



## Mental Health Services and Primary Care: depressive disorders treatment

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### Summary

The management of depression in Primary Care and the importance of a collaborative relationship with Psychiatric Services have been under considerable scrutiny in recent years. This has been the result of an increased recognition of the high levels of morbidity and mortality, variation in the quality of care, and size of direct and indirect costs to the health service. General practitioners are the first to whom patients with psychiatric symptoms turn, therefore it is necessary that they are able to formulate a correct diagnosis and possibly set up drug therapy or request the intervention of psychiatric services. An efficient collaboration between Primary Care and territorial psychiatry can significantly improve the management of patients with organic comorbidities and elderly patients, but also potentially reduce the risk of suicide.

**Key words:** depressive disorder, Primary Care, Mental Health Services, integrated management

### Introduction

For the Mental Health Departments the development of structured collaborative relationships with Primary Care is functional above all for the management of “common psychiatric disorders”: anxiety, mild-moderate depression, somatization, generally reversible and significantly widespread in the population and associated with important quality of life impairments and disabilities. In contrast, patients with severe depression meet more frequently in the Mental Health Services. In our country, in particular, a transformation is taking place from the structure centered on services, towards an organized system of Primary Care, in which the concepts of prevention and integration with other disciplines have more space. Preservation of mental health represents one of the major objectives of the new organization of Primary Care and, in this perspective, general practitioners need to acquire diagnostic and management tools and skills for the management of psychiatric patients.

It has been calculated that mental disorders are 8% of the workload of Primary Care: more than cardiovascular or tumor diseases. In most cases it is often concomitant anxiety or depression; 34% of the primary care patients are of psychiatric relevance and 50% of general practitioner time is dedicated to dealing with emotional problems <sup>1</sup>.

Every week the number of primary care patients with emotional problems is 5 times greater than that seen by specialists and 50 times greater than those who will be hospitalized in psychiatric facilities. In fact, only 10% of patients are sent to the psychiatrist for two orders of opposite reasons: firstly, most common mental disorders do not require pharmacological treatments or common therapies, secondly statistics say that most of these patients are not recognized by general practitioners, unable to make diagnoses and to introduce effective therapies.

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### Conflict of interest

The Authors declare no conflict of interest.

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Psychiatric morbidity in Primary Care is about 10 times greater than that existing in specialist services, but most of these patients will never reach the specialist facility, partly because it is not recognized by general practitioners, partly because of the prejudices that they keep patients away from psychiatrists <sup>2</sup>.

### Integrated management

Primary Care and psychiatrists work in collaboration with increasing frequency within a reality in which the need for interdisciplinary care is emphasized; the main objectives are the improvement of the quality of the interventions and the reduction of costs.

Saraceno et al. <sup>3</sup> found that the sending rate to the specialist is between 8.5% and 22% in Italy.

In the area of Primary Care, anxiety and depression are the prevalent psychiatric disorders, however only a minority of these patients are identified and treated; the support of psychiatric consultants seems effective in improving the diagnostic and therapeutic skills of Primary Care to enable them to identify and treat these widespread disorders early. It would be desirable that general practitioners have therapeutic skills not only related to the use of psychotropic drugs, but also relational skills capable of containing and supporting people who do not need a Secondary Care.

The General Practitioners remain the figures most often asked to provide help in the field of mental health; a trained general practitioner would be able to identify most of the pathological disorders at their onset and would be able to better define the initial stages of clinical symptomatology. The latter statement suggests the need for constant updating and training for generalist practitioners. Flowchart shows approach to the treatment of depression in Primary Care <sup>4</sup>.

### Clinical epidemiology of depression in Primary Care

Behavioral health problems such as depression, anxiety, alcohol or substance abuse are among the most common and disabling health conditions worldwide <sup>1</sup> and common in primary care setting. Depending on the clinical setting, between 5 and 20% of adult patients, including adolescents and older adults, seen in Primary Care have clinically significant depressive symptoms. Depression is one of the most common conditions treated in Primary Care and nearly 10% of all primary care office visits are depression related. From 2012 to 2018, the proportion of depression visits that took place in Primary Care increased from 51 to 64%. For many patients, depression is a chronic or recurrent illness. For example, up to 40% of depressed older adults meet criteria for chronic depression. Depressed patients with chronic medical illnesses are at greater risk for a chronic course of depression or less complete recovery <sup>5,6</sup>.

National surveys have consistently demonstrated that more

Americans receive mental health care from primary care providers than from mental health specialists and Primary Care has been identified as the “de facto Mental Health Services system” for adults, children, and older adults with common mental disorders. Most patients would prefer an integrated approach in which Primary Care and mental health providers work together to address medical and behavioral health needs. However, we have a fragmented system in which medical, mental health, substance abuse, and social services are delivered in geographically and organizationally separate “silos” with little to no effective collaboration. A recent national survey concluded that two thirds of primary care providers reported that they could not get effective Mental Health Services for their patients. Barriers to mental health care access included shortage of mental health care providers, and lack of insurance coverage <sup>6,7</sup>.

The data of the ESEMeD study <sup>8</sup> referring to Italy showed that, among the individuals who had at least one diagnosis of mental disorder in the last 12 months, 38% turned to Primary Care, 21% to the psychiatrist, 28% to both the psychiatrist and the Primary Care. So about 70% of patients asking for help go to the Primary Care.

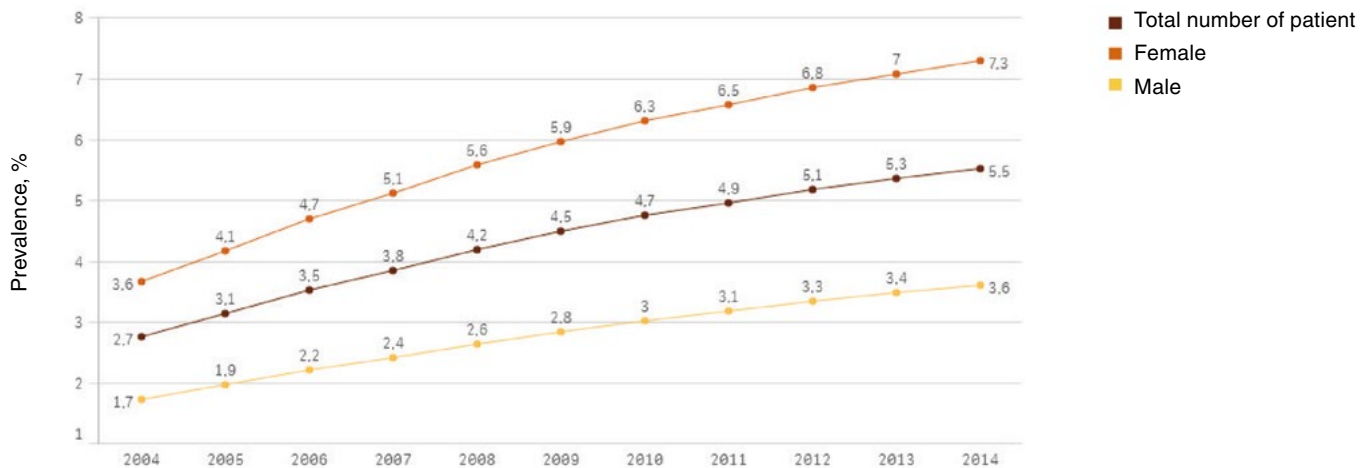
Figure 1 shows lifetime prevalence of depression in Italy, analysed by gender and year (2004-2014). The prevalence of depression shows a growing trend that varies from 2.7% in 2004 to 5.5% in 2014, with estimates significantly higher in women (3.6% in 2004 and 7.3% in 2014) than in men (1, 4% in 2004 and 3.6% in 2014) <sup>8</sup>.

### Screening/diagnosing depression

Depression in Primary Care is underdetected, underdiagnosed, and undertreated. Older adults, men, patients with medical comorbidities, and patients from ethnic minority groups are at particularly high risk of not being recognized as depressed or treated effectively.

The U.S. Preventive Services Task Force (USPSTF) issued recommendations, encouraging primary care physicians to routinely screen their adult patients for depression in clinical settings that have systems in place to assure effective treatment and follow-up <sup>9</sup>.

Brief screening tools for depression are available. A simple question “Do you often feel sad or depressed?” to which the patient is required to answer either “yes” or “no” was tested in a sample of medically ill patients in the community and had a sensitivity of 69% and a specificity of 90% <sup>10</sup>. The Patient Health Questionnaire-2 (PHQ-2) consists of two questions about depressed mood: a) “during the past weeks have you often been bothered by feeling down, depressed, or hopeless?”; and b) “during the past month have you often been bothered by little interest or pleasure in doing things” <sup>11</sup>. Such brief screening tools can be easily administered by office staff or physicians during a primary care visit. Positive response to these questionnaires should alert the primary care provider to further evaluate the patient for depression. Not all depressed patients will



**Figure 1.** Lifetime prevalence of depression in Italy, analysed by gender and year (2004-2014) (adapted from ESEMed/MHEDEA, 2014) <sup>8</sup>.

answer positively to these questionnaires. To address the possible “false negatives”, clinicians may wish to ask additional questions about depressive symptoms for patients who appear depressed, who have a difficulty engaging in care, or whose functional impairment seems inconsistent with objective medical illness.

### Interaction of depression with other chronic illnesses

Successful management of depression in primary care settings is particularly important considering complex interactions between mental and physical health. Major depression is associated with high numbers of medically unexplained symptoms, such as pain and fatigue, and poor general health outcomes. Untreated depression is independently associated with morbidity, delayed recovery and negative prognosis among those with medical illness, elevated premature mortality associated with comorbid medical illness and increased health care costs. Depression also increases functional impairment and decreases work productivity. Depression significantly decreases quality of life for patients and their family members. In a study of 2,558 elderly primary care patients, participants with depression had greater losses in quality adjusted life years than those with emphysema, cancer, chronic foot problems, or hypertension. Depression can also be a barrier to positive and productive relationships between patients and providers <sup>12</sup>.

### Suicide risk

Primary Care has a crucial role in suicide prevention. The data in the literature report that frequently those who commit suicide went to a health worker, first of all a general practitioner, in the months and weeks preceding their death. According to the review by Luoma et al. <sup>13</sup>, 45%

of people who died of suicide had contact with primary medicine in the month preceding suicide. Other studies according to this review indicate that between 25 and 75% of patients who commit suicide have contact with Primary Care in a time span that varies from 30 to 90 days <sup>14,15</sup>.

Extending the period considered up to 180 days, it is learned that 82% of those who die from an overdose had received a medical examination. Anderson et al. <sup>16</sup> in a study including 472 individuals who had committed suicide between 1991 and 1995 in a region of Denmark, observed that as many as 66% of them had consulted a medibase, which said 13 and 7% had been discharged from a psychiatric hospital respectively and from a general hospital. General practitioners often find it difficult to ensure a calm situation in which they can ascertain the risk of suicide <sup>17</sup>. A coordinated management with Mental Health Services and the possibility of consultation between general practitioner and reference psychiatrist is desirable. The general practitioner in suspicion of suicide risk should listen carefully and refrain from any judgment; it should reconstruct the patient’s history and verify the social and family support available to the patient.

Programs aimed at general practitioners with notions regarding the recognition of depression and suicide risk are of great value for exploiting the strategic position of these operators. In 1983-1984 an education program on the recognition of depression addressed to doctors the base of the island of Gotland (Sweden) was followed by a reduction in suicide mortality. The beneficial effects of this program, however, stopped when new doctors replaced those who had taken part in the program <sup>18</sup>. However, the positive effects on the reduction of the suicide rate reappeared when a new program was re-proposed to general practitioners.

More recently, a German study reported a reduction in suicide attempts after an education program on depression <sup>19</sup>. English studies also show that general

practitioner education on how to recognize depression lead to an encouraging better diagnosis and treatment of depression<sup>20</sup>. More recently Szanto et al.<sup>21</sup> reported that in a region of Hungary after a training program aimed at general practitioners to better diagnose depression, a decline in the suicide rate was observed (from 59.7/100,000 to 49.9/100,000 in 5 five years) compared to a region taken as control. In this study, however, the presence of alcoholism made the recognition of depression more difficult and probably did not allow even better results. Notoriously, the general practitioner is trained to deal with somatic emergencies and only with greater difficulty does he face purely psychological emergencies. The result is the poor ability to cope with suicide crises or to relate correctly to those who have attempted suicide. It may happen that the risk of suicide is not suspected when the patient presents with somatic complaints that are not attributable to organic pictures but rather the result of emotional crisis.

What is more serious is the risk of repeating the suicidal gesture on the part of those subjects who came into contact with the healthcare staff, they did not obtain advice on how to behave once they left the place of care, nor the solidarity they hoped to receive from the medical staff.

One of the cornerstones of medical prevention is the diffusion of a culture of the suicidal phenomenon within medical personnel. The general practitioners do not always have those tools and knowledge useful to deal with the risk of suicide. In fact, we are witnessing arbitrary decisions in front of a patient at risk, decisions that for the same case can evoke extremely different responses among mental health professionals. A crucial point in suicide prevention may be reflection on some important data such as that many patients commit suicide within a year of the first visit to a mental health service<sup>3</sup> or that a quarter of people die within a year since the onset of the disease and in the context of contact with Mental Health Services<sup>22</sup>.

### Primary care management of depression in elderly

A meta-analysis, which includes 19 studies conducted in 12 European countries including Italy on over 50,000 over 65 subjects, detects prevalence data of major depressive disorder (major depression, DM) of 3.3% (categorical diagnosis with DSM-IV or ICD-10), a percentage that rises to 27% in the over 85s, and DM previously diagnosed by 16.5%. Although in most developed countries the prevalence remains constant, in Italy found an increase in DM in the over 65s, with values of 9.2% in 2007 and 13% in 2012, ranking ninth among the most common diseases in General Medicine and with more frequent visits (in 47% a time/month, 37% more times/month)<sup>23,24</sup>.

Depressive disorder in the elderly is associated with high comorbidity: poly pathology in 88% of cases (58% cardiovascular diseases, 69% osteoarticular, 25% respiratory, 20% pain, 10% cancer, 17% diabetes) with only one disease in 11%, two in 21%,  $\geq 3$  in 56%. In addition,

depressive disorder is frequently present in comorbidity with various symptoms and neurological diseases, such as insomnia (40%), Parkinson (40%), epilepsy (20-40%). Furthermore reduced levels of quality and availability are a cause of mortality, responsible for 80% of suicides in over 74 subjects. In Italy, low levels of suicide deaths have been reported but, similarly to the world context, the largest share concerns over 65s: one suicide out of 3 is over 70 years old, without gender differences<sup>25,26</sup>.

In addition to major depression we have to consider masked depression (4.9%) and the lower/sub-threshold (10.4% in ambulatory patients, 14.4% in institutionalized patients, 20% in cases with Mild Cognitive are relevant in the elderly Impairment).

Unlike functional genesis in adults, depressive disorder in the elderly mostly recognizes an organic cause, which can be prodromal or a procession to dementia, in particular the vascular form. In developed countries, depressed elderly people turn mainly to Primary Care, obtaining a diagnosis corrected in less than 50% of cases, with higher percentages in the milder forms. Although in Italy there is a better recognition of depressive disorder in the over 65s by Primary Care, which increasingly assumes a role of reference for the elderly population, targeted interventions are needed to optimize the diagnostic-therapeutic process: 35% of antidepressant drugs are prescribed for false positives and 62% of depressed subjects are not treated to<sup>27,28</sup>.

Many psychological, relational and socio-environmental factors contribute to making the diagnosis of depression in the elderly complex: rarefaction of social networks, mourning, unwanted solitude of the places of care, sensorial deafferentation (that due to diseases of sense organs, in particular sight and hearing), emergence of physical and psychological symptoms, tendency to mask the latter with somatic problems, co-presence of chronic pathologies, disability, combination of cognitive deficits with the frailties that tend to accumulate in old age<sup>29</sup>.

Depression is now recognized both as a risk factor and as a prodromal manifestation of degenerative dementias, primarily Alzheimer's disease. The onset of degenerative dementias may even anticipate deficits in the cognitive sphere of a few years, in the form of apathy, social withdrawal, deflated mood, irritability. This implies a proactive attitude of clinicians towards a neurological follow-up cognitive in late-onset depressions.

General practitioners can be assisted in the diagnostic process by using Patient Health Questionnaire 2 (PHQ-2), a short scale derived from Patient Health Questionnaire 9 (PHQ-9). PHQ-2, with a sensitivity of 100%, a specificity of 77% and a positive predictive value of 14%, is indicated to identify elderly patients at high risk of depression. If the score is  $\geq 3$  it is indicated formalize the diagnosis with PHQ-9. The presence of depressive symptoms can be detected and proposed to the general practitioner not only by the patient, but also by the family member, who represents the essential source of information for the correct diagnosis in the clinical setting<sup>11,30</sup>.



Monitoring can also be carried out with the Montgomery-Asberg Depression Rating Scale (MADRS)<sup>31</sup> or the categorical Geriatric Depression Scale (GDS)<sup>32</sup>.

The request for psychiatric consultation, even urgent in the emergency room, is justified on the basis of clinical criteria such as the finding of serious, unusual symptoms, suicidal ideas or plans, or significant functional impairment, on a personal/relational level/working. It should be stressed that depression should not be a diagnosis of exclusion and that its recognition implies management of the elderly patient based on an integrated multidisciplinary approach. Psychiatrist can intervene both for consultancy (diagnostic review and/or management of resistance to treatment), and for monitoring (e.g. serious cases that require hospitalization and activation of extra-hospital social-assistance resources<sup>33</sup>).

### Management models

Primary Care in Italy is ideally positioned in the optimal situation because it is at the center of the National Health Service. This fact is well exemplified by the “gate model” developed by David Goldberg and Peter Huxley<sup>34</sup>. This model aims to describe the most common care path followed by people with mental disorders. According to this model, the path followed by the patient from the general population to the most serious condition of hospitalization can be exemplified in a “gate” system, where each level is related to the presence of a filter, the exceeding of which represents a sort of selection for the patient:

- Level I: psychiatric morbidity in the general population. Filter 1: decision to consult the General Practitioner;
- Level II: total psychiatric morbidity in general medicine. Filter 2: recognition of disturbances by the General Practitioner;
- Level III: psychiatric morbidity recognized by the General Practitioner. Filter 3: sending by the General Practitioner to psychiatric services;
- Level IV: total psychiatric morbidity in psychiatric services. Filter 4: psychiatrist’s decision to hospitalize;
- Level V: psychiatric patients hospitalized.

The National Institute for Health and Clinical Excellence<sup>35</sup> recommends a range of psychological therapies to treat people with depression and anxiety disorders and bring them to recovery. It also recommends these therapies are used to provide a system of stepped care.

Stepped care has two principles:

- treatment should always have the best chance of delivering positive outcomes while burdening the patient as little as possible, and a system of scheduled review to detect and act on non-improvement must be in place to enable stepping up to more intensive treatments, stepping down where a less intensive treatment becomes appropriate and stepping out when an alternative treatment or no treatment become appropriate.

The recommended option within a stepped care model should be the least restrictive of those currently available,

but still likely to provide significant gain in improvement of the presenting problem for the person. The stepped care model is also self-correcting, so if a higher intensity of intervention is required the patient can be supported to access this in a timely way. The definition of “last restrictive” may refer to the impact in terms of cost and personal inconvenience, and well as referring to the amount of time required to support the treatment. In stepped care, more intensive face to face treatments are generally reserved for people who do not benefit from simpler first-line treatments (Fig. 2).

Various clinical guidelines are available to aid the primary care physician in managing patients with depression<sup>36</sup>. However, the primary care physician should also bear in mind that clinical guidelines serve as a guide and should not replace their own clinical judgment, and treatment should be individualised as much as possible to cater to the patient’s best interest.

From the various guidelines it is evident the important role of Primary Care within the whole system and the importance of the correct diagnosis of psychiatric disorder by the General Practitioner (second filter), which conditions the whole process, i.e. taking charge of the patient by the National Health System. It is therefore very important that Primary Care intervention is early, precise and effective, to avoid the worsening of the symptoms with an evident reduction in the quality of life for the patient.

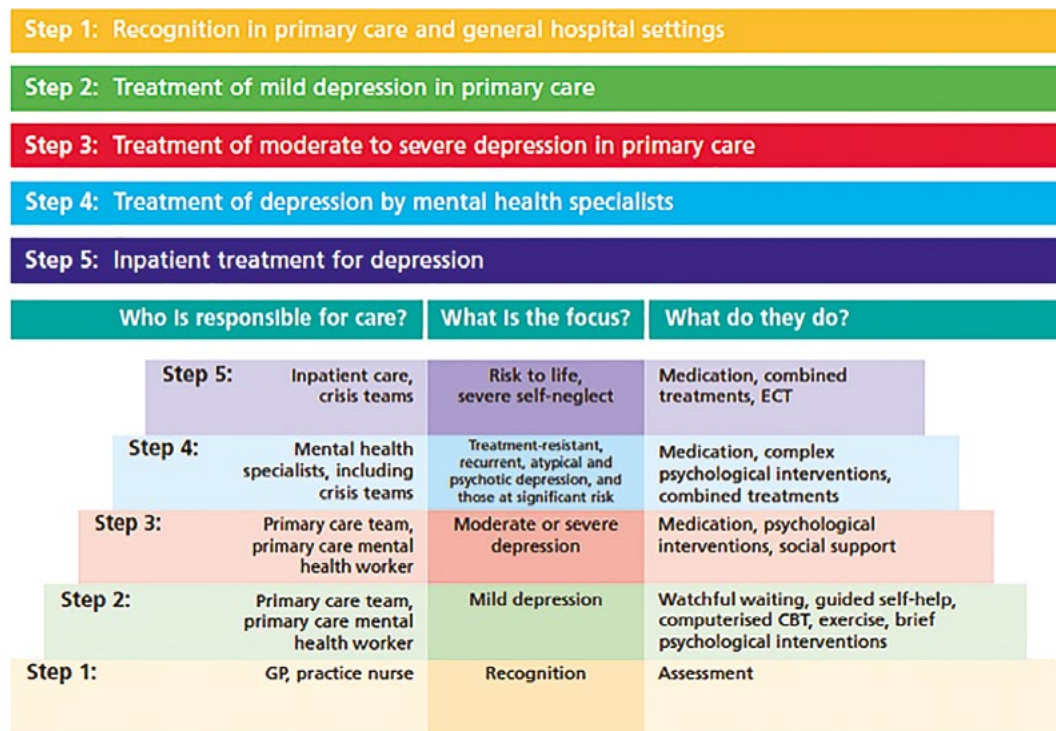
The Goldberg and Huxley<sup>37</sup> model allows us to point out that an accurate diagnosis of psychiatric disorder by General Practitioner is essential; from the literature data it is also possible to maintain that its accurate and early intervention allows to reduce the number of subsequent consultations, decreases the consequences of the disease over time and reduce the duration of pathological episodes.

Despite the evidence of the usefulness of an appropriate approach by, it has been estimated that only 68% of patients with mental disorders ranging from General Practitioner get a correct diagnosis<sup>38</sup>.

In fact, if on the one hand it is necessary to hone one’s diagnostic skills and assume the burden of treating certain patients personally, on the other often a precise classification according to the DSM is impossible for two reasons, described below.

In the first place, in the field of Primary Care, the common emotional symptoms (anxiety and depression) are not synonymous with mental disorder, in fact about 30% of people without mental disorders still suffer from chronic fatigue and 12% of depressed mood<sup>39</sup>.

Most of these symptoms are responses to stressful life events that should not be treated pharmacologically; this concept becomes especially valuable for the general practitioner, who is currently the most important manager of the prescription of psychotropic drugs and therefore the importance of his adequate training in the psychiatric field is evident.



**Figure 2.** The Stepped Care Model (adapted from NICE, 2010) <sup>35</sup>.

Furthermore, the difficulties in making a correct diagnosis derive primarily from the fact that the majority of patients with mental disorders who consult Primary Care present more frequently a physical disorder than a psychological disorder. It has been estimated that in over 90% of cases, in general medicine, psychiatric disorders are initially offered by the patient in the form of somatic disorders (for example, sleep disturbances, the feeling of always feeling tired, the difficulty in managing activities of daily life) <sup>40</sup>.

The ways of presenting physical problems and mental disorders can be summarized as follows:

- somatic symptoms of mental disorders;
- suffering due to physical illness;
  - symptoms that can conceal mental disorders:
  - tiredness, insomnia, lack of energy;
  - vague pains and sufferings, dizziness, headache;
  - worries, tensions and poor memory.

As is known, laboratory tests exist to exclude the organic origin of psychiatric symptoms, but not to confirm their nature. The knowledge of patients and the development over time of an ongoing relationship typical of Generale Practitioner are significant advantages. Making a correct diagnosis, in addition to providing feedback to the patient, also contributes to improving communication between colleagues: in fact the correct transmission of data and collaboration between Primary Care and territorial psychiatry allow both an adequate *referral* (sending patients to specialist services) is an adequate *back-*

*referral* (patients undergoing specialist visits who can be referred to Generale Practitioner).

Finally, we must not forget the crucial role that Primary Care plays in integrating the clinical evaluation and therapy of psychiatric patients with the frequent comorbidities that these subjects suffer from. In fact, there is a significant association between psychiatric diseases and common chronic pathologies (diabetes mellitus, ischemic heart disease, osteoarthritis, chronic obstructive bronchopneumopathy). Examples are the depressive disorder following an ischemic heart disease or the metabolic syndrome favored by the chronic use of neuroleptics in a psychotic patient. Often in these cases, psychiatric pathology, if not recognized and adequately treated, is associated with more modest improvements in organic pathologies and accounts for a greater workload for the family doctor both in terms of a greater number of consultations and in terms of professional commitment <sup>41</sup>.

Another mode of intervention that can help healthcare professionals manage psychiatric patients is the Consultation-Liaison psychiatry<sup>42</sup>. This activity concerns with prevention, diagnosis and treatment of psychopathological conditions that are related to a physical disorder and occur in medical units. Two different types of intervention can be considered: psychiatric consultation deals with diagnosis and treatment (both drug therapy and psychotherapy) of medical inpatients; liaison psychiatry requires a closer cooperation with other physicians and involves relational

issues in medical settings. Research and clinical practice indicated the following trends: to organize specific services of consultation psychiatry that can supply timely measures and continuous and intensive care; to provide professionals who received a specific training in liaison psychiatry and can operate in a team with other physicians.

### Italian experiences of integrated management

Various projects to improve the management of comune psychiatric disorders have been conducted in recent years. We describe two experiences implemented respectively in Emilia Romagna and Lombardia.

In Emilia Romagna for more than ten years, thanks to the collaboration between Mental Health Department, Primary Care and Universities with the support of the Regional Health Department, epidemiological investigations have been carried out, training courses and collaborative projects and links between Primary Care and Psychiatrists<sup>43</sup>.

The “G. Leggieri” program has tried to organize what has been done in recent years, often spontaneously and voluntarily, in all the realities of public health. In fact, in the first phase the experiences were collected, summarized and compared by stimulating an active comparison between the different professional figures through a Regional Training Course and formulating precise indications to the Hospitals to organize formal and corporate work tables, where the actors of the system could meet and carry out joint collaborative actions. At present the further development of the “G. Leggieri” program consists in orienting towards the formulation of appropriate and effective integrated care paths. On the basis of the stepped care model described above, connection programs between Primary Care and Psychiatric Services have been implemented in a logic of networking, which sees the patient and his family at the center of the action in a continuity of care without solutions of continuous.

The VADEMECUM surgery (Evaluation Anxiety and Depression in MEDicine of Community, Monza Unit) represents an attempt response – by the Department of Mental Health of A.O. San Gerardo of Monza – to the request to consolidate an integrated management between Primary Care and Psychiatric Services in order to encourage the diffusion of diagnostic-therapeutic pathways for the population affected by anxious-depressive spectrum.

It is a consulting service that summarizes psychological and psychiatric skills with the aim of offering evaluation interventions for adults with mild to moderate anxiety or depressive disorders. Outpatient activity it was therefore hypothesized to cover a spectrum of specialized services that include interventions of psychodiagnostic framework, psychopharmacological evaluation and advice as well as clinical interviews with patients, interviews with family members and individual counseling. It is therefore

possible – and at the same time it is desirable – that the referral to this surgery, as well as being less stigmatizing, encourage a greater request for psychiatric care, promoting recognition of discomfort.

In almost 90% of cases, at the end of the psychiatric evaluation, have been confirmed – according to ICD-10 criteria – the diagnostic categories of anxiety or depressive disorders should reveal the appropriateness of the referrals formulated by Primary Care and, consensually, the good level of collaboration/integration achieved<sup>44</sup>.

That rate of patients (13% of the population total), for whom psychiatrist made diagnoses other than those related to the anxious-depressive spectrum underlines the importance of perfecting the Primary Care accuracy in the initial evaluation, as well as, moreover, recommended by both the United States Preventive Services Task Force and the National Institute for Clinical Excellence<sup>36,45</sup>.

### Conclusions

A WHO study from 1973 concluded that “In order to develop good territorial psychiatric care, it is necessary to have efficient basic medical services”. Seventeen years later, the same agency (WHO) concluded another study stating that: “In order to develop good psychiatric care by general practitioners, a fabric of good territorial psychiatric services is needed”. These statements highlight the need for interdependence of the two services. General practitioners should develop joint projects with specialists and become more proficient in the ability of psychiatric diagnosis and psychopharmacological therapy. Indeed, it has been shown that the recognition of psychiatric pathology by general practitioners improves the prognosis. At the same time psychiatrists should structure counseling activities to support Primary Care.

Furthermore, more structured assessment methods could prove useful especially in more complex cases, such as in patients suffering from personality disorders, in which the anxiety-depressive symptomatology is only the epiphenomenon of a more complex pathology, or in the prevention of suicidal risk.

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