Comprehensive Protocols with Psychiatry and Primary Care for Depressive and Anxiety Disorders

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SUMMARY

We currently have an extensive base of scientific evidence on the effectiveness of the collaboration programs between the Psychiatry Departments and those of Primary Care for the approach to Depressive and Anxiety Disorders. The problem lies in the heterogeneity of the programs and in the need to establish solid bases for its introduction supported by data on the efficacy of the different components of these protocols.

In this work, we propose a care model for this condition based on management by processes. The clinical management process elaborated among the psychiatry services of a Clinical Management Institute of a University Hospital of Madrid that attends a population of approximately 500,000 inhabitants and the Primary Care Services corresponding to this area is explained. It is aimed to show the methodology for the development and implementation of this Process and the scientific bases for this care management model.

INTRODUCTION

There is an elevated prevalence of mental diseases in Primary Care (PC), this ranging from 14 to 36% in the Western countries.[1-4] It is estimated that approximately 1/3 of the population that contacts on that care level suffers some well-defined psychiatric disorder. This number increases up to 50% in the case of the psychiatric conditions considered as minor ones.[5] Only a small percentage of the patients who come to the general practitioners consultation express psychological malaise, the fundamental complaint being somatic manifestation.[6-9]

The psychiatric disorders that present most frequently in the consultations of the general physician are anxiety and depressive disorders. These are the third most common cause of consultation in PC.[4, 10, 11]

Depression and anxiety are considered as examples of non-self-limiting, chronic diseases, both because of their duration and the extensive population involvement.[12, 13] These conditions represent a significant public health problem given their high grade of associated suffering and functional incapacity.[14, 16]

The high comorbidity of depressive and anxiety disorders with another type of organic conditions, their influence on their course[17-20] and the more global view that the PC professional has of the patient within their setting are factors why these types of patients are mostly treated on this care level.[21] If we add the stigmatization associated to the mental health services to this,[22] we observe that the implication of the primary care physicians (PCP) in the care of depressive and anxiety disorders is essential.

However, the PC professional is faced with several barriers when attempting to carry out a rigorous management of these patients. The first one is the difficulty to detect said disorders and consequently to be able to reach a diagnosis that permits an adequate approach, including the decision to refer the patient to the psychiatry departments.[23-24] Only a small percentage of depressive and anxiety conditions receive formal specialized care.[25]

The second limitation identified is difficulty for effective communication with the psychiatry teams and the limited support received from the psychiatry services in the primary care consultations.[23, 26]

Although communication channels exist between the first care level and the specialized care level in some cases, the coordination between both must be amplified and improved, seeking closer interprofessional collaboration models between primary care and psychiatry departments and mental health,[15, 27-30] especially from the approach that considers depression as a chronic disease.[31, 32]

Considering the difficulties identified in Primary Care to diagnose and treat adequately the depressive and anxiety disorders, on the one hand, and considering the role played by the medical practitioner in the care of these conditions, the need has been recognized to develop new tools to

improve the treatment of these disorders on this care level.[32] A work model that is adapted to the needs of integrated continuing care between Primary Care and Mental Health during the different evolutive phases of the depressive and anxiety disorders and that facilitates systematized and ordered strategies of all the decisions and interventions that should be made is a model based on management by processes.

The Institute of Psychiatry and Mental Health of the Hospital Clínico San Carlos de Madrid (IPySM of the HCSCM) has developed and introduced a clinical management process for depressive and anxiety disorders. This process is made up of integrated protocols between the PC services and the Psychiatry and Mental Health ones.

In the part corresponding to Primary Care, the objective of the clinical management process is to homogenize strategies for the identification, diagnosis and treatment of the depressive and anxiety disorders, decreasing the variability of the practice between the PC professionals and Psychiatry in order to achieve the remission of the clinical episode, its maintenance and a complete functional restitution of the patient.

METHODOLOGY

The management process of depressive and anxiety disorders of the IPySM of the HCSC was elaborated by a work group consisting of psychiatrists, primary care physicians and a specialist in management and health care economy and coordinated by the director or person responsible for the process.

A consensus-based methodology of the work group was used. This included 20 4-hour long meetings held over 9 months. The work method was established following the steps of the management by processes adapted to health care services. Given that this is a process that affects two well-differentiated services, it was necessary to identify the elements of the usual clinical practice and their adaptation to a step-guided model of diagnosis and treatment, inducing a decision algorithm model in both.

In the first place, the subprocesses to be developed were identified, initially establishing four subprocesses:

- Subprocess for Depressive Disorders in Primary Care
- Subprocess for Anxiety Disorders in Primary Care
- Subprocess for Depressive Disorders in Psychiatry Departments
- Subprocess for Anxiety Disorders in Psychiatry Departments

The establishment of the steps for the diagnosis and treatment and associated recommendations was carried out using an expert consensus method, after the work group had reviewed the available scientific literature and the most relevant clinical practice guidelines, taking into consideration their adaptation to the setting and organization frame of the public services where the process is established.

The available scientific literature in English and Spanish regarding the optimization by steps of the diagnosis and the treatment of depressive and anxiety disorders was reviewed.

The intermediate work documents were validated by the administrations of the institutions involved in the process. The final document was distributed among the professionals of the psychiatry departments and a proportion of the PC physicians for contribution of commentaries and corrections.

Once the process was designed, a training session program was carried out among the Primary Care Physicians who were the target of the process. The training was conducted by the physicians who were participating in the work group that created it.

Parallel to the elaboration of the clinical process, an evaluation system was designed, with quality indicators including indicators of results.

The elements that are detailed on the methodology of the process as a whole are shown in the article "Steps for the development of a management process of Anxiety and Depression from Primary Care up to the Psychiatry Departments" in this supplement.

MANAGEMENT PROCESS OF DEPRESSIVE AND ANXIETY DISORDERS IN PRIMARY CARE

Generalities: Limits and reach of the process of Depressive and Anxiety Disorders in Primary Care. Subprocesses in Primary Care

Limits and reach

The process is aimed at the population over 15 years of age who enters into contact with Primary Care or any facilities of the IPySM of the HCSCM and who manifest symptoms that fit into any of the diagnoses included in the process (Table 1). These diagnostic categories, according to the ICD-10 diagnoses, make up the limits of the process. Obsessive -Compulsive Disorders are excluded due to their specific clinical characteristics, as well as Bipolar Disorder.

Subprocess in PC

The gateway for patients with depressive and anxiety

Table 1 Entry limits in Anxiety and Depression Process (ICD-10 criteria)

F32. Depressive episode
F33. Recurrent depressive disorder
F34. Persistent mood [affective] disorders
F38. Other mood [affective] disorders
F39. Unspecified mood (affective) disorder
F40. Phobic anxiety disorders
F41. Other anxiety disorders
F43. Reaction to severe stress, and adjustment disorders

disorders into the process occurs on the first care level, although referrals from other specialties and hospital emergencies should also be considered to a lesser degree. The clinical management process for depressive disorders and anxiety disorders, severe stress reactions and adaptation disorders is a global process in which three key processes have been established, one for PC, another for Outpatient Psychiatric Services, and a third for psychiatric Hospitalization. Four specific subprocesses have been established in the Primary Care setting. Two of them are channeled towards the diagnosis for depression and anxiety disorders and two others are specific for the treatment of these conditions (Figure 1).

Strategies to improve the identification and diagnosis of anxiety and depression in PC

The major problem or limitation for the correct treatment of depressive disorders is their lack of detection or identification.[33, 34] Only 40-50% of patients with major depression are adequately diagnosed by their PC physicians.[35-37] Effective care of these patients begins with the detection of the disorder and their precise diagnosis.[38]

The attitude maintained in the process is to focalize the evaluation on those subjects whose clinical manifestations lead to the suspicion of the clinical presence of a depressive or anxiety disorder or when factors concur that increase the risk of suffering them. Although the use of clinical screening instruments in the population attended in PC has been proposed,[39-42] the results on whether their use by nature only improves the evolution of the disease are contradictory.[43, 44]

One alternative, together with the collection of a complete clinical history, is the elaboration of a systematized protocol for the conduction of the specific clinical evaluation and in agreement with it to be able to determine the treatment setting. In other words, a step-by-step assisted diagnosis.

Use of diagnostic algorithms

Using diagnostic algorithms supposes an aid in decision-making in order to achieve this certainty diagnosis of a depressive or anxiety disorder.[45] To achieve this, a series of decision algorithms based on the following premises is developed within the clinical management process:

- The manifestations presented by the patient should be identified as symptoms or expressions of a mental disease. For that, reference is made to the clinical criteria defined in the ICD-10. The purpose of the comprehensive evaluation of the symptoms is not only diagnostic but also in order to determine the severity of the disorder.

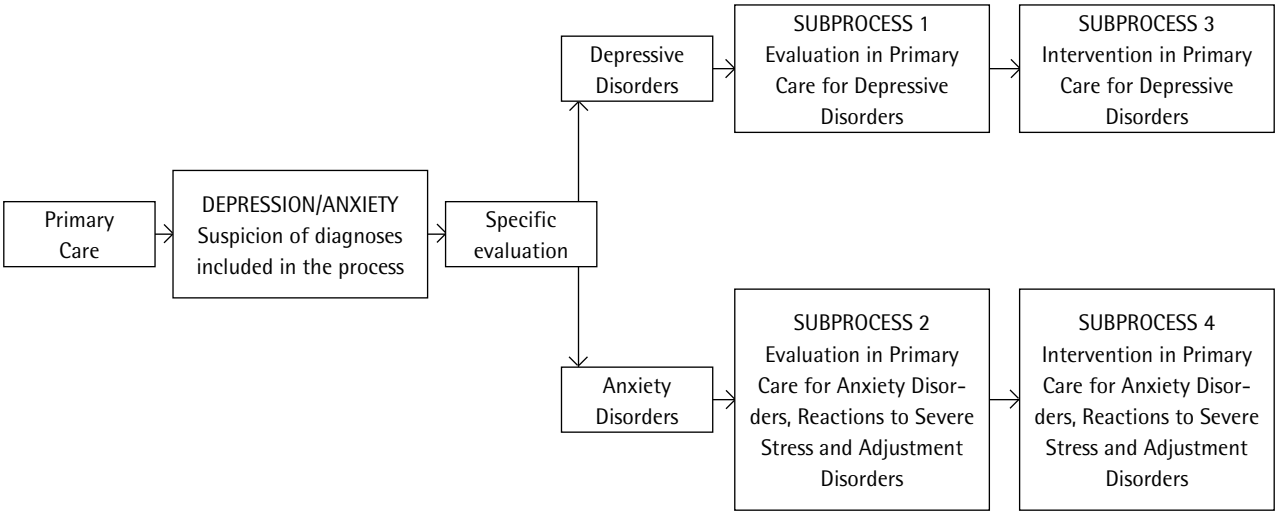


Figure 1 *Subprocesses key in Primary Care*

Some symptoms are indicators of severity by themselves and induce to the consideration of specific alternatives such as a referral to emergency service.

- To make a differential diagnosis excluding the possible organic origin of the symptoms or that they are derived from substance abuse.
- To make a differential diagnosis with other psychiatric disorders.
- Once the clinical diagnosis of depressive or anxiety disorder is determined, identify the specific type of anxiety disorder under study or the number of episodes that the patient has had during the evolution in the specific case of depressive disorders.
- To assess the severity, evaluating the intensity, duration and functional repercussion (use the severity level according to ICD-10 as reference in the case of depressive disorders).
- To consider the comorbidity of these disorders with other diseases, both physical and psychiatric.
- To evaluate risk of suicide.

Subprocess of specific evaluation for Depressive Disorders in PC. (Figure 2)

Subprocess of specific evaluation for Anxiety Disorders, Reaction to Severe Stress and Adjustment Disorders. (Figure 3)

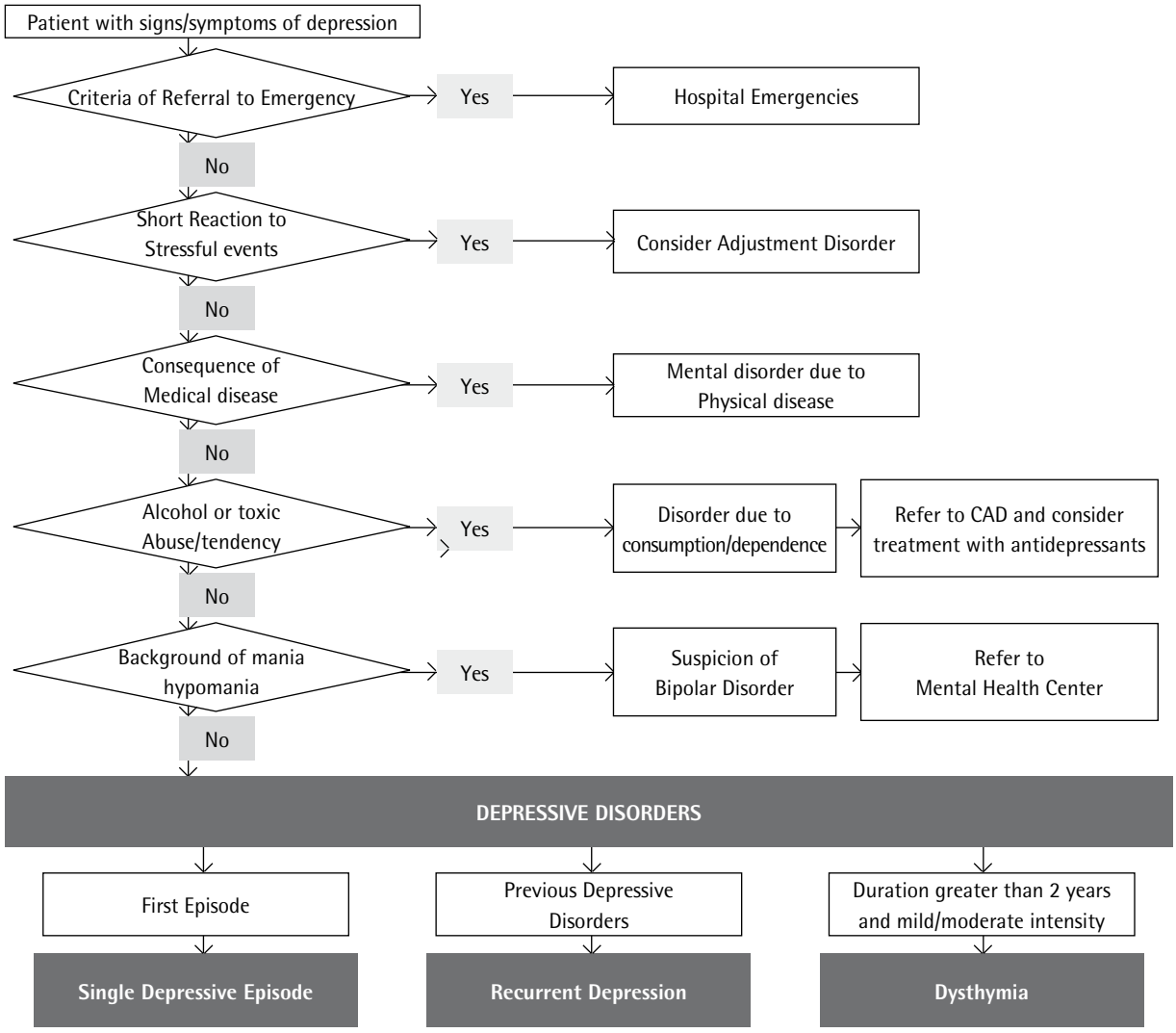


Figure 2 — *Subprocess 1. Specific evaluation for Depressive Disorders in Primary Care*
Source: modified Pascual Pascual P y cols. Guia Clínica El paciente Ansioso. 2005. www.Fisterra.com

Strategies to improve the treatment of depressive and anxiety Disorders in PC

Choice of treatment setting

Once the evaluation and differential diagnosis are made, the PC physician should decide where to carry out the treatment plan. The possibilities include: doing the approach in PC, with or without counseling by the psychiatry services, referral to specialized services, or referral to emergency service for evaluation of hospital admission. The decision is made in accordance with certain factors such as severity of the picture, accessibility to the psychiatric and mental health services and the specific therapeutic approaches required by the case.

Different factors that cause the referrals from PC to Psychiatry and Mental Health to be difficult and not effective have been identified.[22-24, 47, 48] Although there are established criteria with consensus by certain work groups,[49] the indications of referral to specialized medicine from PC in the clinical management process is defined by consensus between the professionals of the two teams involved in accordance with the characteristics inherent to the specific work setting. In this way, some general criteria of referral for any type of psychiatric condition are determined and others specific parameters are established. The specific criteria for the depressive disorders are: presence of psychotic or behavioral symptoms secondary to depressive symptoms that suppose a risk for the patient or for third parties, depression in the puerperium, high recurrence, difficulty in the therapeutic management due to side effects, refractariety in response or maniform symptoms secondary to it. The specific criteria for anxiety disorders are: indication of specific therapies, resistance to treatment, or significant functional and limiting repercussion (Table 2).

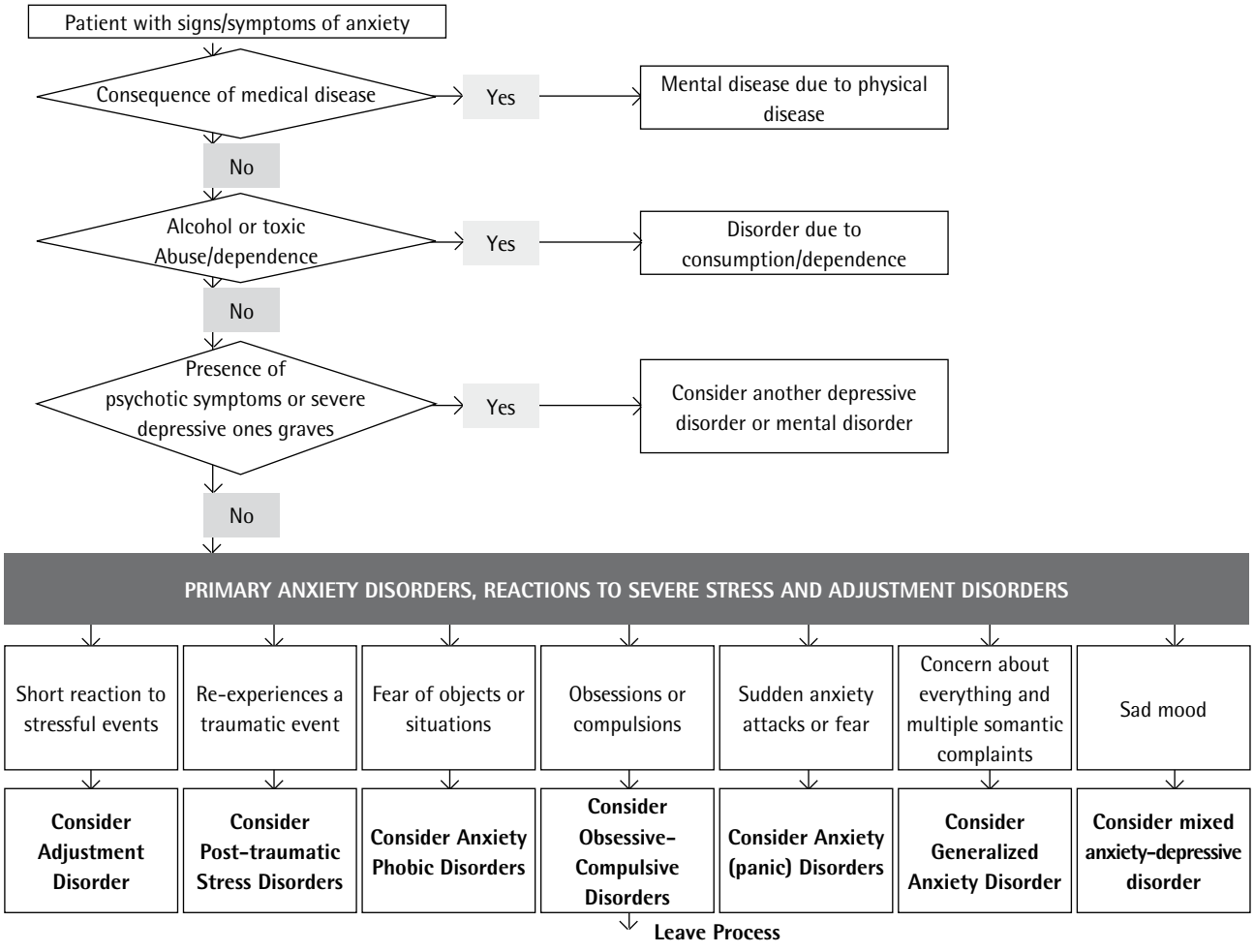


Figure 3 — *Subprocess 2. Specific evaluation in Primary Care for Anxiety Disorders, Reactions to Severe Stress and Adjustment Disorders*
Source: modified Pascual Pascual P y cols. Guia Clínica El paciente Ansioso. 2005. www. Fisterra.com

Table 2 | **Clinical criteria for referral from Primary Care to the Mental Health Center (Psychiatry)**

General Criteria for any disorder

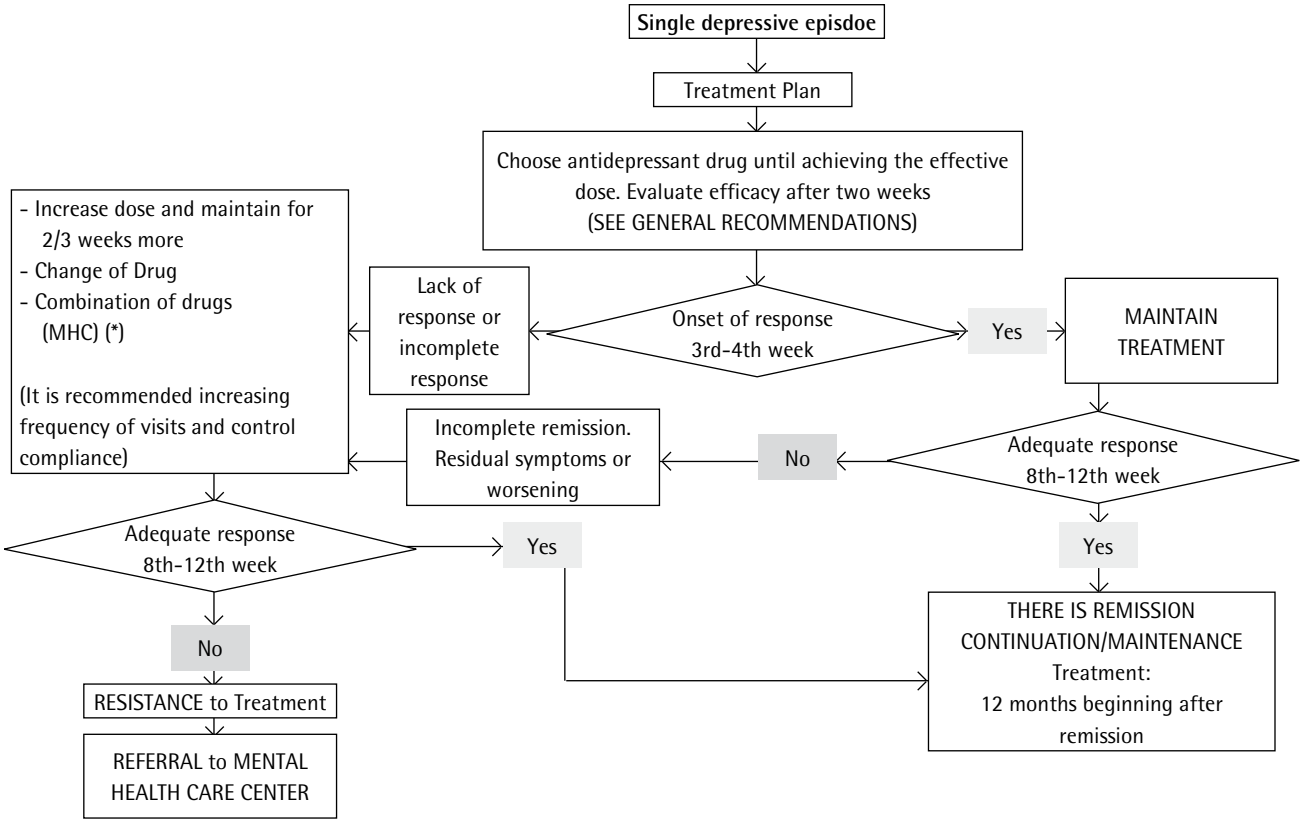
1. Confirmation of the diagnosis if there are serious doubts about it.
2. Difficulty to establish adequate therapeutic relation in PC with a patient susceptible to suffering a psychiatric condition.
3. Worsening of the chronic patient, attending to the specific criteria.
4. When special psychopharmaceutics, mood stabilizers and other potentiating strategies are required.
5. Patients at risk of suicide or heteroaggression.
6. Adolescents under 18 years.

Specific criteria for referral for Depressive Disorders

1. If any of the general criteria are fulfilled.
2. Presence of psychotic symptoms.
3. Important psychomotor alterations (agitation/catatonia).
4. Persistence of the depression with correct treatment at adequate dose and time (refractory depression).
5. Puerperal depression.
6. Maniform symptoms secondary to the treatment.
7. High level of recurrence.
8. Appearance of poorly tolerated or difficult-to-control side effects.
9. Refusal to take medication.

Specific criteria of referral for Anxiety Disorders

1. General criteria.
2. Limiting and incapacitating symptoms.
3. Indication of specific therapies.
4. Persistence of symptoms in spite of correct treatment and during the necessary time.



* Combination of Drugs. Refer to Mental Health Center or Consulting Psychiatrist in Primary Care Program

Figure 4 | *Subprocess 3. Intervention in Primary Care for Depressive Disorders*
Subprocess 3.a. Single Depressive Episode

When the disease supposes a serious threat to the patient or third persons or when active psychotic symptoms are observed, the patient should be referred to the hospital psychiatric emergency service.

There is always the possibility available of consulting between the services prior to the referral. These can be made by telephone or internet within the specific program of "Consulting Psychiatrist in PC." The use of this system may generate a decrease of referrals to specialized services of the moderate disorders and there is evidence about its benefits in training primary care physicians in the detection and management of the mental diseases.[15]

Use of therapeutic algorithms

The objective of the treatment for depressive and anxiety disorders is not only to achieve clinical remission but also to maintain and recover the level of functioning.[32, 49-52] The interventions that should be done are clearly defined and organized.[13, 32] The clinical management process is a model that enables the use of algorithms supported by clinical guidelines,[53-58] thus achieving close monitoring of the symptoms and the treatment. Every algorithm facilitates strategies regarding which treatment should be chosen, how to carry out the guidelines and the order that should be followed when using different therapeutic alternatives.[45, 59, 60] This is a sequential approach in which the professional makes the specific decision regarding the therapeutic process according to certain milestones or critical points,. Although this structure is standardized, one tactic is applied for each patient in particular, establishing individualized plans that help the physician to rationalize the treatment.[60]

The corresponding algorithms, in the case of depressive disorders, in the clinical management process are focused on the number of episodes and duration of the symptoms. In this way, a specific algorithm is established for a first episode (Figure 4), another algorithm for recurrences (Figure 5) and another one for dysthymias (Figure 6). Special emphasis is placed on treatment guidelines not only on the index episode but also on the continuation and maintenance treatment. In the case of dysthymia, its severity is established according to the functional repercussion of the picture.

General recommendations have also been established for the treatment of depressive disorders in the frame of the subprocess (Table 3).

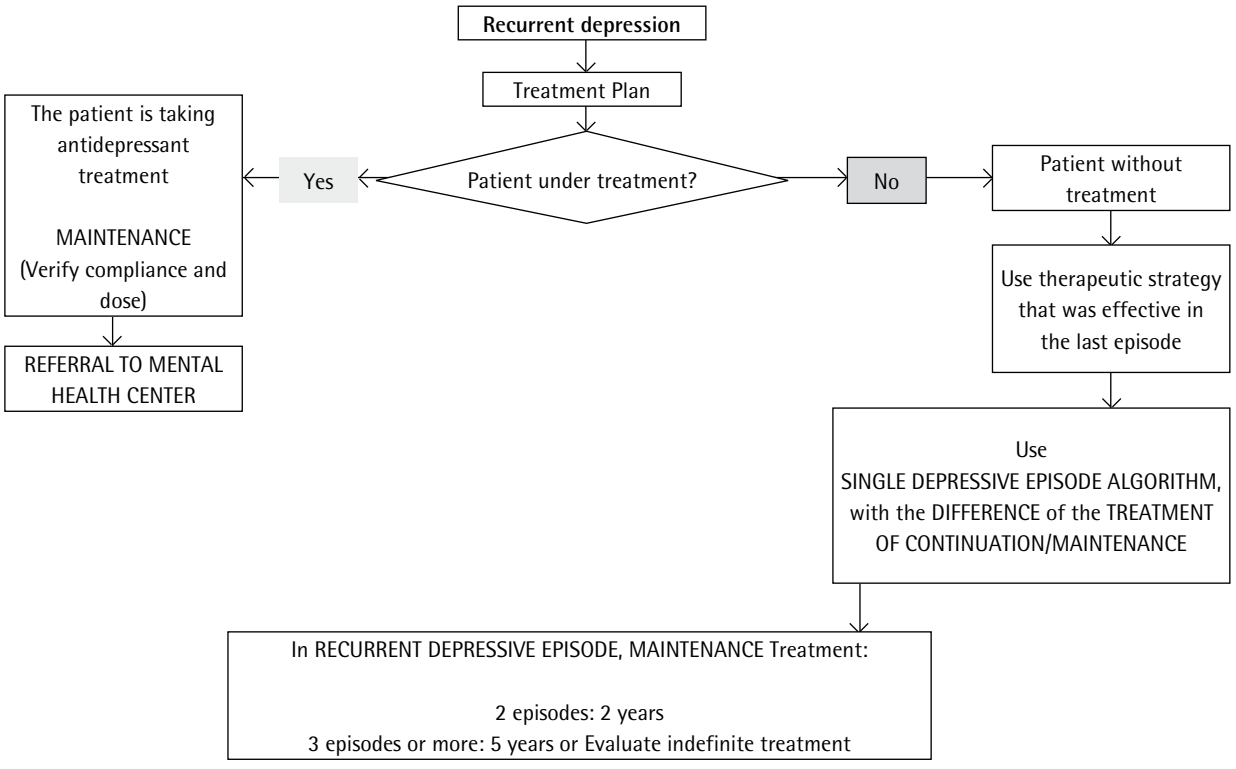


Figure 5 — *Subprocess 3. Intervention in Primary Care for Depressive Disorders*
Subprocess 3.b. Recurrent Depressive Episode

Regarding Anxiety Disorders, the decision trees established correspond to the two most prevalent pictures in PC: Generalized Anxiety Disorder (Figure 7) and Panic Attack Disorder, considering the coexistence or not of Agoraphobia (Figure 8). The general recommendations of treatment for all of the Anxiety Disorders included in the mentioned subprocess are shown in Table 4.

The possibility of having a consultation with specialized care has been contemplated in all of the previous subprocesses. The patient can be directly referred to the psychiatry and mental health service if any of the suppositions defined in the referral criteria are observed or if a specific intervention is needed that requires a rapid response, the option can be used of recurring to the program of "Consulting Psychiatrist in PC" by direct by cell phone or e-mail.

This program consists in a telephone consultation or consultation by E-mail with a reference psychiatrist in each center of specialized care, with a response period of less than three days.

General and specific therapeutic recommendations for Anxiety Disorders and Depressive Disorders in Primary Care

It was long considered that promoting training of the generalized general physician and PC physician would improve the approach to these disorders on the first care level.[59, 60] However, it has been confirmed that if only educational measures are adopted for the primary care professionals, this is not sufficient to improve the management of depression and anxiety because, among other reasons, of the rotation of the physicians in the clinics.[63-65] The passive dissemination of therapeutic algorithms or guidelines among the Primary Care physicians is also not effective.[66]

Therapeutic algorithms and guidelines should be complemented with other measures oriented towards promoting therapeutic adherence and compliance.[67, 68] The Clinical Process facilitates a series of recommendations. These include more complex procedures having a training, psychoeducational, and therapeutic character.

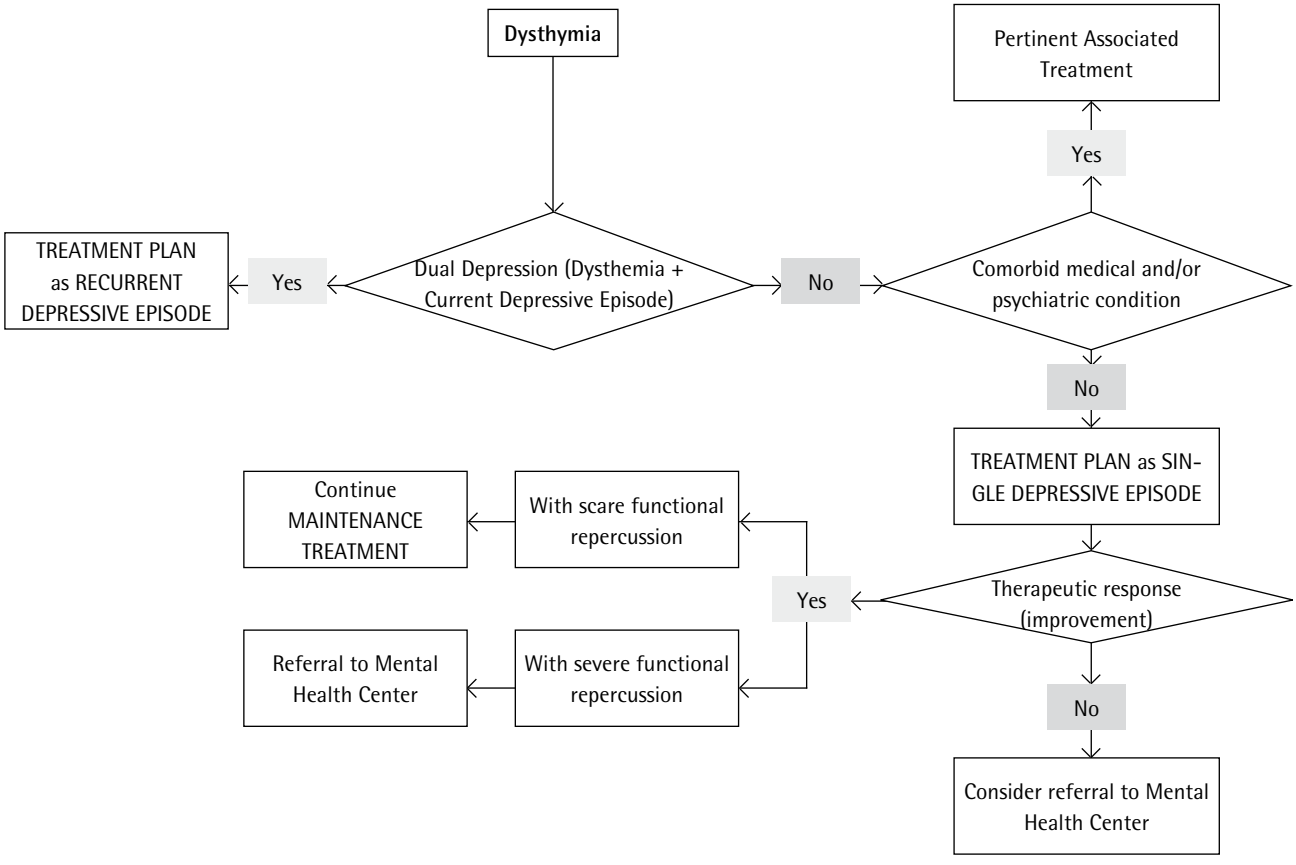


Figure 6 | *Subprocess 3. Intervention in Primary Care for Depressive Disorders Subprocess 3.c. Dysthymia*

Table 3 | **General recommendations for the Treatment of Depressive Disorders in Primary Care (Subprocess 3)**

1. GENERAL CONSIDERATIONS. INITIATION VISITS

Adequate information of the diagnosis to the patient, assuring that the therapeutic intervention is understood and accepted.

Communication on the expected effects of the treatment and time periods in which they may appear.

Communication on the most frequent discomforts and side effects that may appear at the onset of the treatment to avoid alarms and precipitated interruptions from it. Inform that, normally, the side effects decrease in intensity after the continued administration.

Define the action field of the PC physician, informing on the possibility of the use of other resources in case of need (e.g., referral to mental health centers [MHC]).

Evaluation of impulsiveness and risk of suicide.

2. CHOICE OF ANTIDEPRESSANT

Importance of adequate diagnosis with special attention to psychiatric diseases and/or comorbid medical conditions.

Choice of a drug with acceptable profile of side effects and safety for the individual patient individual.

Use of adequate doses. Gradual titration until reaching therapeutic levels.

Duration of adequate treatment according to whether single or recurrent episode is being treated.

In case of previous depressive episodes, prescribe the drug that was clearly effective and well-tolerated in the past.

3. FOLLOW-UP VISITS

Monitoring every 1 or 2 weeks of:

a) Therapeutic response.
b) Therapeutic adherence.
c) Side effects (including the possible emergence of suicidal thoughts and behaviors).

In case of partial or total response, evaluate of the possible causes:

a) Diagnostic rethinking.
b) Lack of therapeutic adherence.
c) Rule or psychiatric and/or medical comorbidity (e.g. alcoholism or thyroid disease).

Therapeutic strategies when there is lack of response:

a) Optimization/Increase antidepressant dose during the adequate time (8-12 weeks).
b) Switch to another drug of a different class or others of the same class but with a different profile of side effects if the problem consisted in poor tolerance.
c) Combination of drugs (reserved to the MHC).

4. CONTINUATION AND MAINTENANCE TREATMENT

In patients responding to treatment, continue antidepressant therapy for a minimum period of 6 months after achieving remission.

Longer duration (years) in patients with chronic course before remission, residual symptoms or multiple previous episodes (3 or more).

Dose: for effective prophylaxis, the same dose that was effective in the index episode is recommended.

Evaluation of side effects and treatment.

Avoid discontinuation syndrome performing a gradual reduction of the treatment after a chronic use.

5. CRITERIA OF REFERRAL TO MHC

1. If any of the general criteria are fulfilled:
   - Confirmation of the diagnosis if there are serious doubts about it.
   - Difficulty to establish adequate therapeutic relation in PC with a patient susceptible to suffering a psychiatric condition.
   - Worsening of the chronic patient, according to the specific criteria.
   - When special psychopharmaceutics, mood stabilizers and other potentiating strategies are required.
   - Patients at risk of suicide or heteroaggression.
   - Adolescents under 18 years.
2. Presence of psychotic symptoms.
3. Important psychomotor alterations (agitation/catatonia).
4. Persistence of the depression with correct treatment at adequate dose and time (refractory depression).
5. Puerperal depression.
6. Maniform symptoms secondary to the treatment.
7. High level of recurrence.
8. Appearance of poorly tolerated or difficult-to-control side effects.
9. Refusal to take medication.

General recommendations

Both in anxiety as well as depression disorders, guidelines are provided on the performance of the PC professional when dealing with the patient with anxiety or depression. In the initial visits, psychoeducational measures aimed at the patient and relatives are added and informative sheets that can be provided to them are even available. This is oriented towards how to plan the therapeutic diagnosis and possibilities to the patient and relatives and the real expectations of such approach. It is indicated how to choose the drug, the use of the antidepressants and anxiety and depression, what dose should be used in the beginning and the difference in the initiation in the case of anxiety versus depression. Furthermore, instructions are given on what effects to expect and when we should expect them.

On the other hand, use recommendations and limitations of benzodiazepines are specified as well as the evaluation within the therapeutic process of the Temporary Work Incapacity and possible risks of it in case of an inadequate indication.

In the successive visits, it is indicated how to carry out the treatment monitoring, indicating the frequency that such monitoring should have, what should be monitored and how to act in the face of side effects, drug intolerance, limited adherence, noncompliance or no therapeutic response.

Considerations regarding continuation and maintenance treatment in anxiety and depression as prophylactics of relapse and recurrences are explained.

Specific recommendations

In this section, the characteristics of pharmacological use and other psychosocial interventions that can be carried out in the PC setting for each one of the anxiety disorders are collected. These include a specific epigraph aimed at the

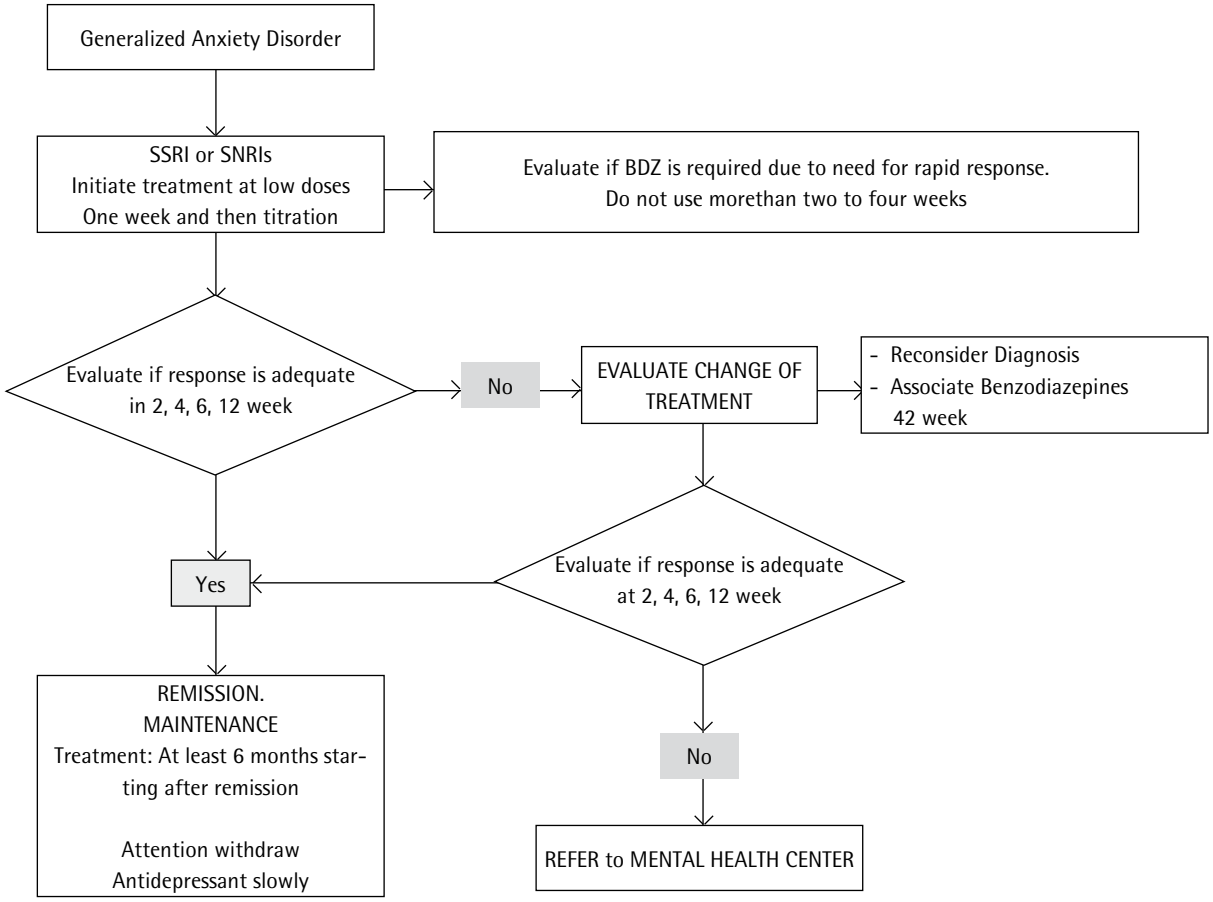


Figure 7 | *Subprocess 4. Intervention in Primary Care for Anxiety Disorders*
Subprocess 4.a. Generalized Anxiety Disorder

Reactions to Acute Stress and to Post-traumatic Stress Disorder.

Strategies to improve the communication between PC and MH. Program "Consulting Psychiatrist in Primary Care"

The use of algorithms and a care system shared between PC and Psychiatry Departments increase the therapeutic efficacy in the depressive patient.[51]

Improvement of communication between both levels is considered necessary.[23] To optimize the coordination, formal and informal contacts should be promoted between PC and Psychiatry, seeking greater accessibility of the primary care physician to the specialist.[21, 69-72] In the clinical management process, a specific support program and specialized counseling have been established for the PC professionals in which their is closer involvement of the "The Institute of Psychiatry and Mental Health (IPySM) of the HCSCM in the primary care setting. The team forming the program is made up of a permanent staff in which both psychiatrists and nursing personnel participate. Contact by telephone or

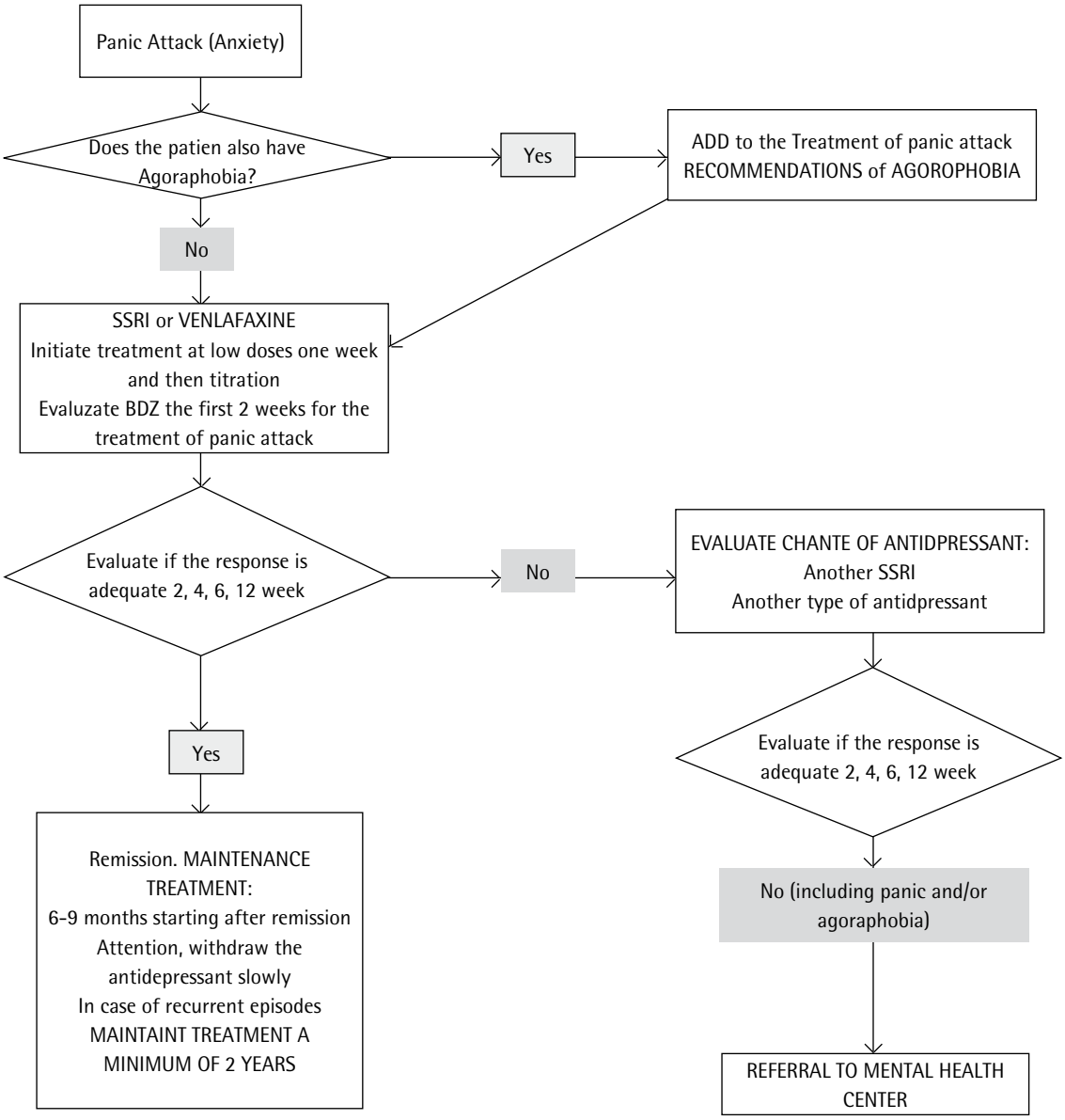


Figure 8 | *Subprocess 4. Intervention in Primary Care for Anxiety Disorders*
Subprocess 4.b. Panic (Anxiety) Attack Disorder

Table 4 | **General recommendations for the Treatment of Anxiety Disorders in Primary Care (Subprocess 4)**

1. GENERAL RECOMMENDATIONS OF THE TREATMENT OF ANXIETY DISORDERS IN PRIMARY CARE

A correct treatment must always be supported by adequate information, which should be addressed not only to the patient but also to the family. This information should be given in an understandable and specific form, focusing on the nature and possible evolution of the disease, on the therapeutic options and on available resources.

Make the patient and family see that this is a disorder that generates greater suffering and incapacity and that said disorder has a wide range of effective intervention possibilities for its treatment.

Consider that greater involvement of the patient and family in the process assures a better response of it.

Avoid erroneous attributions on his/her disease.

To establish a pharmacological treatment for the control of anxiety, we should consider the previous response, the nature of the symptoms that are going to be treated, the associated mediation and the profile of adverse symptoms.

1.1. RECOMMENDATIONS OF USE OF BENZODIAZEPINES (BDZ) IN ANXIETY DISORDERS

Benzodiazepines are used in the acute management of anxiety and as coadjuvant treatment with SSRI and SNRIs.

Benzodiazepines produce initial rapid relief of the anxiety symptoms. Do not prolong their use beyond 4 to 6 weeks.

In moments of acute episodes, the following are recommended: alprazolam, clonazepam, lorazepam and diazepam.

If the use of BDZ is indicated, it is recommended beginning with the smallest possible dose and slowly increasing it.

The use of long acting or intermediate half life BDZ is recommended due to their lower addictive capacity (e.g., diazepam, cloracepate, ketazolam, etc.). In patients with substance abuse problems, alcoholism and personality disorders, avoid the use of BDZ.

In special populations (low liver metabolism) as in the elderly, those with kidney and liver diseases, the use of short half life BDZ such as lorazepam, oxazepam and temazepam is preferable.

1.2. RECOMMENDATIONS OF USE OF SSRI OR SNRIs ANTIDEPRESSANTS IN ANXIETY DISORDERS

The management of SSRI or SNRI antidepressants in anxiety disorders is the same as in depression, but we must consider certain differences for practical effects:

a) Treatment should be started with lower doses and a slowed increase of dose made.
b) BDZ type anxiolytics can be associated during the first two or three weeks of treatment.

The dose and time periods of use of these antidepressant drugs should be the same as that indicated for depression, both in the acute phase and in the continuation phase. In some cases, the use of larger doses may be necessary and also for longer periods of time.

1.3. PRESCRIPTION OF TEMPORARY WORK INCAPACITY IN ANXIETY DISORDER

If the indication of Temporary Work Incapacity (TWI) is prescribed, always consider it as part of the therapeutic process and never separate it from other proposed therapeutic approaches. Establish and explain specific objectives of it at the onset, carrying out periodic monitoring of the evolution and its continuation clinical needs.

Work leave may provide rest and relief of daily tension. After the first moments following a life setback, and once the basic sleep and eating patterns are recovered, the person will be able to recover and reorganize themselves better with return to active life.

Consider the risks of possible iatrogenization:

a) Evaluate if it favors the fostering of certain avoidance behaviors inherent to the disorder itself (e.g. in panic disorders with agoraphobia).
b) Evaluate in personalities with avoidance-dependent traits (e.g. in generalized anxiety disorders).
c) Evaluate the possible secondary benefits.

2. SPECIAL RECOMMENDATIONS OF ANXIETY DISORDERS IN PRIMARY CARE

2.1 ANXIETY DISORDER (AD)

Using the following antidepressants are recommended: the SSRI (citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine and sertraline), SNRIs (venlafaxine retard) and the TCAs (clorimipramine and imipramine).

It is recommended initiating the treatment with the minimum therapeutic doses and performing gradual titration.

2.2 PHOBIA ANXIETY DISORDER

2.2.1. AGORAPHOBIA, with or without associated Panic Disorder.

In Primary Care, a simple behavior management can be initiated based on four steps:

1) Establish a hierarchy of real situations.
2) Motivation to face them.
3) Agree on specific objectives.
4) Follow-Up of the changes.

Refer to Mental Health when the course is not that desired or a more formal therapy is necessary.

2.2.2. SPECIFIC PHOBIA.

If there is no functional repercussion, treatment is not necessary. If there is significant functional repercussion, refer to Mental Health.

At first and except for comorbidity, the use of antidepressants is not necessary.

2.2.3. SOCIAL PHOBIA

The SSRIs and SNRIs make up the treatment of choice in generalized social phobia. Response may be delayed up to 3 months.

Tabla 4 Continuation

The BDZ may be used at the beginning for rapid symptom relief.

The primary care physician may stimulate the gradual exposure and make a follow-up. Training in social skills, sometimes available in community resources (Social Services, public cultural centers, and municipal centers) can complement the treatment.

2.3. MIXED ANXIETY-DEPRESSIVE DISORDER

If pharmacological treatment is use, it should be treated as a depression. Antidepressants are the treatment of choice because they improve both the depressive symptoms as well as the associated anxiety.

Benzodiazepines are not indicated as single treatment because they do not improve the depression.

2.4. ADAPTIVE DISORDERS

The PC clinic is the preferential setting for treatment.

Pharmacotherapy occupies a second place after nonpharmacological interventions. Anxiolytics are the most used given the transitory character of the disorder.

Refer to Mental Health only if there is severe functional involvement or if the duration of the pictures greater than six months.

Refer to Social Services if the sociofamiliar resources are insufficient or cannot be mobilized.

3. SPECIAL RECOMMENDATIONS IN POSTTRAUMATIC STRESS DISORDER

The health care personnel in Primary Care are those which are most likely to be contacted by the patients who have suffered a traumatic event given that the reason for the medical visit is generally a medical and/or psychosomatic problem related directly or indirectly with the traumatic situation.

3.1. ACUTE STRESS DISORDER (ASD)

In ASD, the PC medical visit is the preferential frame for the comprehensive approach, given the characteristics of proximity and accessibility.

The nonpharmacological measures of support and education are of primary source in ASD. These measures include: follow-up visits, information on the disorder and their symptoms.

Evaluation of the emotional impact is recommended as soon as the traumatic event has occurred and a follow-up of the symptoms during the first three months before offering referral to Mental Health. Monitoring of the symptoms may speed up the recovery in some patients and help in the identification of those patients who need a specialized intervention in Mental Health.

NOTE: Avoid encouraging detailed recall in the patient of the traumatic event immediately after exposure and limit the interview to obtaining essential clinical data in order to administer the information and medical care necessary so as to not increase the patient's malaise.

Coordinate social and legal resources of support if necessary, in order to promote a climate of control and safety for the patient.

Pharmacological treatment is relegated to situations of severe and acute symptoms of hyperactivation, insomnia or severe dissociative symptoms, in which case the very timely use of benzodiazepines is recommended to alleviate the most acute symptoms. USE OF BENZODIAZEPINES IS ASSOCIATED WITH A GREATER EVOLUTION TO SYMPTOMATIC CHRONICITY.

If the severe symptoms and insomnia persist, second-generation antidepressants, such as mirtazapine or trazodone, in their use of anxiolytics and hypnotics, should be used.

If there is significant agitation, use atypical antipsychotics (Olanzapine, quetiapine or risperidone).

Beta blockers (propanolol) may be useful as non-benzodiazepine anxiolytic agents, a standard dose according to tolerance.

3.2. POST-TRAUMATIC STRESS DISORDER (PTSD)

SSRI antidepressants are the treatment of choice of the PTSDs.

It is recommended to initiate treatment with half of the standard dose in its use as antidepressant, following a progressive titration according to tolerance until reaching therapeutic doses.

Treatment with Venlafaxine may be useful in those patients with poor tolerance or in whom there is a contraindication to SSRIs.

Benzodiazepines should be avoided in chronic or prolonged use.

Use Nonbenzodiazepine sedative hypnotic drugs; second-generation antidepressants such as trazodone and mirtazapine may be useful against insomnia and the anxious symptoms in combination with the SSRIs or Venlafaxine.

The psychotherapeutic support should be focused on psychoeducation: information on the symptoms, control guidelines, providing guidelines of self-help and normalization of the daily life.

Both in ASD and in PTSD, refer to Mental Health when there is severe functional involvement, situations of psychiatric comorbidity or when the duration of the clinical picture is greater than 6 months (in case of PTSD).

Both in ASD and in PTSD, it is recommended to promote the maintenance of a normalized social and work activity.

Avoid prolonged work leaves. If temporary work incapacity is necessary, evaluate immediate return after the readjustment of the biological rhythms and do not wait for complete absence of symptoms to return to work in order to avoid favoring avoidant and financial motivated behaviors.

E-mail is promoted between the professionals of both teams and another more protocolized type of relation is organized of clinical sessions and workshops.

CONCLUSIONS

There is sufficient evidence regarding the benefits of collaboration work between Primary Care and Psychiatry Services for psychiatric disorders in general and specifically for depression. The improvements refer to, above all, therapeutic adherence, adaptation of the indication, correct use of the treatments and the disease course.

A Clinical Management Process is a clinical management tool that enables the management of the depressive disorders and anxiety disorders from a perspective of "chronic disease," with organized and structured interventions in each one of their evolutionary phases, permitting the incorporation of the approach among different care levels and greater involvement of non-medical professionals.

The Clinical Management Process model of Primary Care is applicable in the Spanish healthcare setting, given the current organization of the services, and could be an instrument at the service of the improvement of the diagnosis and treatment of depressive and anxiety disorders on the Primary Care level.

This process requires a design that is adapted to each care reality. The model can be exported to a similar healthcare system, but specific adjustments should be made according to the characteristics.

It should always be accompanied by an updating system and one of evaluation with adequate indicators.

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