Indian Psychiatric Society Survey on Clinical Practice Guidelines

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ABSTRACT

Aim: This survey aimed to assess the utility of the earlier published clinical practice guidelines (CPGs) by IPS and to understand the expectations of members of Indian Psychiatric Society from the proposed revised CPGs. In addition, the survey also evaluated the current level of practice of psychiatry in terms of availability of different investigation facilities, prescription patterns in terms of use of polypharmacy, and competence in carrying out certain nonpharmacological treatments.

Methodology: An online survey was received by 3475 psychiatrist, of whom 608 (17.5%) participants completed the survey.

Results: Almost all (93.8%) of the psychiatrists agreed that there should be separate CPGs for Indian setting. In terms of problems with the previous version of the CPGs, this survey shows that the previous version of guidelines was used in making clinical decisions by only one-third (31.25%) of the participating psychiatrists. The major limitations of the previous version of CPGs which were pointed out included the lack of consideration of socio-cultural issues (33.2%), lack of recommendations for many clinical situations that are encountered in clinical practice (43.15) and poor dissemination (35.2%). In terms of expectations, the membership expects the society to come up with guidelines, which are shorter in length (82.2%), has significant proportion of information in the form of tables and flow diagrams (58.7%), besides the evidence base must also take expert opinions into account (84.7%), must be circulated before adopting (88.7%), must be disseminated by displaying the same on the website (72%), and also by sending the same by E-mails (62%). Further, the membership expects the IPS to design online continuing medical education program on CPGs (54.3%). The survey also suggests that it is feasible on the part of more than two-third of the psychiatrists to monitor the metabolic parameters in routine clinical practice and carryout various nonpharmacological treatments. Majority of the psychiatrist opined that polypharmacy is not used in more than 25% of patients with schizophrenia and depression and hence the use of polypharmacy should be recommended judiciously.

Conclusion: This survey shows that the membership of the IPS is interested in having own guidelines for the management of various psychiatric disorders in Indian setting. Further, the survey provides insights into why the previous versions of the guidelines were not very popular and what IPS should do improve the acceptability of guidelines in future.

Key words: Clinical practice guidelines, guidelines, India, Indian Psychiatric Society

INTRODUCTION

Indian Psychiatric Society (IPS), started publishing clinical practice guidelines (CPGs) for the management of various psychiatric disorders. However, the previous version of CPGs was not very popular among the members of IPS. The survey also evaluated the current level of practice of psychiatry in terms of availability of different investigation facilities, prescription patterns in terms of use of polypharmacy, and competence in carrying out certain nonpharmacological treatments.

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psychiatric disorders in the year 2005 and between the year 2005 and 2009, published five volumes of treatment practice guidelines, covering most of the psychiatric disorders.[1–5] A survey was conducted in the months of October–November 2008, to evaluate the usefulness, awareness, and implementation of IPS-CPGs. The survey was sent to 1100 psychiatrists, of whom 107 responded to the survey. Among the responders, only half of the responders were aware about the four published volumes of the guidelines at that time, and only 12.7% of the responders had read all the four volumes. About two-thirds of the responders had referred to these guidelines in their clinical practice, either occasionally (46.1%), often (16.7%), or always (2%). More than two-thirds of the responders considered these guidelines to be helpful in making day-to-day clinical decisions in their practice, either occasionally (48%), often (19.6%), or always (3.9%). In the open-ended questions, many of the responders discussed their dissatisfaction with these guidelines and gave suggestions as to how these guidelines could be improved. Some of the areas of dissatisfaction were the lack of uniformity, lack of consideration of local/cultural issues into account, not very useful, lengthy, not user-friendly, poor quality of printing and typographical errors. Some of the suggestions which emerged from this survey included, rather than having guidelines on the basis of evidence base only, guidelines may be drawn on the basis of consensus and may be field tested. Further, the IPS should try to focus on drawing guidelines only on few disorders, rather than having guidelines for everything. In terms of circulation, participants suggested that the guidelines should be sent to all the Indian psychiatrists, and must be made available on the society’s website or on the website of the journal.[4]

Besides criticism, many participants had expressed that overall it was good initiative of IPS and the society should continue to formulate guidelines and must update the same regularly. In 2015, IPS, again formed the Task force to formulate/update the CPGs for various disorders. Keeping in view the findings of the previous survey, the Executive Committee of the IPS and Task force on CPGs in its first meeting decided to carry out a survey, which should assess the scenario in practice and must take the realities into consideration while formulating recommendations as part of various treatment guidelines. Accordingly, the aims of this survey were to assess the (1) utility of the earlier published CPGs by IPS; (2) expectations from the new CPGs; (3) current level of practice of psychiatry in terms of availability and use of different investigation facilities; and (4) prescription patterns in terms of use of polypharmacy and competence in carrying out certain nonpharmacological treatments.

**METHODOLOGY**

This survey was conducted by using Survey Monkey platform. Based on the E-mail address database of various members of the society and E-mail addresses of the trainee psychiatrist collected by the authors, the survey was sent to 4394 E-mail addresses. The survey was approved by the ethics committee of the research and training foundation of the IPS. The cover letter of the survey mentioned that the IPS has decided to revise CPGs for the management of schizophrenia, bipolar disorder, and depression, and the Executive Committee of IPS was seeking inputs from its membership prior to finalizing the CPGs. The participants were also informed that a symposium on the CPGs will be held during the ANCIPS-2016. The participation in the survey was voluntary and the participants had the option of “opt-out” from the survey. Completion of the survey implied informed consent. The survey was sent twice a week for 6 consecutive weeks. Those who responded to the survey or “opted out” were not sent the reminders. Those who completed the survey partially were also sent reminders in between to complete the survey. The survey questionnaire included 41 questions and required about 15–20 min to complete.

The data were analyzed by SPSS (SPSS for Windows, Version 14.0. Chicago, SPSS Inc.). Continuous variables were analyzed in the form of mean, standard deviation, median, and range. Categorical variables were analyzed as frequency and percentages.

**RESULTS**

Of the 4394 E-mail addresses, the invitation to participate “bounced-back” for 712 E-mail addresses and for 207 E-mail addresses, people opted out to participate in the survey. Out of the eligible, 3475 participants, 608 (17.5%) of the participants completed the survey. The mean age of the participants was 41 (standard deviation [SD] 11.78) years, with a range of 26–79 years and a median of 38 years. As is evident from Table 1, about 80% of the participants were ≤50 years with majority of the participants were in the age range of 31–40 years. Four-fifth of the participants were males and about one-fifth were females. More than three-fourth (77.5%) of the participants had done MD only or had done MD along with an additional degree. The mean total experience in psychiatry, including the training period was 14.22 (SD - 10.89) years, with a median of 10 years and range of 1–53 years. Three-fifth of the participants were in the government jobs (either fulltime government job only or government job with private practice) and two-fifth were in full-time private practice only. In terms of place of work, one-fourth were in full-time private practice, one-fifth were in the government medical colleges (without any private practice). About one-sixth were in central institutes [Table 1]. In terms of location, about three-fourth of the psychiatrist were practicing in the heart of the large city or in the suburbs of a large city. One-fifth were practicing in a town and very few were practicing in villages. On an average, a psychiatrist was seeing 30 (SD 26.2) patients a day with a median of 25 patients a day and a range of 2–200. The mean duration of time spent in consultation for a new patient was
A majority (81.6%) of the participants reported that they do follow some treatment guidelines for the management of patients with severe mental disorders such as schizophrenia, bipolar disorder, or depression. Among those who were using guidelines, in terms of most commonly followed guidelines for the management of patients with severe mental disorders, about two-fifth (41%) were following Maudsley Prescribing Guidelines and about one-fourth (28.6%) were following American Psychiatric Association guidelines. About one-seventh (14.3%) were following National Institute of Clinical Excellence (NICE) guidelines and another one-seventh (14.63%) were following IPS guidelines [Table 2]. Majority (82.24%) of those who were using various guidelines reported that they were able to use the guidelines only partially.

When enquired about having separate CPGs for Indian setting majority (93.8%) of the participants answered in affirmation. When asked about earlier IPS guidelines, 83.3% of the participants were aware about the same and about half (52.1%) had used the IPS guidelines. Those who used the same had most often used the same to update their knowledge (43.5%). About one-third (31.25%) used the same for taking day to day clinical decisions and one-fourth (25.65%) used it for teaching and few (11%) had used the same for defending themselves in the court of law. When asked to report about the problems with the earlier version of the guidelines, the most commonly reported problem was that these do not address many clinical situations that are encountered (43.1%), followed by problems in dissemination (35.2%), do not address the socio-cultural issues encountered in practice (33.2%), and not evidence based (20.2%). Other details are shown in Table 2.

### Expectations from the revised clinical practice guidelines

When asked about their expectations from the upcoming CPGs, most of the participants expected that the guidelines should be at best of <5 pages (45.8%) or 5–10 pages (36.4%) of Indian Journal of Psychiatry (IJP) [Table 3]. More than half of the participants expected the CPGs to be presented in the form of tables and flow diagram format. Majority of the participants expected that the guidelines must be based on evidence base along with expert opinion (84.7%), must be circulated before being adopted (88.7%) and having a symposium in ANCIPS would be beneficial (91.4%). When asked about how to improve the use of CPGs, majority of the participants expected that the guidelines must be made available on the IPS website (72%) and this was followed by the expectation of receiving the softcopy of guidelines by E-mail (62%) and presenting major parts of the guidelines in the form of flow charts and tables (58.7%) and by conducting online continuing medical education (CME) programs on the CPGs (54.3%) and least proportion of the participants (47.4%) considered sending parts of guidelines

### Table 1: Profile of participants (n=608)

| Variable                              | Mean (SD)/frequency (%) |
|---------------------------------------|-------------------------|
| Age (years)                           | 41 (11.78) (median: 38; range 26-79) |
| Age categories (in years)             |                         |
| <30                                   | 107 (17.6)              |
| 31–40                                 | 266 (43.6)              |
| 41–50                                 | 111 (18.3)              |
| 51–60                                 | 67 (11)                 |
| 61–70                                 | 45 (7.4)                |
| >70                                   | 12 (2)                  |
| Gender-male/female                    | 479 (78.8)/129 (21.2)   |
| Qualification (n=594)                 |                         |
| MD only                               | 353 (58.1)              |
| MD along with one or more degrees     | 118 (19.4)              |
| DPM                                   | 80 (13.2)               |
| DPM + DNB                             | 25 (4.1)                |
| DNB only                              | 11 (1.8)                |
| MRCPsych/FRCPsych                     | 4 (0.7)                 |
| DPM + MRCPsych/FRCPsych               | 3 (0.6)                 |
| Total experience in psychiatry (including the number of years of training in psychiatry) | 14.22 (10.89) (median: 10; range 1-53) |
| Type of setting in which you are working (n=572) | 238 (41.6) |
| Full time government job with no private practice | 224 (39.2) |
| Full time private practice            | 110 (19.2)              |
| Government job with private practice  |                         |
| Main place of work (n=590)            |                         |
| Central institute                     | 95 (16.1)               |
| Full time private practice            | 151 (25.6)              |
| Government Medical College            | 125 (21.2)              |
| Government medical college with private practice | 62 (10.5) |
| Private Medical College               | 44 (7.5)                |
| Private Medical College with private practice | 62 (10.5) |
| Mental hospitals                      | 33 (5.6)                |
| Charitable hospital                   | 18 (3.1)                |
| Main place of work (n=595)            |                         |
| In the heart of a large city          | 370 (62.4)              |
| In the suburb of a large city         | 88 (14.8)               |
| Town                                  | 117 (19.2)              |
| Village                               | 18 (3.0)                |
| Number of patients seen by you in the outpatient clinic on a typical day (type in just the number) | 31.6 (26.20) (median: 25; range 2-200) |
| Average amount of time spent in evaluating a new patient (in min-enter just the number) | 27.9 (16.3) (median: 25; range 6-120) |
| Average amount of time spent in evaluating a repeat visit patient (in min-enter just the number) | 11.91 (6.94) (median: 10; range 1-60) |
| Are you part of the expert group for the formulation of clinical practice guideline by the Indian Psychiatric Society? | 45 (7.4) |

The additional degrees included DM/DPM/DNB/MRCPsych/FRCPsych/FRANZPsych. DPM – Diploma in Psychological Medicine; DNB – Diplomate of National Board

27.9 (SD - 16.3; median 25) min and that for an old follow-up patient was 11.91 (SD - 6.94; median 10) min. Only a small proportion (7.4%) of the participants had been part of the IPS CPG formulation groups in the past.
Table 2: Views about guidelines (n=608)

| Variable | Frequency (%) |
|----------|---------------|
| Do you generally follow any treatment guidelines published by any psychiatric association for management of your patients with severe mental disorders like schizophrenia, bipolar disorder or depression? | 496 (81.6) |
| Most commonly followed treatment guidelines (n=485) | |
| National institute of clinical excellence | 70 (14.3) |
| American psychiatric association | 139 (28.65) |
| Maudsley prescribing guidelines | 199 (41.03) |
| Indian psychiatric society guidelines | 71 (14.63) |
| Canadian network for mood and anxiety treatments | 6 (1.23) |
| If you follow any treatment guidelines, do you find it useful in your clinical practice (n=490) | |
| Able to follow the guidelines completely | 84 (17.1) |
| Able to follow the guidelines partially | 403 (82.24) |
| Not able to follow the guidelines | 3 (0.6) |
| Do you think that there is a need to have separate clinical practice guidelines for Indian setting? | 556 (93.8) |
| Are you aware that Indian psychiatric society had published the clinical practice guidelines for management of various psychiatric disorders in the past (i.e., between the year 2005 and 2010)? | 506 (83.2) |
| Did you ever use the previously published clinical practice guidelines by the Indian psychiatric society? | 317 (52.1) |
| If you ever used clinical practice guidelines published by Indian psychiatric society, did you find it useful for | |
| In taking day-to-day clinical decisions | 190 (31.25) |
| Updating your knowledge | 221 (43.5) |
| Defending yourself in court of law | 67 (11) |
| Teaching your students | 156 (25.65) |
| What do you think are the problems with the clinical practice guidelines published by Indian psychiatric society? | |
| Too short | 21 (3.45) |
| Too long | 82 (13.5) |
| Do not address the socio-cultural issues encountered in practice | 202 (33.2) |
| Do not address many clinical situations that are encountered | 262 (43.1) |
| Not evidence based | 123 (20.2) |
| Too much emphasis on pharmacotherapy | 88 (14.5) |
| Poorly disseminated | 214 (35.2) |

Table 3: Expectations from the guideline (n=608)

| Variable | Frequency (%) |
|----------|---------------|
| What should be the length of the CPGs for each disorder, which you think could be easily referred to in day to day clinical practice (n=579) | |
| <5 pages of IJP | 265 (45.8) |
| 6-10 pages of IJP | 211 (36.4) |
| 10-20 pages of IJP | 74 (12.8) |
| 20-30 pages of IJP | 18 (3.1) |
| 30-40 pages of IJP | 11 (1.9) |
| Should CPGs for each disorder be presented in the form of flow diagrams/tables only? | 320 (52.6) |
| Recommendations of CPGs be drawn on the basis of (n=589) | |
| Both evidence base and expert opinion | 499 (84.7) |
| Evidence base only | 67 (11.4) |
| Expert opinion only | 7 (1.2) |
| Other | 16 (2.7) |
| Is there a need for circulation of the CPGs to membership of IPS for inputs before adopting the guidelines? | 539 (88.7) |
| Will symposium on CPGs at ANCIPS be beneficial to the members of IPS? | 556 (91.4) |
| What should be done to increase the use of IPS CPGs in clinical practice | |
| Making the guidelines available on the IPS website | 438 (72) |
| Sending the copy of guidelines by email | 377 (62) |
| SENDING PARTS OF GUIDELINES IN THE FORM OF EDUCATIONAL CAPSULES THROUGH EMAIL | 288 (47.4) |
| Educational capsules through email on regular basis | |
| Presenting major parts of the guidelines in the form of flow charts and tables | 357 (58.7) |
| Online CME programs on the clinical practice guidelines | 330 (54.3) |
| Is there a need to make the practice of psychiatry as per the IPS CPGs binding on the membership (n=590) | |
| Cannot say | 124 (21) |
| Definitely | 33 (5.6) |
| May be | 146 (24.7) |
| Not at all | 287 (48.6) |

in the form of small educational capsules through E-mail on regular basis would be of benefit. About half (48.6%) of the participants considered that the society should not make it mandatory for its membership to follow the CPGs and very few (5.6%) considered that it should definitely be made mandatory.

Feasibility of investigations
In terms of feasibility of carrying out investigations, for majority of the participants (>75%), it was feasible to order and get reports of hemogram, fasting blood glucose levels, serum electrolytes, liver function test, renal function test, lipid profile, thyroid function test, ultrasound of abdomen and pelvis, electroencephalogram, computerized tomography of brain, X-ray chest, and electrocardiogram. More than two-third of the participants also had access to serum lithium levels and magnetic resonance imaging. More than half had access to Vitamin B12 and Vitamin D levels.

Investigations carried out routinely prior to starting of various psychotropic medications
In terms of current practice, in general, more investigations were being done prior to starting of antipsychotics and mood stabilizers, when compared to the use of antidepressants. Investigations done prior to starting of antipsychotics by more than half of the psychiatrists included hemogram, fasting blood glucose levels, and lipid profile. Further more than half of the psychiatrists also monitored the same while using antipsychotics.
included hemogram, fasting blood glucose levels, liver function test, renal function test, and thyroid function test. Of these, only liver function tests, renal function tests, and thyroid function tests were being monitored while using mood stabilizers. In general, fewer psychiatrists carried out investigations prior to starting and while using various antidepressants. The most commonly carried out investigations included hemogram, fasting blood glucose level, and thyroid function test.

In terms of option given for other investigations, few reported evaluating serum drug levels (lithium and valproate) (5.9%) and serum prolactin (3.8%), while monitoring patients on various psychotropic medications.

Majority of the psychiatrists were carrying out renal function test (84.9%), thyroid function test (78%), and serum electrolytes prior to starting of lithium. However, very few psychiatrists reported evaluating 24 h urine osmolality and 24 h proteins prior to starting of lithium. Very few (5.6%) of psychiatrists reported not carrying out any investigations prior to starting of lithium.

### Table 4: Feasibility of investigations (n=608)

| Variable                                           | Frequency (%) |
|----------------------------------------------------|---------------|
| What all investigations are feasible at the clinical setting in which you practice (tick on whichever are feasible) |               |
| Hemogram                                           | 554 (91.1)    |
| Fasting blood glucose levels                       | 555 (91.3)    |
| Serum electrolytes                                 | 528 (86.8)    |
| Liver function test                                | 553 (91.0)    |
| Renal function test                                | 535 (88.0)    |
| Lipid profile                                      | 519 (85.4)    |
| Thyroid function test                              | 529 (87.0)    |
| Serum lithium levels                               | 435 (71.5)    |
| Serum valproate levels                             | 259 (42.6)    |
| Serum clozapine levels                             | 90 (14.8)     |
| Urine drug screen                                  | 247 (40.6)    |
| Ultrasound of abdomen and pelvis                   | 458 (75.3)    |
| EEG                                                | 459 (75.5)    |
| CT of brain                                        | 484 (79.5)    |
| X-ray chest                                        | 482 (79.3)    |
| MRI of brain                                       | 407 (66.9)    |
| PET                                                | 111 (18.3)    |
| Electrocardiogram                                  | 485 (79.7)    |
| Vitamin B12 levels                                 | 365 (60.0)    |
| Folic acid levels                                  | 289 (47.5)    |
| Vitamin D levels                                   | 322 (53.0)    |

Which of the following is feasible to measure in all patients before starting psychotropics (tick as many as applicable)

- Height: 436 (71.7)
- Weight: 541 (89.0)
- Waist circumference: 336 (55.3)
- Hip circumference: 239 (39.3)
- Waist-hip ratio: 250 (41.1)
- Blood pressure: 552 (90.8)
- Fasting blood glucose levels: 477 (78.5)
- Lipid profile: 394 (64.8)

PET – Positron emission tomography; MRI – Magnetic resonance imaging; CT – Computed tomography; EEG – Electroencephalogram

### Table 5: Investigations carried out routinely prior to starting of various psychotropic medications

|                      | Antipsychotics (%) | Antidepressants (%) | Mood stabilizers (%) |
|----------------------|--------------------|---------------------|----------------------|
| Hemogram             | 383 (63)           | 302 (49.7)          | 352 (57.9)           |
| Fasting blood glucose levels | 453 (74.5)      | 252 (41.4)          | 304 (50.0)           |
| Serum electrolytes   | 155 (25.5)         | 191 (31.4)          | 224 (36.8)           |
| Liver function test  | 304 (50.0)         | 213 (35.0)          | 374 (61.5)           |
| Renal function test  | 256 (42.1)         | 197 (32.4)          | 364 (59.9)           |
| Lipid profile        | 327 (53.8)         | 120 (19.7)          | 200 (32.9)           |
| Thyroid function test| 168 (27.6)         | 295 (48.5)          | 318 (52.3)           |
| Urine drug screen    | 36 (5.9)           | 25 (4.1)            | 32 (5.3)             |
| EEG                  | 35 (5.8)           | 20 (3.3)            | 46 (3.3)             |
| Electrocardiogram    | 276 (45.4)         | 186 (30.6)          | 211 (34.7)           |
| Vitamin B12 levels   | 36 (5.9)           | 93 (15.3)           | 40 (6.6)             |
| Folic acid levels    | 12 (2)             | 46 (7.6)            | 25 (4.1)             |
| Vitamin D levels     | 25 (4.1)           | 66 (10.9)           | 23 (3.8)             |

EEG – Electroencephalogram
Competence in nonpharmacological interventions
Majority of the psychiatrist (>80%) considered their competence to carry out psychoeducation, cognitive behavior therapy, behavior therapy, family intervention, and relaxation exercises as “average” or “above average” or “excellent.” However, for psychoeducation, only 64.4% considered their competence as “average” or “above average”. In terms of carrying out cognitive remediation therapy, only about half of the participants reported their own competence as average or above average [Table 8].

DISCUSSION
This survey intended to have basic information about the dissatisfaction and utility of previous version of CPGs of IPS and to understand the expectations of the membership with regard to the revised CPGs. In addition, the Task force of IPS on CPGs was also interested in understanding the feasibility of making certain recommendations such as carrying out investigations for the evaluation of metabolic syndrome and various nonpharmacological treatments.

As there are no such surveys which have looked into these aspects of practice of psychiatry, it would be difficult to compare the findings of the present survey with existing literature. Hence, we would discuss the findings of this survey in the context of formulation of newer guidelines.

Table 6: Investigations carried out while monitoring patients on various psychotropic medications

|                              | Antipsychotics (%) | Antidepressants (%) | Mood stabilizers (%) |
|------------------------------|--------------------|---------------------|----------------------|
| Hemogram                     | 318 (52.3)         | 199 (32.7)          | 267 (43.9)           |
| Fasting blood glucose levels | 476 (78.3)         | 209 (34.4)          | 256 (42.1)           |
| Serum electrolytes           | 133 (21.9)         | 181 (29.8)          | 199 (32.7)           |
| Liver function test          | 290 (47.7)         | 176 (28.9)          | 369 (60.7)           |
| Renal function test          | 191 (31.4)         | 146 (24.0)          | 329 (64.1)           |
| Lipid profile                | 387 (63.7)         | 125 (20.6)          | 212 (34.9)           |
| Thyroid function test        | 125 (20.6)         | 235 (38.7)          | 320 (62.6)           |
| Urine drug screen            | 22 (3.6)           | 18 (3.0)            | 25 (4.1)             |
| EEG                          | 25 (4.1)           | 14 (2.3)            | 24 (3.9)             |
| Electrocardiogram            | 216 (35.5)         | 137 (22.5)          | 146 (24.0)           |
| Vitamin B12 levels           | 18 (3.0)           | 50 (8.2)            | 29 (4.8)             |
| Folic acid levels            | 8 (1.3)            | 23 (3.8)            | 19 (3.1)             |
| Vitamin D levels             | 14 (2.3)           | 33 (5.4)            | 11 (1.8)             |

Table 7: Polypharmacy prescription practices (n=608)

| Variable                                                                 | Mean (SD)/frequency (%) |
|--------------------------------------------------------------------------|-------------------------|
| • In what proportion of patients with schizophrenia do you use a combination of antipsychotic continuously for >2 weeks to manage acute phase of illness | 28.23 (30.02) (median 20; range 0-100) |
| • In what proportion of patients with depression do you use a combination of antipsychotics continuously for >2 weeks to manage acute phase of illness | 26.8 (32.01) (median 10; range 0-100) |
| • In what proportion of patients with bipolar disorder do you use a combination of antipsychotics continuously for >2 weeks to manage acute phase of illness | 32.37 (31.64) (median 20; range 0-100) |
| • In what proportion of patients with schizophrenia do you use combination of antipsychotics during the stabilization/stable phase of illness | 24.12 (21.84) (median 20; range 0-100) |
| • In what proportion of your patients with depression do you use a combination of antidepressants to manage acute phase of management | 22.88 (24.99) (median 15; range 0-100) |
| • In what proportion of your patients with mania do you use a combination of 2 classical mood stabilizers during the acute phase (i.e., lithium, valproate, lamotrigine, carbamazepine etc.) | 18.63 (20.48) (median 10; range 0-100) |
| • In what proportion of your patients with mania do you use a combination of one or more classical mood stabilizers (i.e., lithium, valproate, lamotrigine, carbamazepine etc.) and an antipsychotic medication during the acute phase | 58.34 (32.23) (median 70; range 0-100) |
| • In what proportion of your patients with bipolar disorder do you use a combination of 2 or more classical mood stabilizers (i.e., lithium, valproate, lamotrigine, carbamazepine etc.) for maintenance treatment | 21.04 (17.93) (median 20; range 0-100) |
| • In what proportion of your patients with bipolar disorder do you use a combination of one classical mood stabilizers (i.e., lithium, valproate, lamotrigine, carbamazepine etc.) and an antipsychotic for maintenance treatment | 40.54 (26.33) (median 40; range 0-100) |
| • In what proportion of your patients with bipolar disorder do you use 2 classical mood stabilizers (i.e., lithium, valproate, lamotrigine, carbamazepine etc.) and one or more antipsychotic for maintenance treatment | 14.71 (16.34) (median 10; range 0-100) |

SD – Standard deviation

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guidelines for the management of their patients with severe mental disorders. This finding is very similar to the previous survey in which only 8.8% of psychiatrists had reported not following any specific treatment guidelines in managing their patients. In terms of preference, a large proportion of psychiatrists was following treatment guidelines issued by other associations, i.e., Maudsley Prescribing Guidelines, American Psychiatric Association, and NICE and only a very small proportion of psychiatrists based their day to day clinical decisions based on IPS guidelines. This finding can be interpreted as possible lack of satisfaction with the IPS guidelines. This lower reliance on IPS guidelines also can be due to the lack of awareness about these guidelines in about one-sixth of the participants.

In terms of applicability, majority of the participants reported that they were able to use guidelines of different associations only partially in their clinical practice. This suggests that guidelines issued by various associations probably are not in tune with the real life situations faced by the psychiatrists and hence any new guidelines must take these situations into account while making recommendations.

When asked about the need for separate CPGs for Indian setting, almost all (93.8%) of the participants expressed the need to have separate treatment guidelines for Indian setting. This finding clearly reflects that there is a need for development of treatment guidelines by the IPS. Hence, it can be said that decision of IPS to revise these guidelines is in the right direction. In terms of using the previous version of guidelines only 52.1% of psychiatrists reported ever using the IPS guidelines. Only one-third of the psychiatrists, who used the IPS guidelines, reported that these were useful in making day to day clinical decisions. In terms of implementation of treatment guidelines, studies from other parts of the world show that the barriers to implementation to various treatment guidelines include organizational resources, health care professional’s own characteristics, and perception of guidelines and implementation strategies. Accordingly, it is important for the IPS to keep these facts in mind to reduce the barriers in implementation of treatment guidelines.

In terms of expectations, majority of the participants expressed the need to have shorter documents, with lot of information being provided in the form of flow diagrams and tables and drawing the recommendations based on the evidence base and expert opinion. In addition, the membership expects that the society should make these guidelines available to them electronically through various resources. In addition, a significant proportion of the members expect that having online CME program on guidelines could be of help IPS must take these views into account while circulating the revised guidelines.

In terms of problems with the existing guidelines, a significant proportion of participants reported that the guidelines do not take into consideration various socio-cultural issues encountered in practice, do not address many clinical situations that are encountered, are not evidence based and there is too much emphasis on pharmacotherapy. In addition, about one-third of the participants also pointed out the issue of poor dissemination of these guidelines. This again suggest that revised version of guidelines must focus on these issues and must be disseminated properly.

IPS Task force on formulation of treatment guidelines must take these insights in terms of problems with earlier version of the guidelines and expectations of the membership in formulation of future CPGs. Some of the issues like making the recommendations on the basis of current evidence base can easily be done by carrying out proper review of the existing literature and drawing recommendations based on the same. The newer guidelines should provide adequate information about the nonpharmacological treatments, so that these can be easily incorporated into clinical practice and emphasis on the use of only pharmacological measures must be reduced. Problem of dissemination must be addressed by publishing the guidelines as part of the IJP and possibly making the guidelines available at the IJP website and sending the guidelines to the membership by E-mail. IPS must look at developing online CME program for improving the acceptability of CPGs. This can be done probably by having CME program which can evaluate the knowledge of the participant about the content of IPS guidelines. This program can also possibly help in evaluating specific dissatisfactions with the guidelines. In future, there is a need to carry out a survey to understand the socio-cultural aspects and the clinical situations, which clinicians feel that the guidelines do not address.

Table 8: Competence in nonpharmacological interventions (n=608)

| Intervention                        | Below average (%) | Above average (%) | Average (%) | Excellent (%) | Poor (%) |
|-------------------------------------|-------------------|-------------------|-------------|---------------|---------|
| Psychoeducation                     | 78 (14.6)         | 276 (51.5)        | 188 (35.3)  | 91 (17.1)     | 33 (6.2) |
| Cognitive behavior therapy          | 78 (14.6)         | 276 (51.5)        | 188 (35.3)  | 91 (17.1)     | 33 (6.2) |
| Behavior therapy                    | 78 (14.6)         | 276 (51.5)        | 188 (35.3)  | 91 (17.1)     | 33 (6.2) |
| Cognitive remediation therapy       | 78 (14.6)         | 276 (51.5)        | 188 (35.3)  | 91 (17.1)     | 33 (6.2) |
| Family intervention                 | 78 (14.6)         | 276 (51.5)        | 188 (35.3)  | 91 (17.1)     | 33 (6.2) |
| Relaxation exercises                | 78 (14.6)         | 276 (51.5)        | 188 (35.3)  | 91 (17.1)     | 33 (6.2) |
Members of all the societies expect their leaders to fulfill their demands and aspirations. In the survey, a very large proportion of the psychiatrists expressed that having a symposium in ANCIPS is going to help in formulation of guidelines. The Task force on the formulation of treatment guidelines organized a symposium on the revised CPGs in ANCIPS 2016. The attendance in this symposium was far less than expected. This possibly reflects the apathy of the membership on this issue. Till the membership does not take up their own responsibility sincerely, just blaming the leadership and people involved in the task of formulation would be unfair. Accordingly, the membership should take up their own responsibility more sincerely and provide their inputs on this endeavor so that a collective effort can result in the formulation of CPGs which are practical and can be used.

Over the last 1–2 decades, development of metabolic syndrome with the use of psychotropics has become an important issue. Various associations have issued guidelines for monitoring of metabolic syndrome. This survey clearly shows that it is feasible for majority of the psychiatrists to carry out most of the routine investigations in their clinical practice. Further, it was also feasible to carry out anthropometric evaluation on part of majority of psychiatrists. In terms of current practice too, it was evident that a significant proportion of psychiatrists were already carrying out baseline investigations and also were ordering for investigations while using psychotropics in long run. Accordingly, the recommendations of guidelines in terms of carrying out baseline investigations and anthropometric evaluation must take these into account. Accordingly, the guidelines may recommend monitoring of metabolic parameters for patients recommended antipsychotic and mood stabilizers. If in future, these recommendations are followed by the practicing psychiatrists in routine clinical practice, this could possibly help in detecting metabolic abnormalities at early stages and prevention of development of chronic physical illnesses such as diabetes mellitus and hypertension. This all can probably also help in reduction in premature cardiovascular mortality. The findings of this survey also shows that majority of the psychiatrists follow the basic recommendations for prelithium investigations. Accordingly, future guidelines must make recommendations of this with ease.

There is a general perception that there is high rate of polypharmacy in routine clinical practice. Some of the psychiatrists argue about this issue and give this as an excuse for not following treatment guidelines. Some claim that most patients require polypharmacy and it is not possible to manage patients with monotherapy during the acute and maintenance phase. Keeping these views in mind, there is always a pressure of recommending polypharmacy as part of CPGs. However, findings of the current survey clearly shows that in general, polypharmacy is not practiced for significant proportion of patients with schizophrenia and depressive disorders. However, a significant proportion of patients with bipolar disorder receive polypharmacy during the acute and maintenance phase treatment. Accordingly, it can be said that guidelines should judiciously recommend the use of polypharmacy.

In terms of nonpharmacological treatment, more than half of the psychiatrists reported average or above average competence in carrying out nonpharmacological treatments such as psychoeducation, cognitive behavior therapy, behavior therapies, family interventions, and relaxation exercises. These findings suggest that future guidelines must provide more information about the role of these interventions in management of various psychiatric disorders. Further, the findings also suggest that a significant proportion of psychiatrists are not very well versed with cognitive remediation therapy. Accordingly, as capacity building measure, IPS must hold workshops and symposiums on cognitive remediation therapy, so that these can be practiced more often by its membership.

This survey has certain limitations. The survey did not evaluate the specific level of dissatisfaction among the psychiatrists with regard to the existing guidelines. Further the survey did not evaluate the specific expectations of the psychiatrists from the newer guidelines. This survey did not endeavor to assess the barriers to the implementation of treatment guidelines in clinical practice. Only about one-sixth of the membership participated in this survey. Due to this, generalizability of this survey can be questioned.

**CONCLUSION**

The present survey shows that the majority of the psychiatrists are interested in having own CPGs and at present follow one or other treatment guidelines for the management of patients. In terms of problems with the previous version of the CPGs, this survey shows that the previous version of guidelines were used for making clinical decisions by a very small proportion of psychiatrists only. The major limitations of the previous versions which were pointed out included the lack of consideration of socio-cultural issues, lack of recommendations for many clinical situations that are encountered in clinical practice and poor dissemination. In terms of expectations, the membership expects the society to come up with guidelines, which are shorter in length, has more information in the form of tables and flow diagrams, should take expert opinions into account, must be circulated before adopting, must be disseminated by displaying the same on the website, and also by sending the same by E-mails. Further, the membership expects the organization to design online CME program on CPGs. The survey also suggests that it is feasible to monitor the metabolic parameters in routine clinical practice and carryout various
nonpharmacological treatments. In addition, the survey suggests that polypharmacy is not used much; hence its use should be recommended judiciously.

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There are no conflicts of interest.

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