by community staff can also be done after the same has been requested by the treating psychiatrists.

In these circumstances where sufficient information has been collected from the CG but the patient persists in coming alone and if the treating psychiatrist assesses sufficient risks exists in handing over a whole months prescription they can decide to prescribe for a month but the patient would have to come weekly for a refill. The same to be documented in case records.

Under the following circumstances no prescription will be issued during first visit/contact

1. The patient is >65 yrs old and organicity needs to be ruled out. (see protocol for aged pts)
2. The CG who has come un-accompanied by the patients is not a first degree relative (like sister-in-law, cousin's wife etc) however well meaning they may sound.
3. If medico-legal issues are suspected
4. Comorbid medical conditions which are not adequately treated
5. Patient comes alone and there is risk of suicide

Once patients have been registered and issued medication, they will be reminded about their scheduled review dates by the community staff. In case the patient or the CG has not turned up for the schedule review they will be reminded of the same and home visits will also be made by the project staff. If after 3 months of effort, the family or patient do not turn -up for a consultation they will be considered as drop-out and no further efforts will be made by the project staff to engage them in treatment. They will however be welcome to access the treatment any time they choose.

Under exceptional circumstances where there have been genuine reasons that they could not continue to come to the clinic, the psychiatrist can decide that they will be seen & evaluated during their field visit. This is a decision to be made solely by the psychiatrist based on the information provided by the community staff.

Performa for clinical visits:

History from the care giver/ family members with equal importance to functioning and symptoms.

History from the patient and evaluation of the patient

## **2. Review visits**

When patients are not seen at reviews, but they were evaluated initially and only the care giver is seen-prescriptions can be repeated if the clinician thinks it is warranted. However this cannot go on for more than 6 months (for a chronic illness). If the clinicians are concerned, they can ask for a field visit and report prior to renewing the prescription. If patients have never been seen, it is not advisable to reissue meds. The clinician can always request a field visit by a mental health professional.

Under the following circumstances no medicines will be issued during review

1. CG has come alone when they have been asked to bring the patient
2. Patient has come alone when they have been asked to bring a CG
3. When the requested lab assessments or GP / specialist opinion has not been done
4. Medication prescribed during previous visit has not been taken by the patient

### 3. Standards pertaining to treatment prescription

#### 1<sup>st</sup> line treatments and dosages.

A general guideline will be to start low and go slow, while this is a usual practice in old age it is a very useful approach in community practice. The 2 parallel goals in the community are symptom relief and safety. Safety includes prevention of common side effects.

Psychotropics – avoid poly-pharmacy unless there is a definite need.

#### Antipsychotics:

While the initial choice will depend on clinician preferences, avoid use of high dose parenteral antipsychotics. SGAs are preferred by some as the initial drug choice. Doses are kept low. Max doses of Risperidone will be 8 mg/day, olanzapine 15 mg/day, haloperidol 10 mg/day. This group of medicines should not be used for other non-psychotic indications. Remember that with polypharmacy these doses will be exceeded.

Amisulpiride is a 2<sup>nd</sup> generation AP, with a more gentle s/e profile. It does not undergo hepatic metabolism and it can be used in suspected comorbid liver disease. However it is to be used cautiously with renal disease as the GFR impacts the rate of its excretion.

Quetiapine is indicated where EPS is troublesome with the use of other AP's. It can cause significant QTc elongation and therefore watch for arrhythmias. It is also used in the elderly because of its favourable S/e profile

#### Mood stabilizers:

With Carbamazepine( CBZ) use, remember it is both an autoinducer and interferes with the metabolism of various medicines. Many patients are developing side effects to this- sometimes goes unrecognized. To be used very sparingly.

Sodium valproate: The evidence for its use in mania is robust; with its role in prophylaxis only moderate. Start at 200 mg bd and can be increased to 1200 mg/day( titration depends on age/ weight and tolerability). Mainly consider liver functioning before and after starting the drug.

Drugs such as clozapine, CBZ, whose side effects cannot be monitored actively, are best avoided.

#### Antidepressants:

In many patients the temptation is to rescue them with high doses of medication. This is inappropriate for a patient with a significant psychosocial stressor and does more harm than any good. Inability to use psychosocial therapies has to be accepted as another limitation with tele-psychiatry.

### Hypnotics and sedatives:

Time limited use of this if indicated (8-12 weeks). Primary insomnia cannot be managed with tele-psychiatry. There are many non-pharmacological approaches to its management. Caution needs to be used when there is prolonged use or if only the CG/patient comes for reviews. Minor tranquilizers only in the case of anxiety, and not just for insomnia.

### Vitamins and supplements:

Need to exercise caution with these medication as even simple symptoms can be manifestations of underlying major systemic illnesses. In the absence of GPE and lab testing it will be more useful to refer these patients and provide treatment only for MH issues. There can be ethical dilemmas regarding this practice and clinical judgment should be used to guide clinical decisions

### Lab tests:

While no lab tests are mandatory in the practice of psychiatry, special care needs to be exercised in community patients seen only by tele-psychiatry. It is prudent to be safe than sorry. If olanzapine is used, we should ask for blood sugars periodically.

The referral to a specialist or GP opinion and lab tests will be recorded both in the case sheets as well as in the "blue book" by the staff on instruction from the psychiatrist. The "blue book" will be examined during review to ascertain the status of the same.

### Change of treatments:

Adequate reasons for change to med are: Only if there are limiting side effects or lack of response. In the absence of these concerns changes in treatment prior to 6 weeks is unwarranted. If the clinician is changing Rx prior to this a documented reason will be useful.

Use of depot antipsychotics: sufficient clinical grounds should be present before initiation of depot preparations.

### Some indications could be :

1. Previous good response to depots
2. Poor or no compliance with oral medication
3. Review of patient should be possible at least once a month.

### Clinical scenarios in which its use may be inappropriate:

1. Patient has never been seen at the clinic or by a psychiatrist during a home visit.
2. Ongoing treatment with depot is not possible. It is not possible to treat all suspected patients in the community. While this is a laudable goal it is impractical.

### Period for which meds are given:

Clinical needs are weighed along with suicidal risk or accidental over-dosages. Caution needs to be exercised with the elderly, confused patients, patients living alone, and household having young

children. All unused medication is to be returned to the clinic staff eg, when treatment is changed. Sufficient care should be taken to store medicines safely. Usual prescriptions should not exceed 2-4 weeks. Pill count at reviews is an easy but good guide to Rx adherence. It should be made mandatory to receive drugs at follow up.

When patients have come alone and there is concern about accidental overdosage or suicide the prescription should be for a week. Patient to be advised to come for review with a caregiver. There will be situations where the care giver is contacted to provide info/ support etc.

A section of our population may be misusing benzodiazepines and we need to be clear on how long these medicines are clinically indicated.

#### **4. Treating aged patients (>65 yrs)**

An aged patient is generally 65 years or more. Patients of this age group are likely to have other disorders either presenting with psychiatric symptoms or these can complicate their management.

Patients need to be screened as follows:

Recent change with behavioral, psychotic or mood symptoms.- when changes are in days , weeks upto a few months,

Exercise caution when there are pointers to organicity- lapses in consciousness, diurnal variation, severe weight loss, breathlessness, recent onset seizures, chronic headache, incontinence, fever, past h/o TB(untreated or partially treated). In these cases the patients can be referred elsewhere. They can be treated once they have seen a GP. Documentation by GP.

A common reason aged patients are brought is because of restlessness and insomnia with a request that some medication be given till they can seek other services. A tele-psychiatrist should not prescribe for a number of reasons: this may be the only consult and they are not going to other medical services. More importantly such patients may die suddenly and the recent use of psychotropics can be blamed. This scenario in a community camp places the personnel working there at major risk. It will also harm the program.

#### **5. Surreptitious Treatment**

Diagnosis – Schizophrenia & related psychosis, Substance induced psychosis.

Reasons: refusing medications / bed ridden / refusing hospital visit / others..

Procedure : Decision to give surreptitiously should be documented . Consent and willingness of family member or primary care-giver is mandatory prior to starting surreptitious treatment. The treating doctor should adequately explain this treatment option depending on the clinical status of the client and reassure the care-giver. Use discretion when spouse agrees to dispense with medication especially if there is a potential for a medico-legal case (divorce, suicide) etc in the background of a severe marital discord.

Mode - Mouth dissolving tablet / injectable AP / liquid (haloperidol /risperidone liquid? ) if funds permit

Doses –start low go slow in patients 50yrs and above

Adults dosing : Olanzapine (2.5-10mg)  
Risperidone (2-6mg)

Type \_ Monotherapy with AP preferred.

Duration of Surreptitious Rx if patient not brought for first consult :

Medication issued for a week, can be extended by another week if criteria mentioned in section dealing with first contact is fulfilled. Following field visit by community staff (before the 3rd week) the prescription can be continued. Patient can be treated surreptitiously for a maximum of 2 months without being seen by a psychiatrist. This will happen only after a trained MH professional has seen the patient. For further treatment to continue either the patient must be brought to the tele-psy clinic or be seen during a field visit by the psychiatrist.

Surreptitious treatment can be continued indefinitely if patient is being seen at least once in 6 months by the psychiatrist.

Visits : Every visit focus on clinical improvement , side effects (weight gain, tremors, excessive drowsiness, gait disturbances) functioning and willingness to meet the doctor .

***Monitor for blood sugars after 6 months if possible***

Disclosure – Care-givers should make attempts to tell patient based on benefits (nondisclosure vs disclosure about covert treatment). Patient has a right to know regarding treatment but as long as care-givers understand the implications care-givers can decide.

### **Consultation during field visits by psychiatrists**

While tele-psychiatry is an innovative way to reach out a large geographically spread population by leveraging technology to maximize the potential of scarce mental health resources it must be accepted that there are limitations to its reach. The most deserving sections of the population may still lie beyond its reach. Under such circumstances to reach this “unreached’ population field visits by psychiatrists can be undertaken.

Care should be taken to see that work done through tele-psychiatry is not duplicated and those who can access the tele-clinics are not unnecessarily covered during these visits.

Psychiatrists will undertake field visits for the following reasons

1. In circumstances where there have been genuine reasons that the patient or family could not come to the clinic, the psychiatrist can decide that they will be seen & evaluated during

- their field visit. This is a decision to be made solely by the psychiatrist based on the information provided by the community staff.
2. In circumstances where there have been genuine reasons that the patient or family **could not continue to come** to the clinic, the psychiatrist can decide that they will be seen & evaluated during their field visit. This is a decision to be made solely by the psychiatrist based on the information provided by the community staff.
  3. Patient on surreptitious treatment who could not be brought to the tele-clinics even after two months.
  4. In circumstances where the mandated home visit by the community staff has proved inconclusive the patient will be evaluated by a psychiatrist during field visits before further treatment can continue.

### List of Medicines Available Under STEP Program

1. Chlorpromazine 50 mg
2. Chlorpromazine 100 mg
3. Haloperidol 1.5 mg
4. Haloperidol 5 mg
5. Risperidone 1 mg
6. Risperidone 2 mg
7. Olanzapine 5 mg
8. Olanzapine 5 mg
9. Trihexyphenidyl 2 mg
10. Nitrazepam 5 mg
11. Carbamazepine 200 mg
12. TF –Plus
13. Inj.Prolinate
14. Inj.Phenerghan
15. Amitryptiline 25 mg
16. Sertraline 50mg
17. Quitipin 50mg
18. Autrin
19. Becosules
20. Clonazepam 0.5mg
21. Fluoxetine 20mg
22. Sulphitac 50mg

## QUARTERLY RATINGS

### Clinical Global Impressions (CGI)

<b>BASELINE RATING</b>		
<b>Severity of illness</b>		
Considering your total clinical experience with the particular population, how mentally ill is the patient at this time?		
Severity of illness	0 = Not assessed 1 = Normal, not at all ill 2 = Borderline mentally ill 3 = Mildly ill 4 = Moderately 5 = Markedly ill 6 = Severely ill 7 = Among the most extremely ill patients	

<b>QUARTERLY/FOLLOW-UP RATING</b>		
<b>Global Improvement</b>		
Compared to Baseline, how much has the patient's condition changed?		
Global improvement	0 = Not assessed 1 = Very much improved 2 = Much improved 3 = Minimally improved 4 = No change 5 = Minimally worse 6 = Much worse 7 = Very much worse	

### Global Assessment of Functioning Scale (GAF-SCALE) Functions

Rate symptoms in the past month (30 days). Select the rating that best describes most of the last month. Use intermediate codes appropriate. Eg., 45.68,72. Do not include disability due to physical or environmental limitations.

81-90	Good functioning in all areas, interested and involved in a wide range of activity, socially effective, generally satisfied with life, no more than everyday problems or concerns (eg an occasional argument with family members).
71-80	No more than slight impairment in social, occupational or school functioning (e.g., temporarily falling behind in school work)
61-70	Some difficulty in social, occupational or school functioning (eg., Occasional truancy of theft within household) but generally functioning pretty well, has some meaningful interpersonal relationships
51-60	Moderate difficulty in social occupational or school functioning (eg., few friends, conflicts with co-workers)
41-50	Any serious difficulty in social, occupational or school functioning (e.g, no friends, unable to keep a job)
31-40	Major impairment in several areas, such as work or school, family relations, judgement, thinking or mood (eg., depressed man avoids friends, neglects family, and is unable to work, child frequently beats up younger children, is defiant at home, and is falling at school)
21-30	Inability to function in all areas (e.g., stays in bed all day, no job, home or friends)
11-20	Occasionally fails to minimal personal hygiene (e.g., smears feces)
1-10	Persistent inability to maintain minimal personal hygiene

## STEP Program

### Home Visit Assessment Schedule

#### (When the patient has not been brought to the clinic)

Patient Name :

Clinic Id:

CG name:

Relationship to pt:

Address:

Date of home visit:

Home visit made by:

BP:

Height (cms):

Weight (kgs):

Anemic: (eyes, lips, tongue)

Body Build (emaciated/ obese /

moderately built):

1. Description of appearance of patient (clean and neat, well kempt/uncombed hair, unshaven, dirty clothes, body odor, etc)
2. Communication (eye-contact, reaction towards the interviewer- hostile/ cooperative, mute/mono syllable responses/ excessive speech/ incomprehensible speech/ irrelevant speech, slurred speech, unchanging /limited facial expressions, inappropriate expressions, no/limited hand/body movement, inattentiveness, etc)
3. Behavior (disorganized, violent, aggressive, agitated, catatonic, talking about delusions& hallucinations, acting out hallucinations & delusions, etc)
4. Orientation (Time, place, person)
5. Any observable side effects to medication (Tremors ,excess salivation, robot walking, skin rashes ,etc)
6. Movement in all 4 limbs ( reduced movements of limbs on any one side or any one limb, swinging of arms normal while walking)
7. Suicide ( thoughts, plans)
8. Any other observation or comments

## **STEP Program**

### **Home Visit Assessment Schedule**

### **(When the CG has not come to the clinic)**

Patient Name:  
CG name:  
Address:

Clinic Id:  
Relationship to pt:

Date of home visit:

Home visit made by:

#### Demographic details

Age :

DOB:

Gender:

Marital Status:

Education status:

Employment status:

#### Clinical details

Age of onset:

DOI:

DUP:

Age & date of first Psychiatric treatment:

1. Hospitalizations (psychiatry)
2. Last prescription & date (Psychiatry)
3. Any physical health problems ((Diabetic, HT, Cancer, Thyroid, etc):
4. Hospitalizations (physical health)
5. Last prescription & date (physical health)
6. Any history of (a)Head Injuries (b) Seizure(c) suggestive of MR (details)
7. (a)Alcohol: (b)smoking: (c) other addictions:
8. Symptoms at onset of illness:

STEP - SOP

9. Current symptoms:
  
10. Description of an average day of the patient ( from the time gets up from the bed till he goes back to bed again)
  
11. Personal functioning (time he gets up from the bed, brushing, bathing, shaving, changing the dress, eating - how long he takes for the activities, supervised or unsupervised)
  
12. Social functioning (interaction with family, neighbors, relatives, etc) including leisure activity:
  
13. Occupational functioning: Is he going for any work (paid)  
  
If yes how often (daily, alternative days, weekly once, when there is a work/demand etc)
  
14. Any other comments