

CONSULTATION LIAISON PSYCHIATRY - I

Experts Meeting at Srinagar 03072026:

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Priority Thesis areas identified in CLP, based on expert consensus:

1. Delirium
2. Self-harm
3. Compliance in medical disorders/addiction
4. Sleep
5. Illness perception
6. Rating scales

PG thesis topics on each of the above areas are listed below in the framework of P-I-C-O (Population, Intervention/Exposure, Comparison/Control, Outcome) in addition to study design.

DELIRIUM	
01	Incidence, course, risk factors and resolution of delirium in different settings
	Research gap: Prospective, multi-setting Indian data on the incidence and natural course of delirium are limited; most existing work is cross-sectional prevalence estimation confined to a single ICU or ward, so the true burden, risk-factor profile, and trajectory of delirium across the full spectrum of general-hospital settings in India remain poorly characterized. Objective: To determine the incidence, risk factors and clinical course of delirium across different medical, surgical and intensive-care settings. Population: ICU setting, ward, age groups, time span, diagnosis/disease, medical vs surgical I/E – Exposure – to meds, substance use, metabolic disturbances Outcome: incidence, course, resolution Study design: Prospective, cohort study
02	KAP (knowledge, attitude, practice) about diagnosis and management of delirium amongst physicians and allied healthcare professionals (each professional can be a separate study)
	Research gap: Delirium is frequently under-recognized/ underestimated by non - psychiatric clinicians who form the first point of contact for these patients, yet Indian data quantifying the actual knowledge, diagnostic practice and management approach of physicians, critical-care specialists, anaesthetists, nurses and trainees are sparse, limiting the ability to design targeted educational interventions.

	Objective: To assess the knowledge, attitude and practice of other healthcare professionals regarding the diagnosis and management of delirium. P - Nurses, OT, PT, critical care physicians, general physicians I - Sensitization, training C - Nil O – Agreement with treating physician, adequacy of knowledge, Cf of delirium, type of assessment, diagnostic practices, non-pharmacological, referral practices to psych Research design: Cross-sectional, pre-post (controlled /non-controlled, non-randomized).
03	Study of risk factors associated with sub-acute or chronic delirium
	Research gap: Subacute and chronic delirium presentations are frequently mislabelled as dementia in routine Indian clinical practice, yet the risk factors that distinguish this presentation, and the management approaches actually followed, are not well documented, hampering accurate diagnosis and appropriate treatment. Objective: To identify the factors associated with subacute and chronic delirium and to characterize how it is differentiated from dementia in clinical practice. P - Patients in medical and surgical wards, age group, time span I/E – Risk factors, to differentiate from dementia C – Nil O – How these pts are managed at home- family member, home nurse etc Study design: Cross-sectional study
04	Management practices in delirium (pharmacological and non-pharmacological)
	Research gap: So far, as per the evidence, there is no one approved medication for delirium, though several drugs are administered off-label. Some studies have even shown that non-pharmacological approaches are superior to medication. Such an exploratory study from our context can shed insight on making safe and effective medical choices. Objective: exploring different medications and treatment methods in delirium and comparing them. P – ICU setting, ward, age groups, time span, diagnosis/disease, medical vs surgical I/E – different medication, environmental modification, or both. C – Can compare 2 or 3 arms above as decided based on feasibility O – Common management practices, effective management practices, comparative efficacy. Study design: Cross-sectional or longitudinal as feasible.
05	Study of referral patterns of delirium cases to psychiatrists (each specialist can be a separate study)
	Research gap: Not all cases of delirium are referred to psychiatrists. Also, some are referred early in the course and some late. Referral patterns vary widely among specialists. Sometimes delirium is missed esp. if it is hypoactive. There is no uniformity in the referral of delirium patients Objective: To study the pattern of referral of delirium by different specialists to psychiatry

	P – Critical care physicians, general physicians, general surgeons, etc I/E – Nil C – Comparison of different specialists for referral practices O – Time lag in referral, is it different for different specialty; what percentage are not referred at all; advise if followed or not upon consultation... Study design: Cross-sectional study
06	Study of factors associated with delirium (including psychotropic medication) and their role in course and prognosis
	Research gap: Most delirium referrals that psychiatrists see are associated with co-morbidities, especially in old age. It is important to study what medical disorders and what medications affect the course of delirium adversely and hence plan management accordingly. Objective: to study the association of various risk factors associated with delirium P – Patients admitted to different wards with delirium I/E – Nil C – Nil O – Risk factors associated with delirium (medical disorders, psychiatric comorbidities, medication including psychotropic drugs, etc) Study design- cross-sectional study
SELF-HARM	
07	Qualitative study of experiences of patients with self-harm without psychiatric diagnosis
	Research gap: Patients who attempt suicide but do not carry a diagnosable comorbid psychiatric disorder are often under-served by services oriented toward those with clear psychiatric diagnoses, and their lived experience around the attempt has rarely been explored qualitatively in Indian consultation-liaison settings, limiting understanding of the psychosocial drivers unique to this group. Objective: To explore the lived experience of suicide attempters without comorbid psychiatric disorders across the peri-attempt period. P – Self-harm/idea/plan/attempt (or to include all-suicidal behaviour) in subjects without psychiatric diagnosis I/E – Nil C - (Context) - Consultation-liaison psychiatry i.e., medical and surgical wards, ICU, HDU O – experiences - reasons for self-harm, type of coping, mood state, personality, interpersonal relationships, substances etc Study design: Cross-sectional, qualitative study
08	A (qualitative/quantitative/mixed method) study of the attitude of non-psychiatry physicians OR surgeons toward suicide. AND A (qualitative/quantitative/mixed method) study of attitude of allied mental health professionals towards suicide.
	Research gap: Attitude of all medical and allied personnel towards self-harm is not uniformly non-judgemental. There is a lack of awareness on factors leading to self-harm, which leads to a biased attitude. It is important to know to what extent such a

	negative attitude exists among different medical professionals Objective: To study differences in attitude on self-harm among medical professionals P – All non-psychiatry physicians / surgeons / allied mental health physicians I/E – Attitude C – Can compare different specialists' or mental health professionals' attitudes O – Difference in attitudes/referral practices to psychiatry Study design: cross-sectional, exploratory study
09	A study similar to the above may be planned for all 3 components of the K-A-P (knowledge, attitude, practice) model among non-psychiatry physicians and allied mental health staff.
10	An interventional study of psychoeducation to non-psychiatry physicians/ AND allied mental health professionals with a negative attitude towards suicide.
	Research gap: As differences in attitude exist among different medical professionals for self-harm, it is essential to evolve a psychoeducation/sensitization module to address the negative attitude. Objective: To design a educative module to address negative attitudes among medical/ allied health professionals P – All non-psychiatry physicians / surgeons / allied mental health physicians I/E – Psychoeducation module/ sensitization module C – Nil O – Educational intervention for professionals with negative attitudes Study design: Cross-sectional for assessment of attitude/ cross-sectional or prospective for the next phase of the interventional study
ADHERENCE TO MEDICAL DISORDERS/ADDICTION	
11	A study of Psychosocial factors associated with non-adherence to treatment in chronic medical disorders (Eg: CAD, HTN, DM, Bronchial Asthma etc. Each medical disorder can be a separate study)
	Research gap: The psychosocial determinants of treatment non-adherence in Indian patients with chronic medical illness, health beliefs, family/caregiver dynamics, illness burden, stigma and mental-health comorbidity among them, remain fragmented across single-condition studies, without a comparative, cross-condition understanding suited to Indian consultation-liaison practice. Objective: To identify the psychosocial factors associated with treatment non-adherence among patients with chronic medical conditions. P – Chronic medical condition – DM, HTN, CAD, CVA, Asthma, epilepsy, etc E – Psychosocial factors like primary support, secondary support, financial issues, interpersonal issues, marital issues, unemployment etc. C – Nil O – Level of adherence and association with psychosocial factors Study design- qualitative or quantitative or mixed method study
12	The above study can be conducted among patients with substance use disorders also, i.e., non-adherence to medication in substance use disorders.

13	A study of the feasibility and efficacy of Motivational Interviewing to improve treatment adherence among patients with chronic medical disorders
	Research gap: Motivational interviewing has a substantial evidence base for improving adherence in Western populations, but robust Indian interventional data, particularly with a genuine comparator arm, evaluating its feasibility and efficacy when adapted to Indian chronic-disease populations, are scarce. Objective: To evaluate the feasibility and efficacy of motivational interviewing in improving treatment adherence among patients with chronic medical conditions. P – Chronic medical disorder (each disorder can be one study) I/E – Motivational interviewing technique C – Nil O – Level of adherence, effectiveness of motivational interviewing Study Design: interventional, prospective, randomized or non-randomized, cohort
SLEEP PROBLEMS IN MEDICAL SETTING	
14	K-A-P (knowledge, attitude, practice) of treating (non-psychiatry) physicians for sleep problems in patients with primary medical disorders
	Research gap: As sleep disturbance is a common clinical problem in medical wards, it is important to know the level of understanding of sleep problems and their management among non-psychiatry clinicians. Objective: To assess if there is any gap in knowledge, attitude and clinical practice in treating insomnia among non-psychiatry clinicians P – Physicians, interns, PGs of other specialities, nurses I/E – Nil C – Nil O – Knowledge and management practices of insomnia (sleep hygiene, choice of medication, referral pattern to psychiatrists) Study design: cross-sectional
15	Study of management practices in insomnia in medical problems, among non-psychiatry clinicians
	Research gap: Sleep disturbance is common among the medically ill but is frequently under-assessed by treating clinicians, and where recognized, management appears to default to pharmacological approaches; the extent of this practice gap, and whether sleep hygiene and other non-pharmacological strategies are being used, has not been systematically documented in Indian medical settings. Objective: To describe current management practices and referral patterns for insomnia among non-psychiatry clinicians managing patients with medical disorders. P – Treating physicians I/E – Nil C – Nil O – Medication choice, use of ICBT, liaison with psychiatrist Study design: cross-sectional study
16	Feasibility, acceptability and efficacy of internet-delivered CBT (ICBT) for insomnia in medical disorders

	Research gap: Access to trained sleep-focused psychotherapists is limited in India, and while internet/technology-delivered cognitive behavioural therapy for insomnia (ICBT) could offer a scalable solution for patients with comorbid chronic medical illness, Indian data on its feasibility, acceptability and efficacy in this population are lacking. Objective: To evaluate the feasibility, acceptability and efficacy of ICBT for insomnia among patients with chronic medical conditions. P – Patients with insomnia and chronic medical conditions I – Internet-delivered cognitive behavioural therapy for insomnia (ICBT) C – Active placebo O – Insomnia severity Study design- Interventional study
ILLNESS PERCEPTION IN MEDICALLY UNEXPLAINED SYMPTOMS	
17	Illness anxiety in patients diagnosed with medically unexplained symptoms (MUS) referred from the medical and surgical OPD
	Research gap: Illness perception, cause, controllability, timeline and consequences, is likely to shape symptom persistence and health-seeking behaviour in patients with MUS, yet this has been little studied using combined quantitative and qualitative designs in Indian MUS populations, and change in illness perception with treatment has been almost entirely unexamined. Objective: To assess illness anxiety and illness perception, and change in illness perception with treatment, among patients diagnosed with MUS referred from medical and surgical OPD. P – Identify those with illness anxiety / MUS who go back to parent dept 2nd time, despite being referred to psychiatry for follow up I/E – Nil C – Medical disorder O – Their illness perceptions, their pathways, the reasons for not continuing Study design- cross-sectional, qualitative/ quantitative.
18	Illness anxiety and MUS patient population can be two separate studies with same methods as above
19	K-A-P (knowledge, attitude, practice) of physicians with respect to MUS or illness anxiety can be a study with methods explained above under delirium and self-harm.
RATING SCALES IN PSYCHIATRY	
20	Linguistic translation and cultural validation of rating scales
	Research gap: The great majority of standardized psychiatric and consultation-liaison rating scales in use in India were developed and validated in Western, English-speaking populations; where regional-language translations exist, they are often undertaken informally without a standard forward–backward translation and cognitive-interviewing methodology, and without formal psychometric validation, limiting confidence in their clinical and research use. Objective: To linguistically translate and culturally validate a selected rating scale for

	use in the Indian population. P – Specific clinical condition for which the rating scale is used I/E – Translation using the standard WHO method (forward–backward translation with consensus by cognitive interviewing); validation C – Local setting/applicable population O – Reliability and validity Study design: Cross-sectional study
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