

# Diploma in primary care psychiatry: Do primary care doctors need training in cannabis use disorder module?

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## ABSTRACT

**Background:** Cannabis is one of the most used illicit substances in India but is under-recognized and under-represented in clinical settings of India, especially at primary care. Patients usually do not seek treatment primarily for cannabis use, but it is identified on pro-active questioning by doctors. The aim is to study the clinical profiles of patients with cannabis use disorders (CUD) at primary care and to derive learning points from collaborative consultations to devise an optional module for CUD primarily for primary care doctors (PCDs). **Methods:** File review of general patients with cannabis use, identified by PCDs during collaborative video consultation module of Diploma in Primary Care Psychiatry, was performed, and their profile and management difficulties were assessed. **Result:** Twelve patients with a mean age of  $31.25 \pm 12.04$  years were identified by PCDs over a year. All were males with psychosis being the most common comorbidity. None of the patients presented primarily for cannabis use disorder. **Conclusion:** Identifying cannabis use among patients visiting PCDs becomes all the more important as the use of cannabis is not usually revealed spontaneously unless specifically probed. This warrants establishing guidelines for CUD specifically for use of PCDs for identifying and managing CUD.

**Keywords:** Cannabis, primary care, tele-psychiatrist, video consultations

## Introduction

Cannabis, a widely grown plant in India, is one of the most used illicit substances.<sup>[1]</sup> It is available in various forms: charas, ganja, hashish, bhang. According to the National Drug Survey, 2019, about 2.8% of Indians aged 10–75 years (3.1 crore people) use cannabis. Around 0.66% of Indians aged 10–75 years need

help for their cannabis use. The use of bhang is more prevalent in India as compared to other forms. Uttarakhand ranks 13th amongst the Indian states in terms of cannabis use.<sup>[2]</sup> Cannabis dependence accounts for around 2 million disability-adjusted life years (DALY) globally and has a rising trend with a 22% increase in crude DALYs since 1990, which is largely due to population growth.<sup>[3]</sup> Although it has not been found to directly increase mortality like other illicit substances, but it indirectly increases morbidity and mortality. Cannabis increases the risk of psychosis, respiratory and cardiac problems including lung cancer, reproductive effects, cognitive decline, and road traffic accidents.<sup>[4]</sup> In spite of significant direct or indirect morbidity,

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the proportion of patients seeking treatment for cannabis is very small. According to a study conducted in north India in an addiction center of a tertiary care hospital, only 7% of cannabis users seek help for cannabis<sup>[1]</sup> and only about 11.6% of patients seeking help in various drug treatment centers report cannabis use.<sup>[5]</sup> The situation at primary care maybe even more worrisome. This indicates that even though cannabis use is a menace in India, it appears that it is under-reported, under-detected, under-addressed, and underrepresented in our country. Within this frame of reference, it becomes imperative to proactively assess cannabis use disorders, at least in patients who come with complaints related to drug abuse; not only by addiction specialists but also by primary care doctors (PCDs). The role of PCDs in this context is even more important owing to the lack of mental health and addiction resources and as they are the first contact for the majority of patients with psychiatric disorders across India. However, PCDs in India are not adequately trained to treat psychiatric and substance use disorders.<sup>[6]</sup>

In the context of limited mental health resources and PCDs being the first contact for the majority of the population, task shifting of mental health and addiction services to PCDs appears to be a pragmatic solution for improving the mental health care system and addressing such crunches. A similar approach has been suggested by the Mental Health Gap Action Program (MHGAP) (WHO)<sup>[7]</sup> and the National Mental Health Program of India.<sup>[8]</sup> Tele Medicine Centre, Department of Psychiatry, National Institute of Mental Health and Neuro Sciences (NIMHANS), Bengaluru, India came up with an innovative one-year, part-time, modular-based, digitally-driven, distance-education-based clinical course called as “Diploma in Primary Care Psychiatry” (DPCP) for actively practicing MBBS primary care doctors, especially from resource-poor states of India. Description of DPCP and individual modules have been given elsewhere.<sup>[6,9]</sup>

A batch of ten PCDs from the state of Uttarakhand, India, where the lack of mental health professionals is alarming, was deputed from the National Health Mission of Uttarakhand to the NIMHANS Bengaluru for digitally-driven Primary Care Psychiatry Program (PCPP) where PCDs participated from their hospitals in all modules except initial 10 days basic on-site module. Under the collaborative video consultation (CVC) module of PCPP, a tele-psychiatrist provided video-based consultations for the PCDs to provide collaborative clinical care to selected patients at primary care who needed specialist inputs. CVC module allows PCDs to ask for instant live video consultations from specialists for their chosen patients.<sup>[6]</sup> Under the Tele-On Consultation (Tele-OCT) module, hand-holding training to identify and treat psychiatric patients was conducted as a live, real-time clinical scenario while PCDs were providing consultations to their general patients. This was done to ensure minimal disruption to their clinical work.<sup>[6]</sup>

In the DPCP mandatory curriculum, the cannabis module was not included owing to its lesser prevalence at primary care.

Another important flexible dimension of DPCP course is that there is a provision of optional modules for PCDs depending on their clinical need such as opioid use module,<sup>[10]</sup> cannabis use module, sleep disorders module, headache module, etc., For these disorders, initial training is given during the on-site basic module (classroom training), and the CVC module is used for further training whenever the PCDs come across such patients. In this article, we describe cannabis users at primary care encountered during DPCP training. PCDs were sensitized about cannabis use disorder during the on-site basic module, but as mentioned above Clinical Schedules for Primary Care Psychiatry (CSP), a point of care manual, does not cover cannabis use disorder, so PCDs requested CVC for all cannabis patients they encountered.

The aim of this article is to describe characteristics of treatment-seeking general patients in whom cannabis use was found, along with the difficulties faced by PCDs during their management and to derive teaching/learning point from each patient, which can be used to design and develop optional cannabis use module for PCDs’ use in the future.

## Method

File review method was used for this study. The Ethical Committee of the institute approved this study. All files of one-year DPCP course of 10 PCDs were reviewed for this study. Consultations related to cannabis use either primary or secondary reason were tracked in both consultation-based modules-Tele-On Consultation (Tele-OCT) and CVC modules. A total of 22 Tele-OCT (6–10 patients in each session) and 315 CVC patient files were reviewed.

## Results

During the file review, we did not come across any patient who had a history of cannabis use in the Tele-OCT module. We found 12 patients with a history of cannabis use in files of CVC module over one-year duration and reviewed the same for this study. Seven PCDs identified these 12 patients. None of the patients consulted PCDs primarily for cannabis use, but the use of cannabis was elicited on proactively questioning for the same by the respective PCDs and then asked for CVC by a trainer tele-psychiatrist from Tele Medicine Centre, NIMHANS.

The Table 1 suggests that, out of 12 patients of cannabis users, 8 presented with psychotic symptoms (including one with catatonia), 2 with an opioid, and 2 with alcohol and nicotine. We did not come across any patients with cannabis use disorder during Tele-OCT sessions when all general patients were seen by the PCD and tele-psychiatrist. Cannabis was identified by the PCDs as an incidental finding only on proactive interviewing, for which they requested CVC. Management included managing comorbid disorders pharmacologically and brief counseling for cannabis use primarily focusing on harm reduction.

**Table 1: Characteristics of Patients with cannabis use (n=12)**

Variable	N (%)
Mean Age	31.25±12.04 years
Sex	All Males
Medical Comorbidity	1 patient had comorbid HIV and TB was on antiretroviral therapy (ART) and anti-tubercular treatment. (8.33%)
Presentation	8 patients presented with a comorbid psychotic disorder (66.67%) 2 patients presented with multiple substance use (alcohol, cannabis, and nicotine). (16.67%) 2 patients were identified from opioid substitution therapy clinic. (16.67%)
Diagnosis	8 patients: Comorbid Psychotic disorder and Cannabis dependence (66.67%) 2 patients: Comorbid Cannabis, Alcohol, and Nicotine use disorder (16.67%) 1 patient: Comorbid Cannabis, Opioid, and Alcohol dependence (16.67%) 1 patient: Comorbid Cannabis, Opioid and Sedatives Dependence
Learning Point for PCD during CVC	understanding psychopathology in 4 patients, deciding management in 8 patients, and demonstration of elicitation of catatonic signs and symptoms in 1 patient
Locus of management	10 patients (83.33%) at primary care Only 2 patients required referral: One patient was referred to a neurologist to rule out organicity in patients with catatonic symptoms for 8 months.
Active use (during a month before consultation)	10 patients (83.33%)

## Discussion

In resource-poor developing countries like India, the scarcity of mental health resources is remarkable, and PCDs are the first point of contact for patients with psychiatric and substance use disorders. However, not only in developing countries but also in developed countries PCDs may feel inadequately prepared to cater to the needs of these patients. In a study to determine how primary care physicians address substance use disorders, less than 20% described themselves as very prepared to identify alcoholism or illegal drug use, and more than 50% of the patients with substance use disorders said their primary care physician did nothing to address their substance abuse.<sup>[11]</sup> This article describes the profile of patients with cannabis use at the primary care level and the effectiveness of digitally-driven CVCs between tele-psychiatrist and PCDs in managing these patients. Cannabis is one of the most underdiagnosed substance use disorders amongst psychiatric inpatients.<sup>[12]</sup> Also, looking at the population requiring help for cannabis use disorder, it is important to sensitize not even mental health professionals but also PCDs to actively look for comorbid cannabis use disorder and take steps to manage the same.

All patients with cannabis use at primary care were males with a mean age of 31.25 ± 12.04 years and none of the patients in our study sought consultation primarily for cannabis at primary care. The most common comorbidity with cannabis use was psychosis (66.67%). Similar results have been seen in other studies.<sup>[13]</sup> This indicates that not only substance use patients, but all psychotic patients and young adults should also be proactively screened by PCDs for cannabis use. Screening, brief intervention, and referral to treatment is an evidence-based approach in case finding in substance use disorders. Brief intervention by PCDs has promising results in cannabis use disorders.<sup>[4]</sup> Patients' visits to a primary care clinic may also contribute to expand the reach of prevention

programs and provide a “teachable moment” for brief interventions (BIs).<sup>[14,15]</sup>

PCDs can try to establish a positive therapeutic relationship, express empathy, incorporate motivational interviewing and determine goals or help in establishing goals of either abstinence or harm reduction, and provide practical strategies to reduce harm in patients with cannabis use disorder. In the above sample, around 85% of the patients were managed at the primary care level and only around 15% of patients required referral to addiction specialists. Conditions requiring specialist referral are usually persistent use despite recognition of harms, those with severe comorbid mental health problems, and those who are pregnant.<sup>[16]</sup> So, it does not appear to be an unrealistic goal to train PCDs in identifying and initiating management of cannabis use disorder at primary care. This would help in retaining these patients in the treatment program and regularly sensitize them to the potential harms of cannabis use. Also, as per India's Narcotic Drugs and Psychotropic Substances (NDPS) Act, 1985, the production, manufacture, possession, sale, purchase, transport, and use of cannabis is a punishable offense.<sup>[17]</sup> It was earlier included in the same category as heroin and synthetic opioids. But in 2019, the World Health Organization recommended loosening of control on cannabis in favor of research for its medicinal use. On 2 December, 2020, “Commission on Narcotic Drugs” of “United Nation” voted to remove cannabis from the most tightly controlled drugs to less tightly controlled drugs. However, the commission has not completely legalized cannabis and it continues to list cannabis among drugs that are “highly addictive and liable to abuse.” The point to focus here is that India was one of the countries to vote in support of this.<sup>[18]</sup> With the above-mentioned policy change in favor of medicinal use of cannabis, the cannabis growth and use/abuse in India is likely to increase. This is likely to increase the potential for intervention by primary care doctors in India. Substance use screenings in primary care are usually envisioned to identify patients in need of further assessment and

treatment, but they may also be worthwhile in identifying patients at risk for poor health outcomes and acute care utilization.<sup>[19]</sup> This also warrants establishing a guideline for cannabis use disorder, which can be used specifically by PCDs to identify, treat, and refer patients of cannabis use disorder.

### Future directions

Addition of an optional module of cannabis disorders in CSP for needy PCDs is warranted.

### Conclusion

The majority of cannabis use/dependence patients present primarily with complaints other than cannabis use, most common being psychotic symptoms. Especially in cases of acute onset psychosis, PCDs need to rule out cannabis-induced psychosis for proper management. No specific pharmacotherapy for CDS is available; hence, PCDs may be trained in harm reduction strategies and brief counseling/intervention for cannabis use, along with managing these primary psychiatric disorders in these patients.

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### Conflicts of interest

There are no conflicts of interest.

### References

- Sarkar S, Parmar A, Singh A. An exploratory study of cannabis use pattern and treatment seeking in patients attending an addiction treatment facility. *Indian J Psychiatry* 2020;62:145-51.
- Ministry of Social Justice and Empowerment G of I. Magnitude of Substance Use In India-2019 [Internet]. 2019. Available from: <http://www.ndusindia.in/report.html>.
- Degenhardt L, Ferrari AJ, Calabria B, Hall WD, Norman RE, McGrath J, *et al.* The global epidemiology and contribution of cannabis use and dependence to the global burden of disease: Results from the GBD 2010 study. *PloS One*. 2013;8:e76635.
- Turner SD, Spithoff S, Kahan M. Approach to cannabis use disorder in primary care: Focus on youth and other high-risk users. *Can Fam Physician* 2014;60:801-8.
- Ray R, India. Ministry of Social Justice and Empowerment, United Nations Office on Drugs and Crime. Regional Office for South Asia. The Extent, Pattern and Trends of Drug Abuse in India: National Survey [Internet]. Ministry of Social Justice and Empowerment, Government of India and United Nations Office on Drugs and Crime, Regional Office for South Asia; 2004. Available from: <https://books.google.co.uk/books?id=pB5iGwAACAAJ>.
- Manjunatha N, Kumar CN, Math SB, Thirthalli J. Designing and implementing an innovative digitally driven primary care psychiatry program in India. *Indian J Psychiatry* 2018;60:236-44.
- World Health Organization. Mental health action plan 2013-2020. 2013. ISBN: 9789241506021.
- Roy S, Rasheed N. The national mental health programme of India. *Int J Curr Med Appl Sci* 2015;7:7-15.
- Pahuja E, Santosh KT, Harshitha N, Fareeduzaffer, Manjunatha N, Gupta R, *et al.* Diploma in primary care psychiatry: An innovative digitally driven course for primary care doctors to integrate psychiatry in their general practice. *Asian J Psychiatry* 2020;52:102129.
- Pahuja E, Kumar S, Kumar A, Uzzafar F, Sarkar S, Manjunatha N, *et al.* Collaborative video consultations from tertiary care based telepsychiatrist to a remote primary care doctor to manage opioid substitution therapy clinic. *J Neurosci Rural Pract* 2020;11:498.
- Abuse S. Missed Opportunity: National Survey of Primary Care Physicians and Patients on Substance Abuse. Columbia Univ., New York, NY.: National Center on Addiction; 2000.
- Ley A, Jeffery D, Ruiz J, McLaren S, Gillespie C. Underdetection of comorbid drug use at acute psychiatric admission. *Psychiatr Bull* 2002;26:248-51.
- Lai HMX, Sitharthan T. Exploration of the comorbidity of cannabis use disorders and mental health disorders among inpatients presenting to all hospitals in New South Wales, Australia. *Am J Drug Alcohol Abuse* 2012;38:567-74.
- Walton MA, Resko S, Barry KL, Chermack ST, Zucker RA, Zimmerman MA, *et al.* A randomized controlled trial testing the efficacy of a brief cannabis universal prevention program among adolescents in primary care. *Addiction* 2014;109:786-97.
- Monti PM, Barnett NP, O'Leary TA, Colby SM. Motivational enhancement for alcohol-involved adolescents. In: Monti PM, Colby SM, O'Leary TA, editors. *Adolescents, Alcohol, and Substance Abuse: Reaching Teens Through Brief Interventions*. New York: Guilford Press; 2001. p. 145-82.
- Winstock AR, Ford C, Witton J. Assessment and management of cannabis use disorders in primary care. *BMJ* 2010;340:c1571.
- Government of India. THE NARCOTIC DRUGS AND PSYCHOTROPIC SUBSTANCES ACT, 1985. 1985.
- UN drug agency votes to remove cannabis from list of most dangerous drugs [Internet]. *The Indian Express*. 2020 [cited 2020 Dec 10]. Available from: <https://indianexpress.com/article/world/un-drug-agency-votes-to-remove-cannabis-from-list-of-most-dangerous-drugs-7082740/>.
- Matson TE, Lapham GT, Bobb JF, Johnson E, Richards JE, Lee AK, *et al.* Cannabis use, other drug use, and risk of subsequent acute care in primary care patients. *Drug Alcohol Depend* 2020;216:108227.