


## Introduction

Mental disorders are common and affect all of us at some time, if not ourselves directly then friends, family or work colleagues. Most people who suffer from mental disorders and who receive care from the health service do so in primary care, with the number of consultations for mental disorders second only to those for respiratory infections.<sup>1</sup> The numbers are very high<sup>2</sup> and, while most people suffer from mild conditions and recover quickly, a significant proportion suffer from chronic conditions<sup>3</sup> which cause moderate or high disability.<sup>4</sup> This book has been written to support primary-care professionals, primary care organizations and local health groups in this aspect of their work. It deals with conditions that are frequently seen in primary care and which can be managed effectively by general practitioners and their teams, supported as appropriate by secondary care. For each condition, a brief summary of how to diagnose and manage it is given. The management summaries include information for the patient, advice and support, descriptions of treatment methods and indications for specialist referrals. They are supported by a linked set of resources to help the General Practitioner (GP) or other clinician to carry out the management strategies recommended.

### Resources provided

- **A mental disorder assessment guide.** This is to help the assessment of depression, anxiety, alcohol, sleep, chronic tiredness and unexplained somatic complaint disorders. To use it, start with the screening questions (in top boxes) to explore the presence of disorders and, if the disorder exists, you can continue below.
- **Interactive summary cards.** For the six disorders most common in primary care (depression, anxiety, alcohol problems, chronic fatigue, unexplained somatic complaints and sleep problems) two-page summaries have been produced. One page contains information for the practitioner; the other for the patient. With less information than the main summaries, but easier to see at a glance, they are meant to be used interactively. These are found on the disc, as well as on pages 174–185. They may be printed out and mounted on either side of a piece of A4 card and used

to facilitate discussion between practitioner and patient within a consultation.

- **A linked set of patient information and self-help leaflets** giving more information about the treatment and self-help strategies recommended. These are on the disc and can be printed out and given to patients to help reinforce the information that has been provided and also to encourage active participation in treatment. These vary in length and complexity. Some (for example, the one-page Problem-solving sheet) are suitable for use by General Practitioners in a consultation. Others (for example, the leaflet on Chronic Fatigue Syndrome) are more likely to be used by another member of the team, such as a counsellor, nurse or physiotherapist. The notation (R: x-x)  appears in the text of a summary to indicate the existence of a linked resource leaflet.

### Why were these disorders chosen?

The book contains a list of categories of mental disorders from the ICD-10 classification.

This is the result of a selection process that reflects:

- the public health importance of disorders (ie prevalence, morbidity or mortality, disability resulting from the condition, burdens imposed on the family or community, healthcare resources need)
- availability of effective and acceptable management (ie interventions with a high probability of benefit to the patient or his/her family are readily available within primary care and are acceptable to the patient and the community)
- a reasonable consensus exists among primary-care practitioners and mental-health professionals regarding the diagnosis and management of the condition
- cross-cultural applicability (ie suggestions for identification and management are applicable in different cultural settings and healthcare systems)
- consistency with the main ICD-10 classification scheme (ie each diagnosis and diagnostic category corresponds to those in ICD-10)

All disorders included in this book are fairly common in primary-care settings and a management plan can be written for each of them.

- 2 The section for people with a learning disability has been separately identified because recognition and treatment of mental

disorders present particular difficulties in this group and because mainstream adult mental-health services may not be appropriate for them. Learning disability is, of course, not itself a mental disorder.

### **How the diagnostic and management summaries were developed**

The World Health Organization (WHO) developed a state-of-the-art classification of mental disorders for use in clinical practice and research. The *Tenth Revision of the International Classification of Diseases (ICD-10)* has many features that improve the diagnosis of mental disorders. To extend this development to primary-care settings, where most patients with mental disorders are seen, diagnostic and management guidelines were combined into the WHO book *Diagnostic and Management Guidelines for Mental Disorders in Primary Care (ICD-10 Chapter V, Primary Care Version)*. The guidelines were developed by an international group of GPs, family physicians, mental-health workers, public health experts, social workers, psychiatrists and psychologists with a special interest in mental health problems in primary care, using a consensus approach. The WHO guidelines were extensively field-tested in over 40 countries by 500 primary-care physicians to assess their relevance, ease of use and reliability. This work has been published.<sup>5,6</sup> Field trials using the WHO guidelines continue in various centres in the UK.

The diagnostic and management summaries in this handbook consist of the WHO's *International Diagnostic and Management Guidelines for Mental Disorders in Primary Care*, specially adapted (and up-dated) for use in Britain. They have been adapted in two stages. The first stage of adaptation to the UK setting was carried out in South Bristol by a panel of GPs and multidisciplinary representatives from community mental-health teams, using a consensus methodology. A randomized controlled trial of the handbook in 30 general practices in Bristol, measuring a range of mental-health outcomes, was then carried out.

The second stage of adaptation was carried out by a national, editorial team, coordinated by the WHO Collaborating Centre of the Institute of Psychiatry. The evidence base was reviewed (see below), information on psychological therapies was added, and information (on the Mental Health Act of England and Wales 1983, community resources and referral) was made appropriate to the whole of the UK. Representatives of primary-care nurses, counsellors and patient groups have made valuable suggestions to ensure that the information is accessible to these important groups.

Several rounds of consensus, including a conference, were held to debate the amendments and agree the final text. Names of those involved in this stage can be found in the Acknowledgements section.

The interactive handycards, the diagnostic checklist and most of the patient information leaflets were produced by the WHO's Division of Mental Health and Prevention of Substance Abuse, and endorsed by The Collegium Internationale Neuro-Psychopharmacologicum, the World Organization of National Colleges, Academies and Associations of General Practitioners and Family Physicians and the World Psychiatric Association. Some of the leaflets were developed by the WHO Collaborating Centre for Mental Health and Substance Abuse, as part of the Treatment Protocol Project.

### **The evidence on which the summaries are based**

The diagnosis sections are based on the ICD-10 classification of mental disorders. ICD-10 is itself a consensus document, tested for reliability. The ICD-10 PHC diagnostic criteria presented here have been tested among primary-care professionals to check for validity and usefulness.

References supporting evidence have been given in line with the principles set out below:

#### **a) Treatments (medication and psychotherapies)**

The recommendations about medication are all in line with the British National Formulary (BNF). Where recommendations about medication are unexceptional and in line with both the BNF and established practice for many years, references have not been given.

References have been reserved for key statements about medication and about particular psychotherapies or for statements about which evidence and opinion are divided. It should be noted that most studies have been carried out in a secondary care setting. The mixed presentations of disorders found in primary care means that, generally speaking, both drugs and psychotherapies prove less efficacious, in comparison to placebo, in that setting than they do in more selected groups in secondary care. We have therefore included some discussion about what the evidence says, along with the references to the studies themselves. A grading of the quality of the evidence is also provided in the reference/notes section. Where possible, evidence has been given from Cochrane reviews, high-quality published reviews and meta-analyses or randomized controlled

trials (RCTs). Discussions have been held with experts and authors of key areas of research.

The evidence has been graded as follows:

**Strength of the evidence supporting the recommendation**

A = Good evidence to support

B = Fair evidence to support

C = Preliminary evidence to support

**Quality of the evidence supporting the statement**

I = Evidence obtained from a meta-analysis of trials, including one or more well-designed RCTs

II = Evidence obtained from one well-designed RCT

III = Evidence obtained from one or more controlled trials, without randomization

IV = Evidence obtained from one or more uncontrolled studies

V = Opinions of respected authorities, based on clinical experience, descriptive studies or reports of expert committees. Occasionally the 'respected authorities' comprise collective patient experience. Where this is the case, it is clearly stated.

Where a qualitative review of previously published literature without a quantitative synthesis of the data is referenced, it has been graded in accordance with the type of studies the review includes.

Where a reference is marked 'N', this means that the notes contains additional information or a discussion of the issues, as well as the reference.

**b) Information and advice**

The sections on 'Essential information for patient and family' and 'Advice and support for patient and family' are primarily the result of consensus. There are no trials comparing the outcome of patients given different sorts of advice by their GP. The advice itself is based on a mixture of evidence and consensus of professionals and/or patients. A small number of references to supporting evidence have been given.

**c) Referrals**

The referral recommendations are based on consensus and will vary from place to place, depending on services available in all care sectors.

**Connections to ICD-10 Chapter V**

The ICD-10 PC Chapter V mental disorders classification, primary-care version, is a 'user friendly' version of the Tenth

Revision of the International Classification of Diseases (ICD-10) Chapter V. For practical reasons, the ICD-10 PC is a condensed version of ICD-10 Chapter V for easy application in busy primary-care settings. It has 23 categories instead of 457. It intends to cover the universe of mental disorders seen in primary-care settings in adults. As a classification, it is 'jointly exhaustive and mutually exclusive'. It may seem simplistic; however, it corresponds to the ICD-10 main volume. A chart that shows the grouping of the detailed specialty-adaptation categories into ICD-10 PC categories can be found on the disks.

### **How an individual practitioner might use the handbook**

In the field trials, some practitioners used the summaries as a resource between consultations, to look something up. Others used the summaries interactively with the patient, to help explain the disorder and determine a treatment plan. The appropriate information and/or self-help leaflet can be printed out and given to the patient to reinforce what is said in the consultation. The interactive summary cards can be used to facilitate discussion between clinician and patient.

The text of the handbook, the leaflets and the interactive summary cards have been placed on disc as rich text format files. GPs or other team members, with regular access to a computer, could install the handbook on their computer, for ease of searching.

The handbook will also be a useful resource for educators of all generalist doctors and nurses.

### **Patients as partners**

It is crucial for practitioners to decide on a management plan in partnership with the patient. This will help reduce the well-documented high level of 'non-compliance', where people do not take the medication prescribed for them. A partnership approach also lays stress on the patients' responsibility to help themselves. Many patients get better faster, or cope better with chronic illness, if they are actively involved in understanding what is happening to them and making changes to their lifestyle. Because the summaries are brief, they may appear prescriptive. Yet we hope that they can be used as a basis for discussion between the practitioner and patient about what is happening to them and why, which takes account of the patient's personal and cultural beliefs, and that they can together agree a plan of what to do.

### Care programme approach

Where a patient is receiving care from mental-health services, they should have a Care Programme (comprising a written care plan reviewed regularly, and a named key worker who coordinates their care). There needs to be clear agreement about which elements of care are provided by the GP and which by the community team. Both team and patient need to know what the plan is in case of relapse, and have names and telephone numbers of the key people to contact easily to hand (eg the key worker identified on the front page of the notes). The summaries assume that these discussions will take place.

### Needs of carers

People with chronic disorders are often cared for by friends or members of their family. The strain on these informal carers can be severe, resulting in an increased risk of both physical and mental ill health. It is important to review how the carer is managing and to encourage them to find ways of reducing the stress on them. Self-help groups, day care and respite care can all help. An assessment of the needs of the carer (under the Carer's Recognition and Services Act) can be requested from the local Social Services department. This advice is relevant to all chronic disorders and we have not repeated it on each individual summary.

### Beyond diagnosis — a multi-axial approach

A short, diagnostic summary cannot capture the full clinical and social picture. The summaries focus on the diagnosis, severity and duration of the disorder, as an essential prerequisite of a specific management plan. The practitioner needs to add to this, as appropriate, assessing other factors such as social stresses linked to the symptoms, physical health, past and family history and the level of social support available from family and friends. Some of the management strategies outlined in the summaries and patient leaflets are easier for a patient who has good support from family or friends. Increased professional support could perhaps then be focused on those people who are more isolated.

### Medication

Wherever possible, medication recommendations refer to a class of drug or a generic form. Where it is considered particularly useful or important, however, examples of particular, named drugs are given. **These are examples only and should not be**

taken as a **WHO recommendation to prescribe that particular brand**. The summaries should be read in conjunction with the British National Formulary, which contains information on every individual drug.

### **How a practice team, primary care organization or local health group might use the handbook**

#### **Team working and training within primary care**

The diagnostic and management summaries assume that the resources available to primary-care teams will vary widely. The 'support to patient and family' can be offered by any member of the primary-care team, who has suitable training and skills. GP, nurse, health visitor, school nurse, practice counsellor and psychologist may all contribute, and discussion to clarify the roles of each is essential. It will be helpful to carry out an assessment of the mental-health skills available within the team, in order to make best use of the skills of all members and inform practice training plans, as well as referral to external resources. This assessment could be done by an individual practice, group of practices or whole primary care organization. A list of sources of training in primary mental healthcare and a checklist of ways a practice can respond to the mental health needs of its patients is provided on p. 146.

#### **Team working between primary, secondary and social care**

Primary care organizations could use the diagnostic and management summaries as a basis to discuss and agree locally appropriate referral criteria with specialist mental-health services. It would be possible to work on a small number of disorders or to work through all of them. This process might reveal gaps in local services; for example, in the availability of structured psychological therapies for affective disorders. Primary care organizations may wish to consider ways of addressing these gaps in their service development plans or in the commissioning plans of Training Consortia.

Some primary care organizations or health groups might wish to go further and address systems for communication between primary and secondary care. Effective communication is a crucial element of effective care, and misunderstandings between primary care and mental-health services are very common.

8 Primary-care teams and community mental-health teams may

wish to meet to agree the roles, responsibilities and expectations of each member of both teams. A variety of different models have been tried, to improve communication as a whole and to improve the care of patients who are 'shared' between primary and secondary care in particular. Joint case registers of people with chronic mental illness is one of these. See the 'Further reading' section for sources of more information on this topic.

#### Information about resources in the community

The primary care organization or local health group might also produce a locally appropriate directory of services and community resources and distribute to its constituent practices. The information could be made available on computer or in a wall-chart format. Consideration will need to be given to regular up-dating of this information. Within each practice, the practice manager, or other team member, will need to consider how best to make the patient information leaflets available, how to obtain and insert the information about local services into the template wall charts and how best to make that information readily accessible to patients and all members of the practice team.

#### Localization

The diagnostic and management summaries are meant as a resource to local agencies. They will only be useful if they are actively disseminated — at practice, primary care organization and Health Authority levels. Local adaptation of the summaries to suit particular situations is welcomed and encouraged. To make it possible, we have included the text of the summaries in electronic format on a disc. Locally adapted pages can easily be inserted where required. A template to be filled in with information about local services is provided. While the diagnostic information is standard and used internationally, the management plan, particularly the referral criteria, will vary according to the availability of services locally and the training of healthcare workers.

The copyright for the diagnostic and management summaries rests with the World Health Organization. Where a primary care organization, local health group or Health Authority is producing locally adapted guidelines using the WHO summaries as a basis, we ask that you contact Professor Rachel Jenkins at the WHO Collaborating Centre Office, Institute of Psychiatry, De Crespigny Park, Denmark Hill, London SE5 8AF, UK. Tel: 020 7848 0383; E-mail: r.jenkins@iop.kcl.ac.uk

## References

- 1 McCormick A, Fleming D, Charlton J. *Morbidity Statistics from General Practice: Fourth National Study 1991-1992*. London: HMSO, series MB5 no 3, 1995.
- 2 Ustun TB, Sartorius N. *Mental Illness in General Health Care: An International Study*. Chichester: John Wiley & Sons, 1995.
- 3 Mann A, Jenkins R, Besley E. The twelve month outcome of patients with neurotic illness in general practice. *Psychol Med* 11, 535-550, 1981.
- 4 Meltzer H, Gill B *et al*. *OPCS Survey of Psychiatric Morbidity in Great Britain Report 3: Economic Activity and Social Functioning of Adults With Psychiatric Disorders*. London: HMSO, 1995.
- 5 Goldberg D, Sharp D, Nanayakkara K. The field trial of the mental disorders section of ICD-10 designed for primary care (ICD10-PHC) in England. *Family Practice* 1995, 12(4).
- 6 Ustun B, Goldberg D, Cooper J, Simon G, Sartorius N: A new classification of menta disorders based on management for use in primary care (ICD10-PHC) *Br J Gen Pract* 1995, 45: 211-215.

## Prevalence of mental disorders

### Population and estimated general practice prevalence of mental disorder

Diagnosis	Weekly prevalence per 1000 adults aged 16-64	Number of patients aged 16-64 on GP list of 1800 (Assumes 63% of GP list is aged 16-64)
Mixed anxiety and depression	77	87
Generalized anxiety	31	36
Depressive episode	21	24
All phobias	11	13
Obsessive compulsive disorder	12	14
Panic disorder	8	9
All neuroses	160	182
Functional psychoses	4.4	5

Source: OPCS Survey of Psychiatric Morbidity Report 1. London: HMSO, 1995.

### Variations in prevalence of mental disorders in adults aged 16-64 living in private households in Great Britain between rural and urban areas in the UK

Disorder		Urban	Semi-rural	Rural
Prevalence per 1000 adults				
Neuroses	Women	216	156	150
	Men	133	117	78
Psychoses	Women	5	5	1
	Men	6	5	3

Source: OPCS Survey of Psychiatric Morbidity, Report 1. London: HMSO, 1995.

## General referral criteria for mental disorders

A main objective of the *WHO Guide to Mental Health in Primary Care* is to extend the expertise of the primary-care clinician and improve the cooperation and communication between primary care and secondary mental-health services. With this understanding, the following guidelines have been prepared.

Referral to secondary mental-health services should be considered in the following circumstances:

- if the patient is displaying signs of suicidal intent or if there seems to be a risk of harm to others
- if the patient is so disabled by their mental disorder that they are unable to leave their home, look after their children or fulfil other activities of daily living
- if the GP requires the expertise of secondary care to confirm a diagnosis or implement specialist treatment
- if the GP feels that the therapeutic relationship with the patient has broken down
- if primary care interventions and voluntary/non-statutory options have been exhausted
- if there is severe physical deterioration of the patient
- if particular psychotropic medication is required eg clozapine, lithium or donezepil
- if the patient requests a referral.

When making a referral to secondary mental-health services, social services or voluntary/non-statutory organizations, the GP should:


- have access to a local resource directory
- consider coordination issues around the referral (eg care programme approach, key worker)
- consider implications for the continuing care of the physical health of the patient.

All referral criteria constitute part of the guideline for that particular disorder and assume that, as far as possible, the guideline for diagnosis and management has been followed.

It is helpful if referral letters include as many as possible of the following:

- The patient's name, hospital number (if known), date of birth, address and telephone number
- The presenting complaint
- The reason for referral, including whether for advice only for GP to manage, or for psychiatrist to manage
- Past psychiatric history
- Background
- Current mental state
- Current medication, details of any medication tried in the past few weeks
- Drugs and alcohol history
- Details of carers and significant others.

**Key to signs used in the main text:**

 R: 1-1      A resource relevant to the point in the text may be found on the disk — usually a patient information and self-help leaflet or a diagnostic questionnaire. (R = resource. The number refers to the number of the leaflet or questionnaire.)

N2      The reference section contains further information about the point made in the text. (N = further information. The number refers to the number of the reference.)

F23      This is the code in ICD-10 PC Chapter V (ie the International Classification of Diseases, primary care version, mental health chapter. A full list of how the primary-care codes relate to the codes from the main ICD-10 volume can be found on disk 2.

The '#' code is used in ICD-10 PC Chapter V only. It refers to 'condensed' codes. For example, 'F00# — Dementia' refers to all different types of dementia listed in F00–F03 and their related fourth and fifth character codes.

*Reference numbers.*

A grading of the evidence can be found in the reference section. The evidence has been graded as described in the Introduction.