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Is it the Time to take a Re-look at the Telepsychiatry Operational Guidelines- 2020?

Arghya Pal

Department of Psychiatry, All India Institute of Medical Sciences, Raebareli, Uttar Pradesh, India

Abstract

Our reliance on tele-health services has increased considerably over the last couple of years since the advent of the COVID-19 pandemic. It has changed the landscape of psychiatric practice considerably. The telepsychiatry operational guidelines were published by a collaboration of leading governing bodies to provide explicit structured guideline regarding the same. However, the experience of using this guideline over the last 2 years has brought forth a few limitations which have been highlighted in the current manuscript. Recommendations based on the review have also been provided.

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Correspondence:
Arghya Pal
drarghyamb@gmail.com
Department of Psychiatry, All India Institute of Medical Sciences, Raebareli, Uttar Pradesh, India

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Introduction

The year 2020 has been a landmark year for medical sciences from many aspects. The COVID-19 pandemic and the subsequent lockdown had brought life to a standstill. Efforts were made worldwide to preserve the essential services. Telemedicine evolved as a very important mode of providing consultation at that time. Prior to the pandemic, the practice of telemedicine was not appropriately regulated in terms of uniformity. As a result, a guideline was published by the Board of Governors of the Medical Council of India, which was common to all specialties.[1] Though the guideline was comprehensive, issues arose pertaining to individual disciplines. To address such issues, a specific Telepsychiatry Operational Guidelines (TPOG) was published by National Institute of Mental Health and Neurosciences, Bangalore in collaboration with Indian Psychiatric Society in 2020.[2]

Framework

Both the mentioned guidelines provided a structured framework to clinicians to adhere to while providing tele-health services. Both these guidelines were essentially aligned to each other and was also in sync with various other related legal structures like the Information Technology Act 2000, the Drugs and Cosmetics Act 1940, the Rights of Persons with Disability Act 2016, the Mental Healthcare Act 2017 and the Narcotic Drugs and Psychotropic Substances Act 1985. The TPOG provides explicit and unambiguous guidelines about what

drugs can be prescribed by physicians during a consultation and under what circumstances. The various circumstances that govern the prescription choices include: type of consultation (first or follow-up) and mode of consultation (text, audio or video). The drugs have been thus classified into four lists. The list O include drugs that are available over the counter, while list C contains drugs that can't be prescribed in teleconsultation. ist A includes drugs considered having low potential for misuse and considered safe. To prescribe list A drugs, the first consultation should be a video consultation, but subsequently they can be prescribed following any (audio/video/text) consultation. List B medication can be considered as add-on medication and can be prescribed only in the follow-up consultation (and not in the first consultation). Importantly, it has been notified that the drugs in list B is subject to change from time to time based on recommendations of the governing bodies.

What's needs to be looked into?

Though there can be no denying the fact the guidelines have been beneficial in the practice of telemedicine. However, in clinical practice, there has been situations where the existing guidelines failed to facilitate good clinical practice. In this manuscript let us go through a few such situations.

Are our choices truncated?

The TPOG currently contains escitalopram and fluoxetine as antidepressant in list A. It means that while teleconsultation if a patient is diagnosed with a condition that requires prescription of antidepressants after the first consultation (if that is a video consultation), our choices are limited to these two drugs. The scenario is also very similar for antipsychotics where our choices in a similar situation can be risperidone, olanzapine or haloperidol. However, I feel that this list is too restrictive that can cause difficulty in deciding treatment in various situation. Current evidence shows that many drugs like sertraline, agomelatine and vortioxetine are more or equally tolerable and acceptable to patients compared to the existing list A[3] burdensome, and costly psychiatric disorders worldwide in adults. Pharmacological and non-pharmacological treatments are available; however, because of inadequate resources, antidepressants are used more frequently than psychological interventions. Prescription of these agents should be informed by the best available evidence. Therefore, we aimed to update and expand our previous work to compare and rank antidepressants for the acute treatment of adults with unipolar major depressive disorder. Methods: We did a systematic review and network meta-analysis. We searched Cochrane Central Register of Controlled Trials, CINAHL, Embase, LILACS database, MEDLINE, MEDLINE In-Process, PsycINFO, the websites of regulatory agencies, and international registers for published and unpublished, double-blind, randomised controlled trials from their inception to Jan 8, 2016. We included placebo-controlled and head-to-head trials of 21 antidepressants used for the acute treatment of adults (≥18 years old and of both sexes. The argument also stands true for antipsychotics because the various agents could not be significantly differentiated in terms of efficacy in a network meta-analysis of placebo controlled randomized control trials of antipsychotics.[4]

Our choices are also restricted regarding the use of various anti-epileptic drugs which are also commonly used as mood stabilizer in various mood disorders. Currently, list A contains phenobarbitone, diphenylhydantoin and sodium valproate whereas, list B contains only divalproex sodium. As a result, various popular clinical choices like levetiracetam, lamotrigine and topiramate can not be prescribed in tele-psychiatric practices. Furthermore, The separate classification of sodium valproate in list A and divalproate sodium in list B also appears ambiguous as the two molecules do not particularly differ in therapeutic efficacy and adverse effects profile.[5]

List B? Some other day

Another clinical situation that could be encountered is that say a patient presents for a first video consultation and after detailed evaluation a diagnosis of 'Major Depressive Disorder' is made and from treatment history it is deduced that the patient in the past has not been a good responder to Escitalopram and Fluoxetine. In such a situation the current guidelines disallow us to prescribe any other drug in the first consultation. Technically there is always a possibility to recall the patient for another consultation (which will then be considered as a

follow up consultation) and prescribe medication from List B. But this approach doesn't appear to be very prudent and unnecessarily taxes the resources.

This paradox also becomes apparent while prescribing long-acting depot antipsychotic preparations. Haloperidol and Fluphenazine can be prescribed as List A drugs while an online consultation with registered medical practitioner in the first encounter, but the same can't be done for drugs like zuclopenthixol, paliperidone and flupentixol. While inclusion of first generation antipsychotics in List A appears judicious, putting the second generation antipsychotics in List B appears strange as the second generation antipsychotics (in injectable forms) are better tolerated than the first generation counterparts.[5]

Add-on? But they seem essential

The guidelines specify that the drugs included in List B are 'add-on' medications. But a closer look into the guidelines show that in many respects, List B drugs do not differ from List A drugs in terms of either efficacy or effectiveness. It appears that this concept was borrowed by TPOG from the guideline published by the Board of Governors of the Medical Council of India and this framework doesn't fit very well to psychotropic drugs in the context of clinical practice of Psychiatry.

List C and other issues

There are a few groups of drugs the status of which is not clear. For example, drug like methylphenidate might be assumed to be under 'other drugs' in list B (under anti-ADHD drugs) and thus can be tele-prescribed. But then methylphenidate is also scheduled in the Narcotic Drugs and Psychotropic Substances Act (NDPS Act) and its inclusion in List B will be questioned because other drugs listed in NDPS like morphine, buprenorphine, methadone, benzodiazepines (except clobazam and clonazepam) and zolpidem are included in List C and thus can not be tele-prescribed.[5]

The guideline also remains silent about the various issues pertaining to the care of suicidal patients. Though one argument could be that suicide is a psychiatric emergency and such patients may be deemed better manageable in traditional face-to-face consultation. But complete silence of the guidelines on this issue can create doubts in the mind of tele-psychiatrists while providing online care and future editions of this guideline should look into this matter[6] access to smartphone, and gains achieved in increased internet speed and data transfer have expanded the scope of health care service delivery through the digital platforms. In India, telemedicine services remain poorly adopted and integrated due to various barriers. The important reasons are lack of legal and administrative clarity in using technology for service delivery and inertia from health service providers to adopt newer developments. However, during coronavirus disease COVID-19.

What was the rationale behind this framework?

The rationale behind the current state of the framework could be appreciated from a viewpoint article published by a group of authors that also includes the authors of TPOG.[7] In that article the authors have explained that the approach behind the formation of this lists were to include the drugs present in the National List of Essential Medications in List A only and place the rest drugs in List B. The authors reveal that this approach will ensure that only those patients who receive a firm diagnosis will be prescribed medication and rest will be called for a traditional face-face consultation.

What is the way forward?

It has to be appreciated that the TPOG was prepared in a very testing time and under pressing needs. It has been almost 2 years since the publication of the guideline and given the increase in the use of telehealth over the last two years, we have gathered enough experience. From the above review, the following recommendation can be made. The scope of List A should be broadened, which will result in much more freedom for psychiatrists practicing tele-psychiatry.

References

1. The Telemedicine Practice Guidelines, 2020 [Internet]. [cited 2022 Jul 24]. Available from: https://www.legalserviceindia.com/legal/article-3450-the-telemedicine-practice-guidelines-2020.html
2. e-Book: Telepsychiatry Operational Guidelines-2020

| Indian Psychiatric Society [Internet]. [cited 2020 Aug 11]. Available from: https://indianpsychiatricsociety.org/e-book-telepsychiatry-operational-guidelines-2020/

3. Cipriani A, Furukawa TA, Salanti G, Chaimani A, Atkinson LZ, Ogawa Y, et al. Comparative efficacy and acceptability of 21 antidepressant drugs for the acute treatment of adults with major depressive disorder: a systematic review and network meta-analysis. Lancet [Internet]. 2018 Apr 7 [cited 2021 Mar 9];391(10128):1357–66. Available from: https://pubmed.ncbi.nlm.nih.gov/29477251/
4. Huhn M, Nikolakopoulou A, Schneider-Thoma J, Krause M, Samara M, Peter N, et al. Comparative efficacy and tolerability of 32 oral antipsychotics for the acute treatment of adults with multi-episode schizophrenia: a systematic review and network meta-analysis. Lancet (London, England) [Internet]. 2019 Sep 9 [cited 2022 Jul 24];394(10202):939. Available from: /pmc/articles/PMC6891890/
5. Rina K, Padhy SK, Chadda RK. The Telepsychiatry Operational Guidelines 2020 in India: a welcome step. BJPsych Int [Internet]. 2021 Nov [cited 2022 Jul 24];18(4). Available from: /pmc/articles/PMC8554922/
6. Dinakaran D, Basavarajappa C, Manjunatha N, Kumar CN, Math SB. Telemedicine Practice Guidelines and Telepsychiatry Operational Guidelines, India-A Commentary. Indian J Psychol Med [Internet]. 2020 Oct 25 [cited 2022 Jul 24];42(5 Suppl):1S-3S. Available from: http://www.ncbi.nlm.nih.gov/pubmed/33354058
7. Nirisha PL, Malathesh BC, Manjunatha N, Kumar CN, Math SB, Kiragasur RM. Prescribing Psychotropics: Perspective From Telepsychiatry Operational Guidelines 2020. Indian J Psychol Med [Internet]. 2020 Oct 1 [cited 2022 Jul 24];42(5 Suppl):80S. Available from: /pmc/articles/PMC7736728/