

## Short Communication

# Proposal Procedure for Primary Care Management of Anxiety or Depression in Spain

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**Keywords**

- Primary health Care
- Depression
- Anxiety
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- Assessment

**Abstract**

**Introduction:** Depression and anxiety are the most common psychiatric disorders attended in Primary Care. This study aims to evaluate the implementation of a simple method to help Primary Care Physicians to assess the patients who may have an anxious and depressive health problem providing them with useful and easy to use tools and to provide them with information on whether or not to allow Temporary Incapacity.

**Methods:** The intervention consisted of three training sessions about depression and anxiety problems, how to manage them in a Primary Care setting and the implementation of a protocol on assessment of anxious or depressive symptoms which included a collection data form for each patient. The form consisted of Ans5 and Dep5scales, a clinical assessment scale, another associated disability scale and the final diagnostic received.

**Results and Discussion:** A total of 135 collecting data forms were obtained. Most people showed moderate disability and also a moderate clinical severity assessment. The most common diagnosis was anxiety depression. This result corroborates the usefulness of the transdiagnostic perspective that anxiety and depression clinic often occur together in many patients.

**Conclusions:** Depression and Anxiety could be assessed and treated more efficiently in Primary Care Settings. The proposal of assessment is valuable due to lack of feasible screening items widespread and accepted. More studies and methods of implementation are needed to be tested in order to get a better assessment and treatment in mental health common illnesses in Primary Care Services.

**ABBREVIATIONS**

PC: Primary Care; PCP: Primary Care Physician; MH: Mental Health; ICD: International Classification of Diseases; TI: Temporary Incapacity

**INTRODUCTION**

Several epidemiological studies in Europe have shown that approximately 25% of patients visiting primary care (PC) have some form of mental disorder [1-4]. This prevalence is very similar in multicenter studies conducted in Spain, with ranges between 29.5% and 53.5% [5-8].

In fact, many authors have referred to them as “common mental illnesses” [9]. Although depression and anxiety disorders

are classified as different diagnostic categories, the concept of common mental illness is valid for the PC services given the high level of co morbidity between these diseases and treatment response similarity [10]. The common mental illnesses tend to cause marked disability and are associated with higher costs in healthcare spending and reduced productivity [11,12]. Many of these conditions are the main cause for labor absenteeism, which is a relevant therapeutic element in some mental illnesses to get better and sooner full recovery.

Anxiety and depressive disorders commonly share multiple vulnerability factors, and respond to similar psychosocial and pharmacological interventions. However, anxiety and depression may also be considered distinct constructs and differ on some

underlying properties. The advent of transdiagnostic approaches for these emotional and anxiety disorders may be helpful in this kind of study [13].

It is therefore very important that the Primary Care Physician (PCP) can effectively treat these diseases because PC is the natural entrance gate of these patients [14]. The probability of treatment of Mental Health (MH) problems is much higher in PC Services than in MH Units [15]. But nowadays, between 30 and 60% of common mental illnesses are not detected by the PCPs [15-18]. This happens even though in recent years the PCP have become increasingly involved in the care of patients with this type of problems [19]. We also know that the use of diagnostic tools might improve detection of anxiety disorders in PC [20].

In recent years, the departments of health in western countries' governments emphasize the need for close coordination between PC and MH services in order to increase the detection of mental disorders and the adequacy of treatment of these [21,22].

The literature has accumulated an abundance of evidence to support collaborative care models between PC and MH and they can be recommended for implementation [23]. In some parts of Spain they have been some experiences of collaboration, such as in the health area of La Ribera in Valencian region [24]. The collaborative program that takes place in La Ribera presents a set of indicators for continuous improvement of the quality of collaboration PC-MH, which include those for the proper management and treatment of such diseases. In Spain, there are government-funded mental health services available to everyone. People who deserve or need to be attended by psychiatrist or psychologist usually are referred by PCP or by the Emergency Department when there is a mental disease.

Our hypothesis is that PCP would have a greater capacity to meet the needs of patients with anxiety and depression through a process established, clear and concise, applicable to these patients. It was established that the PCP would need help to obtain clear information on the severity of anxious or depressive disorders, on how the patient is disturbed by these symptoms and associated disability to help determine whether the patients need Temporary Incapacity (TI) or Disability and whether they should refer or not the patient to MH Services. A TI is a labor situation in which the worker is unable to work while receiving health care from the National Spanish Health Service or Mutual Services associated to some working settings, having a maximum duration established. In psychiatry diseases, TI is often used until the patient gets better and may be able to return to his/her working duties.

This study aims to evaluate the implementation of a simple and useful method to help PCP to assess the patients who may have an anxious and depressive health problem providing them with useful and easy to use tools and to provide them with information on whether or not to allow TI.

## MATERIAL AND METHODS

### Study Location

The health department of La Ribera, in Spain, consists of a total of 31 municipalities, with 259,874 inhabitants in January

2013. Alzira is the biggest town and the Hospital de La Ribera was built there. This department is organized in 11 health areas, consisting of a total of 5 integrated PC health units, 12 PC health units, 25 auxiliary offices and 4 offices that open only in summer. There are 3 MH Adult Units, 1 MH Unit of Adolescence and childhood Disorders, one Eating Disorders Unit and an Addictive Behavior Unit.

### Type of study

Quasi-experimental design or community intervention regarding the assessment of depressive and anxious problems. Regarding the rest of the study, the design was exclusively descriptive (the information concerning the study was not collected previously and the beginning of collection was precisely part of the intervention itself). It was possible to compare before and after this intervention for TI parameters.

The sample consisted of all the patients that attended to routine PCP visits with age above 15 years that had a possible depressive or anxiety problem. It was a study of implantation or real efficiency with the purpose to examine the application of this model of collaboration/link between MH and PC services. All the patients included would be assessed following the data collection form by PCP in order to obtain the information regarding both Depression and Anxiety scales, disability associated to illness, clinical severity assessment and the CIE-11 diagnosis.

### Population and sample

**Target population:** All patients suffering from depressive or anxious problem in PC.

**Study Population:** All patients suffering from depressive or anxious problems in PC within the Department of Health of La Ribera.

### Sample

All patients with a fulfilled data collection form during the months of January to April 2014 with age above 15 years old.

The study variables can be seen in (Table 1).

### Intervention

The intervention consisted of three training sessions for PCP and the implementation of a protocol on assessment of anxious or depressive symptoms in PC which included a collection data form for each patient with Ans5 and Dep5 scales a clinical assessment scale, another associated disability scale and the final diagnostic received (Figure 1). It was proposed that the form were passed to each patient with possible depressive or anxious problems which came to PC in order to determine whether or not there was a case and to try and set out what to do according to the results (Table 2). Case was considered if the patient had answered positively the first two questions Ans5 (feeling nervous during the past two weeks and being unable to control concerns) or Dep5 scale (the main two symptoms of depression: Feeling sad for the past two weeks and hypohedonia). PCP participation was voluntary. These scales had already been used by a multicenter WHO study on mental illness in ICD 11: "Depression, anxiety, and somatic symptoms in primary care centers worldwide: Field study of ICD-11-AP" and they opted by them and not by other methods

**Table 1:** Variables, possible answers and information source.

VARIABLES	POSSIBLE ANSWERS	INFORMATION SOURCE
Anxiety, questions A1, A2, A3, A4 y A5	Yes - No	Data collection form
Depression, questions D1, D2, D3, D4 y D5	Yes - No	Data collection form
Severity clinical assessment	totally normal / sub clinically disturbed / slightly disturbed / moderately disturbed / very upset	Data collection form
Disability	no disability at all / you can perform all activities but with increasing difficulty / deterioration of at least one activity / deterioration of all activities (work outside the home / social activities)	Data collection form
Diagnosis	Anxious depression / Depression Only / Only anxiety	Data collection form
Number of days with Temporary Incapacity (TI)	0-Infinite	
Diagnosis associated to TI in Depression / anxiety	Any ICD-9 diagnoses within depression / anxiety groups associated do TI.	Healthcare electronic system

**Abbreviations:** TI: Temporary Incapacity

**"FULLFILL THIS FORM IF YOU SUSPECT DEPRESSION OR ANXIETY"**

Health system identification number: \_\_\_\_\_ Patient age: \_\_\_\_\_ Patient sex: Man Woman

Check the appropriate box on the questions in the two scales of five items. If the patient answers positively at least one of the first two questions, you should continue asking the rest of the listed questions.

D1 Have you felt depressed every day for the last two weeks?

D2 Have you noticed during the past two weeks that certain activities which used to like you please you less?

D3 Did you concentrate without problems?

D4 Have you had feelings of worthlessness?

D5 Did you felt you want to die or had death-related thoughts?

A1 Have you felt nervous or anxious during the last two weeks?

A2 Have you noticed that you cannot control your concerns?

A3 Have you had trouble relaxing?

A4 Have you been restless?

A5 Have you had fear that something horrible could happen?

In the following questions, mark only one box for each question:

1. The disability associated is

0 = no disability at all

1 = you can perform all activities but with increasing difficulty

2 = deterioration of at least one activity

3 = deterioration of all activities (work outside the home / social activities]

2. My own clinical severity assessment is that the patient is

0 = totally normal

1 = sub clinically disturbed

2 = slightly disturbed

3 = moderately disturbed

4 = very upset

3. My diagnosis (ICD-11-AP] would be:

Anxious depression

Depression Only

Only anxiety

**Figure 1** Collecting data form.

"screening" and valuation given its ease of use (field study of ICD-11-AP, RPC 565, version 2, 04/08/2013). Dep5 and Ans5 scales were developed and evaluate in clinical PC services. Correlations between dimensions of anxious, depressive and somatic symptoms were found to be high [25]. If the questions are used with patients that the clinician suspects may have a psychological

disorder, the positive predictive value of the scale is between 78 and 90% [26].

All forms were collected during May - July 2014 to assess the applicability of the method and also study the possible link to certain TI parameters.

<b>Table 2:</b> Suggestions to PCPs according to disability and clinical assessment severity	
Disability	TI could be appropriate if the patient scores 3. If the patient scores 2 it is recommended an individually assessment regarding the convenience of TI (if the affected activity is essential for the work the patient may need TI procedure). TI is not indicated if patient scores 1 or 0. Every 15 days the patient should be assessed again and can return to work if the patient returns to rate 0, 1 or 2 (without affecting work-related activity)
Clinical assessment severity	When patients scored positive at least the first two questions in Dep5 scale, one must see the score of section 2 in collection data form (clinical assessment of PCP). If section 2 scores 0 or 1 there is no treatment needed. If score is 2, it is suggested a behavioural activation from PC with cognitive behavioural recommendations. If score is 3, pharmacological treatment could be used and therapy may be also useful in PC. Assess again four weeks later and refer the MH if the patient is not better. If rate 4, the patient may need drug treatment and should be referred to MH Services.
<b>Abbreviations:</b> TI: Temporary Incapacity; PC: Primary Care; PCP: Primary Care Physician; MH: Mental Health	

## Analysis of results

Dep5 and Ans5 scales answers, responses in clinical severity and disability associated were explored. Relative frequencies of each of the sections were described and the information was also presented pie charts. The average age of patients and the distribution of the sample by gender were also studied. The results were also presented in pie charts.

The number of days of work absenteeism because of depressed or anxious illnesses coded in ICD-9 (the classification system at that time used in the electronic records) 6 months before (July-December 2013) and 6 months after intervention (May-October 2014) were compared in the basis of electronic health record's diagnosis. The information was presented in bar graphs on days of TI in relation to each condition was presented.

## RESULTS

A total of 135 collecting data forms were obtained. 77% of the sample was women and 23% men. The mean age was found to be 47.6 years old.

Most patients have responded in the Dep5 scale that they had felt depressed every day (D1) and that certain activities which used to like them seemed less interesting in the last two weeks (D2). 57.8% of patients had D1 and D2 items answered positively, meaning that these people were possible cases of depression. Also more than half of patients pointed out that had concentration problems (D3). Slightly more than half of the patients said they had felt uselessness recently (D4). However, the vast majority had no thoughts of death (D5).

Regarding the Ans5 scale, the majority of patients responded that they felt nervous during the last two weeks and that they were not able to control their concerns. That means that those patients were probable cases of some anxious problem. Patients also answered mostly that they had trouble relaxing (A3). Slightly more than half of patients answered that they had been restless and slightly less than half had the feeling that something horrible was going to happen. More detailed information of the answers to the Dep5 and Ans5 scales can be seen in Figure (2).

16% of patients had no disability at all, 33% had increasing difficulties when performing all activities, 34% had a significant

deterioration of at least one activity and 17% showed an intense disability in all activities.

PCPs' clinical severity assessment results can be seen in the figure 3. Most patients were considered mild or moderately altered by the pathology that led them to consultation.

There was no diagnosis in 2% of cases with fulfilled data collection form, depression in 12%, anxiety in 33% and anxiety depression in 53%.

As for data related to the TI in the six months prior to the intervention, the most frequent diagnoses associated were major depressive disorder (single episode or the unrated), anxiety (with and without specification), dysthymic disorder and adjustment disorders of all types. The total number of days of TI regarding any diagnosis in the field of depression and / or anxiety was 42592.

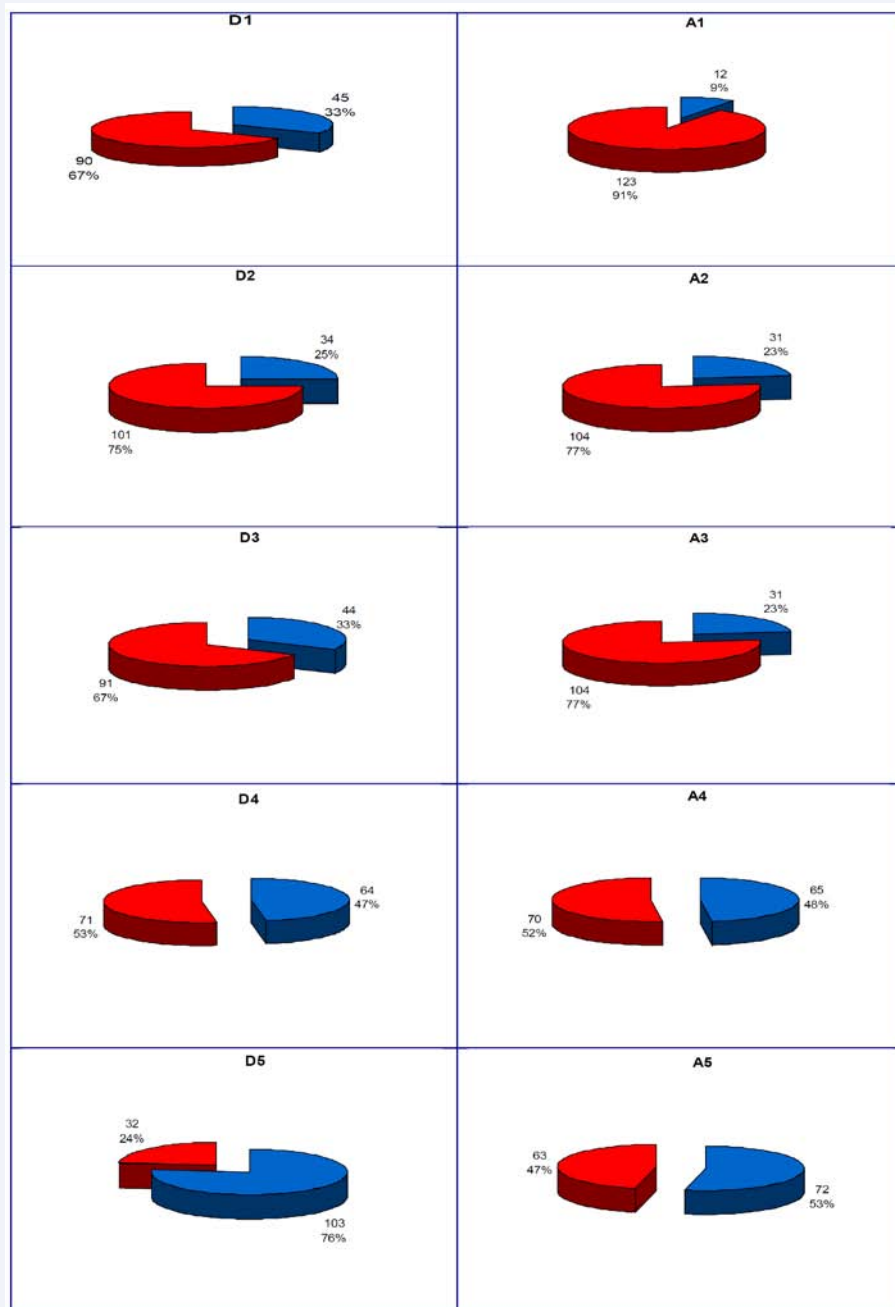
After the intervention the major diagnoses were similar to the previous group, but the number of days of TI related to depression and / or anxiety disorders increased to 59403.

## DISCUSSION

A total of 135 data collection forms were collected. The average age and gender distribution is similar to other Spanish MH studies) [20, 27-29]. Almost all were from patients who did have a problem with depression or anxiety or both. Most patients had mild or moderate disabilities and more than half of diagnoses proposed were anxious depression. Days of TI related to depression or / and anxiety illnesses increased after the intervention.

The number of collection forms data is less than expected. On one hand, the establishment of a new pattern of attention and having to fill a data form it is more complicated than it was firstly thought. Perhaps, PCP filled in only the forms when they remembered the study or when they had enough time. On the other hand, it has been remarkable the variation of implication in the study among the different PCP. It may be helpful to use more emphatic motivational strategies that only the intervention described in this study.

More than half of the patients were treated because of depression and three quarters because of anxiety according to



**Figure 2** Answers to Dep5 and Ans5 in pie charts. Absolute frequencies are shown above relative frequencies. Red means yes and blue means no. Figure 2 sub-headings: 57.8% of patients were possible cases of depression. 74.1% of patients suffered from anxiety disease.

the scales. Otherwise, most of the people responded negatively to both questions about suicidal ideas and fear that something horrible happened. These data may suggest that the Dep and Ans5 scales may not help discern “no cases” or that PCP used the described method only with people who they were sure that had a problem of depression or anxiety.

Moreover, it is noteworthy that, according to PCP, 16% of patients have no disability but only 1% of patients were “normal” according to clinical assessment. One possible explanation is that there are people who do not have disabilities to do their job but the clinicians may think they have emotional pain and they really

have a mental health problem.

Only 3% of patients had no diagnosis in data collection forms, probably because they were used only in patients in whom suspicion of depression and anxiety was very high. The use of this tool is supposed more useful to assess patients in PC when there is doubt (usually masked clinical symptoms, somatoform or more attenuated than a severe case of depression or anxiety). It is evident that this proposal has not been achieved. Perhaps there was a mistake not including a “nondiagnostic” section in the diagnostic section of the collection data form.

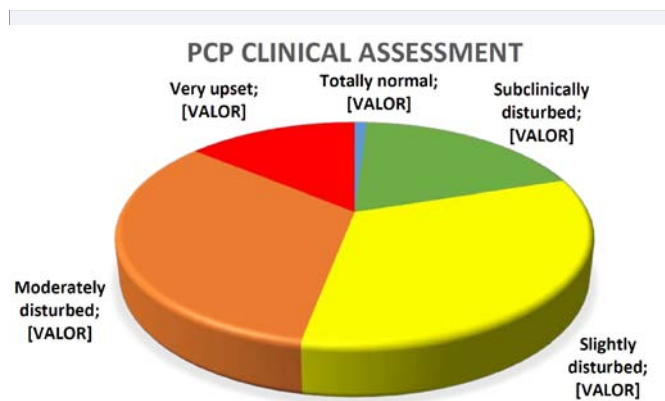


Figure 3 PCP's clinical severity assessment.

It is very remarkable that most patients were diagnosed with "anxious depression". This fact corroborates the usefulness of the transdiagnostic perspective that anxiety and depression clinic often occur together in many patients [13,30–35].

The increase in the number of total days of TI may be related to increased attention by the PCP at the time of this study to detect cases of depression and anxiety. It could also be happening an over-diagnosis of mental illness during this period of time. Findings of other diagnostic studies suggest that PCP both under- and over-diagnose depression [36]. As happened in other studies related, the direct question that they were asked about the possible presence of depression in each patient and the fact that the PCP were aware that there was a study being conducted in this sense may have artificially increased sensitivity to this diagnosis and correspondingly decreased the specificity [37].

## LIMITATIONS

Few collection data forms were received compared to what was expected according to the prevalence and incidence of depression and anxiety in PC settings described in several epidemiological studies [38]. However, the age and sex of our sample is representative of the general population visited in PC settings in Spain [39].

As noted by others screening should be considered only as part of a package of enhanced care [40]. Using methods of "screening" has to be supplemented with a clinical assessment [41]. On the other hand, there are not yet published results in large samples by the WHO in relation to Dep5 and Ans5 scale according to the study of ICD-11 in Spain or similar countries. Regarding this lack of data, the ICD-11 clinical descriptions and diagnostic guidelines were developed with the goal of improving clinical utility while maintaining diagnostic reliability. However, whether this is in fact the case remains an empirical question. The WHO is conducting both Internet-based and clinic-based field trials for the mental disorders section of ICD-11, which are designed to investigate both the clinical utility and the diagnostic reliability of the proposed clinical descriptions and diagnostic guidelines [42].

The intervention is hardly measurable. The work described is immersed in a collaborative framework that exerts an undeniable influence on the results described here.

## Lack of control group

As the system of collaboration between PC and SM has proven positive results for patients, it did not look convenient to do a control group. But it is also true that it had not been possible to make a control group given that the framework of cooperation has been present since the program began in 2006. In addition, all the material presented in the liaison meetings was available to all PCP in the health area through intranet.

Regarding the TI, this study used data of all TI in the health area and not just a sample, which makes not feasible to know the days of TI average per patient. The study also fails to address the issue of presenteeism, which may be evidence now suggests may be even more prevalent and costly amongst those with common mental disorders.

## Contributions of the study

It is a study of applicability in the "real world" with very few comparable studies. This study tries to improve the lack of implantation or "real efficiency" studies. Many studies and interventions developed in idyllic situations that have little to do in daily clinical practice. Doing a study like this without a control group and so far-reaching interventions may have limitations, but also the virtue of having a great external consistency and applicability in other environments similar to ours.

Ambition when assessing and managing cases of depression and anxiety in PC in only one visit. It has been a limitation have fewer data collecting forms filled the expectable in dealing with depression and anxiety, but it is also true that we were satisfied with the profitability of each of the forms filled. With each of these forms the PCP had clear information on whether the patient could suffer anxiety or depression or not, whether to proceed TI or credible information about whether it was advisable to refer the patient to MH services or start treatment and what kind. We believe that the data collection form is a valid proposal to address cases of depression and anxiety in PC, mainly where there are doubts about whether or not the patient has the disease or doubts about the desirability of TI.

It was possible to collect all the information regarding TI days throughout the health area related to any of the diseases studied.

## Future implication and research

Further investigation in common mental health disorders screening in PC is required. It would be necessary to look for concrete strategies to assess depression in PC. In this sense we must not forgive that only the fact to cater training to the MAP at the same time to treat common mental illnesses is not sufficient [43].

## CONCLUSIONS

Depression and Anxiety could be assessed and treated more efficiently in Primary Care Settings.

The proposal of assessment is valuable due to lack of feasible screening items widespread and accepted.

More studies and methods of implementation are needed to be tested in order to get a better assessment and treatment in mental health common illnesses in Primary Care Services.

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