



# Severe Mental Disorders (SMD) For MO





# CLASSIFICATION

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- **First/ Acute Episode Psychotic Disorders**

Includes First/ acute episode of schizophrenia, first/ acute episode of mania, acute severe depression

**Acute psychotic disorders Symptoms last for less than six months**

## **Subtypes:**

- a. Predominantly psychotic symptoms: Acute transient psychotic disorder (ATPD), schizophrenia-like symptoms, etc
- b. Predominantly affective (mood) symptoms: Mania/hypomania with/without psychotic symptoms and Severe Depressive Disorder with psychotic symptoms.
- c. Mixed affective and psychotic symptoms: Presence of Affective (Mood Symptoms) symptoms and psychotic symptoms

# CLASSIFICATION

2. Episodic Psychotic Disorders: if presented with more than one episode i.e symptoms usually subside completely in between two episodes. It includes Bipolar Affective Disorder (BPAD) where there may be episodes of mania or depression or Recurrent depressive disorder/ Severe depression with psychotic symptoms.

3. Chronic Psychotic Disorders (Symptoms persist for more than 6 months): Includes Schizophrenia





# DIAGNOSTIC CRITERIA FOR ACUTE PSYCHOTIC DISORDERS:

- Agitation or restlessness
- Bizarre behaviour (irrelevant speech, poor self-care)
- Hallucinations (hearing of voices/noises, muttering to self, talking to self, laughing to self.)
- Delusions (false, firm and fixed beliefs), e. g., Beliefs such as patient is related to royal family, receiving messages from television, being followed or somebody planning to kill/harm)
- Social withdrawal (sitting alone, not interacting with others, etc)
- Low motivation or interest, self-neglect (poor self-care, not going for work, etc)
- Non-understandable speech or irrelevant talking.



In case of Bipolar affective disorder (BPAD): Episodic Illness (More than 1 episode) – Mood disorder – Presents with mood symptoms listed below, can often present as Psychosis.

Mood Symptoms are:

**1) Manic Episode:** Elated (excessive happiness) mood or irritable mood, Over cheerfulness/ over talkativeness/ over religiosity/ over-familiarity/ excess spending of money/increased libido, etc.

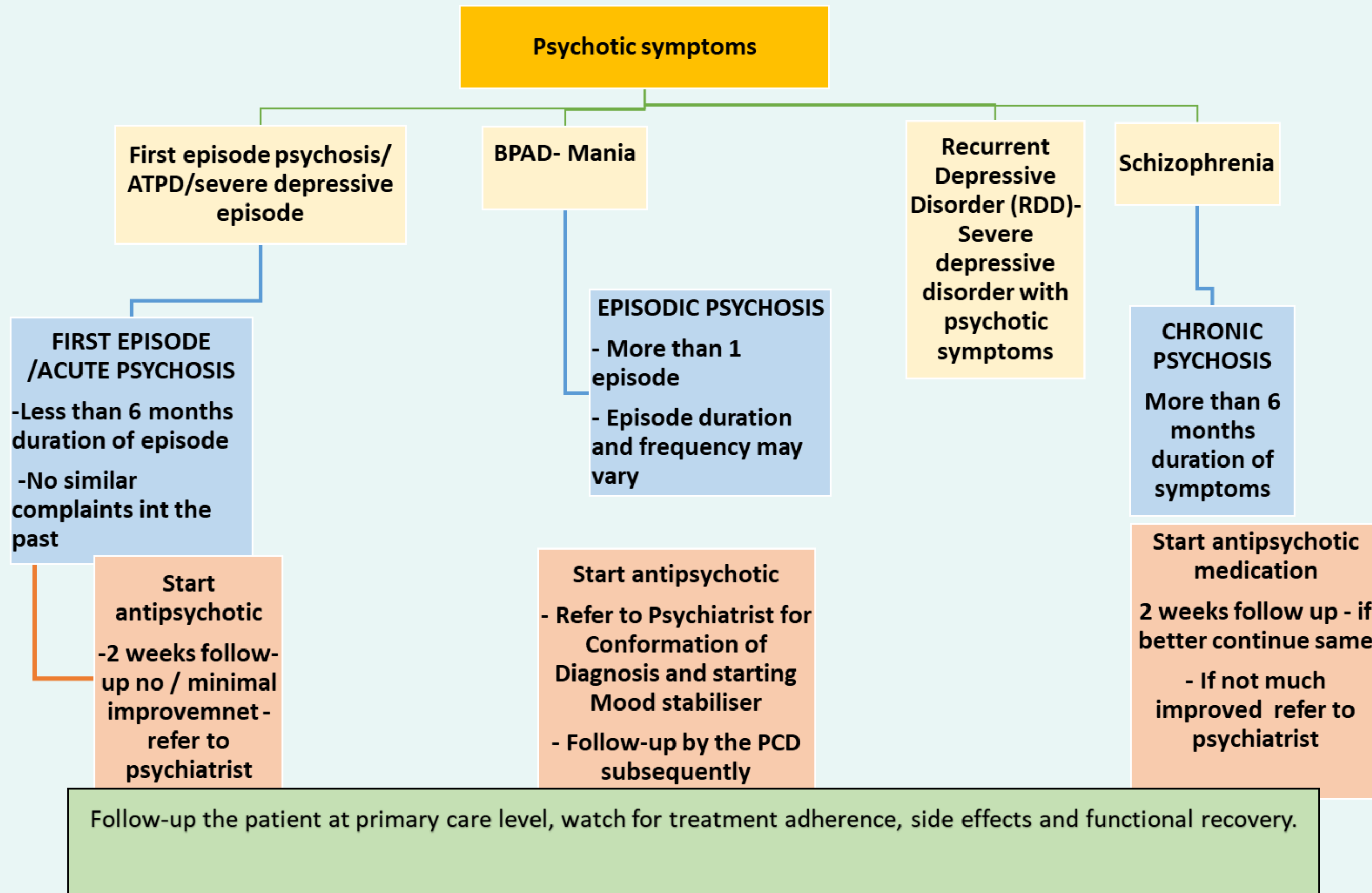
Increased energy levels, decrease the need for sleep and increased activity levels, Grandiosity, tall claims, etc

**2) Depression:** Episode of Depression presents with symptoms of depression





# FLOW CHART: IDENTIFICATION, MANAGEMENT & REFERRAL PSYCHOTIC DISORDERS





In some patients with Major Depressive Disorder (MDD), depressive episode can be severe wherein patient has all the core symptoms of depression (Low mood, Easy Fatiguability and loss of interest plus other associated symptoms) along with psychotic symptoms.

It can present as first episode of severe depression or Recurrent Depressive Disorder (RDD).

There are two types of SDD: SDD with/without psychotic symptoms. SMDs cover SDD with psychotic symptoms.

However additional psychotic symptoms in SDD are hallucinations, delusions, and significant psychomotor retardation (may include symptoms of catatonia).



- Hallucinations: Hallucinations are primarily false perceptions i.e. perceptions without real external stimulus. It can be various types and different modalities i.e., auditory (hearing of voices), visual (Someone might see lights, objects, people, or patterns), olfactory (this can include pleasant and bad smells), gustatory (this can include pleasant and bad taste) and tactile (this creates a feeling of things moving on your body, like hands or insects). The most common type are auditory hallucinations where the patient hears the noises/voices which of a single person or group of people.



- Delusions: Delusions are false, firm and fixed beliefs which are illogical and out of sociocultural background of the patient. Delusions are the disorder of thought content where patients have false belief, they are not ready to accept the alternate arguments and difficult to convince them. Based on the content various types of delusions include:

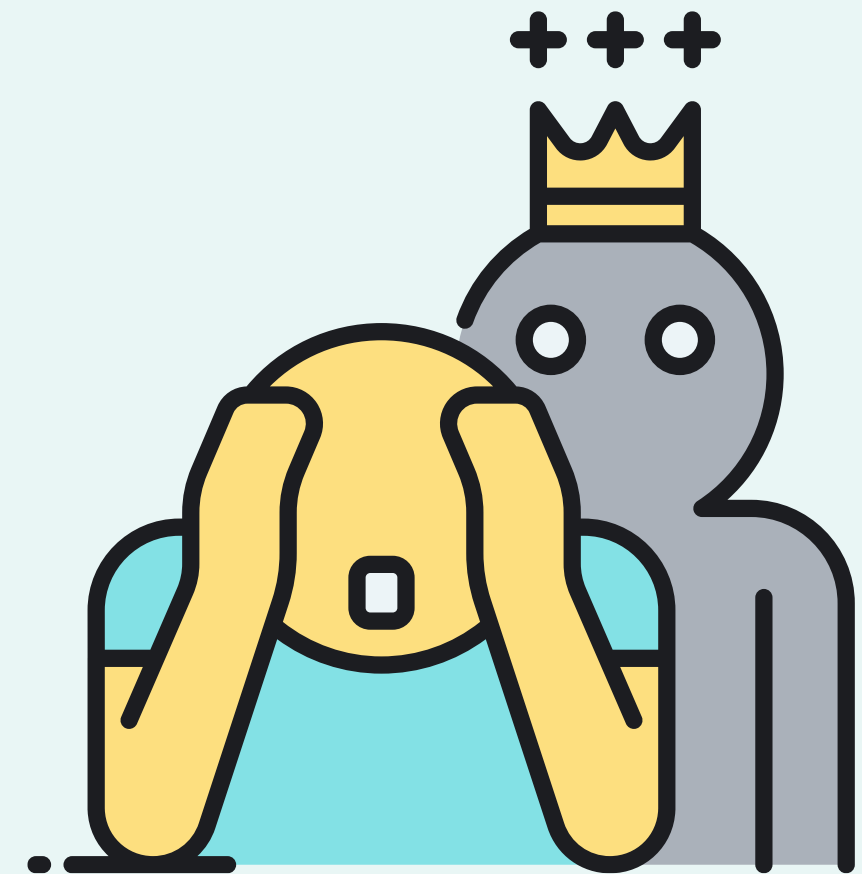
I. Persecutory delusions: The feeling someone is after them or that they are being stalked, hunted, framed, or tricked.

II. Referential delusions: When a person believes that people are talking about him or referring about him. They believe public forms of communication, like song lyrics or a gesture from a TV host, have a special message just for them.



III. Delusion of infidelity: A person has a strong belief that their intimate partner or spouse is cheating on them and having another relationship.

IV. Grandiose delusions: They consider themselves a major figure on the world stage, like an entertainer or politician and having special identity, ability, and roles.



# BIPOLAR AFFECTIVE DISORDER (BPAD)

Bipolar Affective disorder (BPAD) is a disorder of mood. BPAD is an episodic illness with acute or subacute onset of symptoms with either of mania or depression. Episodes may last for weeks to months. Patient mostly improves in between the episodes with continued medications.

## Etiology

- Etiopathogenesis of BPAD is complex and heterogeneous with genetic and environmental factors contributing to illness





## Risk Factors

- Factors that may increase the risk of developing bipolar disorder or act as a trigger for the first episode include:
- Family History: Having a first-degree relative, such as a parent or sibling, with bipolar affective disorder
- Periods of high stress, such as the death of a loved one or other traumatic event
- Drugs or alcohol use





**Depressive episode:** symptoms similar to the depressive episode mentioned in common mental disorders with/without psychotic or psychomotor retardation.

**Manic episode:** elated mood, over cheerfulness, over talkativeness, over the religiosity, over-familiarity, excess spending of money, increased libido, increased energy levels, decrease the need for sleep hyperactivity, grandiosity, tall claims, etc. present throughout for a period of one week.





# TREATMENT GUIDELINES: PHARMACOLOGICAL INTERVENTION

1. Psychosis is a severe mental disorder, characterized by excess of dopamine in some regions of brain and reduced dopamine in other regions.

- Excess of dopamine leads to delusions and hallucinations.
- Reduction of dopamine in few brain areas leads to social withdrawal, reduced interactions and sitting aloof.
- So, symptoms of delusions and hallucinations can be reduced very effectively, but social withdrawal, reduced interactions cannot be treated very effectively.





- While treating Psychosis irrespective of the subtype – First Episode/ Episodic Psychosis – BPAD / RDD or Chronic psychosis, first initiate antipsychotic and subsequently patient may be referred to a Psychiatrist in Case of BPAD and RDD to confirm the diagnosis and to initiate Mood stabilizer in case of BPAD. The follow-up to be continued.

Sr.No.	Medication	Adult dose (mg/day)		Side effects
		Acute dose	Maintenance dose	
1	Risperidone	2 – 4mg	Same as acute dose	EPS, Menstrual disturbances,
2	Olanzapine	5-20mg	Same as acute dose	Weight gain, metabolic syndrome
3	Haloperidol	5-10mg	Same as acute dose	EPS

### Non – pharmacological interventions (psychosocial interventions)

- Explaining about the illness, duration of treatment and the need for strict adherence to treatment.
- Addressing family burnout by using supportive counselling



# FOLLOW UP CARE, FREQUENCY AND FOLLOW UP ASSESSMENT AT PRIMARY CARE LEVEL

- The follow-up to be done every month.
- In follow up need to assess for improvement in symptoms and side effects that are relevant to the medication as mentioned in the table above
- At the end of 1st month: If improvement is less than 50% then to consider increasing the dosage to the next level (from 2mg to 4mg of Risperidone)
- At the end of 1st month: If improvement is more than 50% then consider observing for a period of another month before deciding on dose titration, and if the improvement remains less than 50% even after 2 months then consider increasing the dosage to next level.





## 2. BIPOLAR AFFECTIVE DISORDER (BPAD)

Sr.No.	Medication	Adult dose (mg/day)		Side effects
		Acute dose	Maintenanc ce dose	
1	Lithium	600-900mg	Same as acute dose	Tremors, Thyroid dysfunction, Renal dysfunction
2	valproate	10-15mg/kg body wt	Same as acute dose	Weight gain, hair fall, liver injury, tremors
3	Carbamazepi ne	200 – 800mg	Same as acute dose	Ataxia, cerebellar toxicity, hyponatremia

# MENTAL DISORDERS

**Psychoeducation (educating patient and family about illness, medication compliance, and follow-ups)**

- Counseling is not psychotherapy, counselling is in fact practiced by every doctor in one or the way while dealing with patients of different medical illnesses, similar things should be practiced for psychiatric illnesses as well.



- Counseling should include information about the nature of the illness, duration of treatment, important side effects, need for regular follow-ups, setting realistic expectations from treatment, and practical tips to handle stressors.
- Educating patient and families about SMDs will impact the outcome of the illness





# FOLLOW UP CARE, FREQUENCY AND FOLLOW UP ASSESSMENT AT PRIMARY CARE LEVEL

- The follow-up to be done every month.
- In follow up you need to assess for improvement in symptoms and side effects that are relevant to the medication as mentioned in the table above
- Titrating the dosage of mood stabilizers should be done by a psychiatrist, If patients has any issues regarding improvement or side effects, refer to psychiatrist





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- Regular serum lithium levels should be done once in 3-6 months.
- Regular Renal function test and thyroid function test to be done once in 6 months for those who are on T. Lithium
- Regular Liver function test to be done once in 6 months for those who are on valproate



Drug	Doses available (mg)	Starting dose	Maximum Dose for GPs	Common Side effects	Remarks
Antipsychotics					
Risperidone	2, 3, 4	2	6	EPS, Sexual side effects, Menstrual disturbances	Avoid in those who are planning pregnancy
Olanzapine	5, 10, 15, 20	5	10	Sedation, weight gain, metabolic syndrome	Avoid in those with high BMI
Haloperidol	5, 10	5	10	EPS, Sexual side effects	
Inj. Fluphenazine	25mg/1ml	12.5/ fortnightly	25 – 50mg / fortnightly	EPS	
Mood stabilizers					
Lithium	300, 450	600	1200	Tremors, nausea, thyroid dysfunction	NSAIDs increase serum lithium level and might cause toxicity
Valproate	200, 250, 500, 1000	250	750	Tremors, nausea, weight gain, hair loss,	
Carbamazepine	100, 200, 400	100	600	Nausea, blurred vision, ataxia, hyponatremia, reduced blood counts	Regular serum Sodium level monitoring



# MEDICAL OFFICERS' ROLE IN REHABILITATION OF PERSONS WITH SMI



In a proportion of patients, MOs can prevent disability with treatment. In those with substantial disabilities despite the best treatment, can facilitate rehabilitation efforts to ensure that such persons live with dignity and enjoy the best possible quality of life.

- **Limiting Disability- This should be the first goal for every person with SMI**

A. Early identification and treatment of SMI can result in prevention of disability. MOs should help the community in this. Many persons with SMI remain untreated or get delayed treatment because of poor awareness, alternative explanations and stigma about mental illness, and difficulty in accessing services due to logistic and financial reasons. MOs, with the help of healthcare staff and other community resources, should take steps to improve awareness, reduce stigma and make treatment accessible.





B. Poor continuity of care is a common cause of relapse and adverse long-term outcomes in persons with SMI. This is commonly due to the same factors mentioned above. Unsatisfactory improvement and adverse effects (actual and feared/imagined) also contribute to the discontinuation of treatment. MOs should address these concerns in liaison with higher centers, healthcare staff, and families.

- **Facilitating Rehabilitation**

When disability persists despite best efforts, the MOs should coordinate the provision of disability certificates and welfare benefits. Please note that 'disability' here means the inability to function and participate in activities expected of most people in the community. MOs should also educate the individuals with mental illness and their families about centers where interventions to improve functioning and quality of life are available





# Thank You

