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Differences in management of depression in Spain from psychiatric and primary care physician point of view

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Introduction. Given that depression is the most prevalent psychiatric disorder in our society, the current situation in pharmacotherapy of depression in Spain has been studied from the point of view of psychiatrists and general practitioners (GP).

Method. A total of 339 interviews were carried out with two groups of physician (238 primary care physicians and 101 psychiatrists) from different Spanish cities. Distribution, application and questionnaires collection were made throughout 2002.

Results. The diagnostic instruments most commonly used by more than 90 % of both medical groups to detect a depressive disorder in a consultation are the evaluation of symptoms and the interview with the patient. However the main diagnostic problem was «masking» of depression with other symptoms/disorders. Most GP (95 %) and psychiatrists (99 %) establish a pharmacological treatment in all their depressive patients. Both groups coincide in most community use of SSRI as drugs of first choice (93% from both samples). The pharmacological agents most used by the psychiatrist are the serotonine selective reputake inhibitors (SSRI) (98.3 %), followed by venlafaxine (84.4 %), anxiolytics (68.4 %), mirtazapine (58.9 %) and reboxetine (55.8 %). In the case of GP, the most commonly used pharmacological groups are SSRI (98.3 %) and anxiolytics (73.4 %). In primary care, the SSRI are considered the most effective antidepressant group. However, the tricyclic antidepressives (TCA) would be the most effective for the psychiatrists.

Conclusions. For psychiatrists and GP, the quality of care of depression in Spain is rated positively. However, there is a group of deficiencies and some aspects that need to be clearly improved, such as the time of consultations, coordination between GP and psychiatrists, waiting lists and available resources for mental health units.

Key words:
Depression. Quality of care. Psychiatry. Primary care. Spain.

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Aspectos diferenciales del manejo de la depresión en España entre la atención psiquiátrica especializada y la atención primaria

Introducción. Dado que la depresión constituye el trastorno psiquiátrico más prevalente en nuestra sociedad, se ha estudiado en qué situación se encuentra la asistencia sanitaria a la depresión en España merced a la opinión de los facultativos encargados de la misma, médicos psiquiatras y médicos de atención primaria (AP).

Método. Se realizaron 339 entrevistas estructuradas a dos muestras diferenciadas de médicos (238 médicos de AP y 101 psiquiatras) de diferentes ciudades de España. La distribución, aplicación y recogida de los cuestionarios se realizó a lo largo del año 2002.

Resultados. Los instrumentos diagnósticos más utilizados por más del 90 % de médicos de ambos colectivos son la valoración de la sintomatología y la entrevista con el paciente, siendo el principal problema diagnóstico el enmascaramiento de la depresión con otra sintomatología. La mayoría de los médicos de AP (95 %) y de psiquiatras (99 %) instauran un tratamiento farmacológico en todos sus pacientes depresivos. Ambos colectivos coinciden en la utilización mayoritaria de los ISRS como fármacos primera elección (93 % de ambas muestras). Los agentes farmacólogicos más utilizados por el psiquiatra son los ISRS (98,3 %), seguidos de la venlafaxina (84,4 %), ansiolíticos (68,4 %), mirtazapina (58,9 %) y reboxetina (55,8 %). En AP los grupos farmacólogicos más empleados son los ISRS (98,3 %) y los ansiolíticos (73,4 %). Los ISRS son considerados el grupo antidepresivo más eficaz en AP y los ADT para los psiquiatras.

Conclusiones. La valoración que hacen los médicos de la asistencia sanitaria actual al paciente deprimido es buena, aunque se ponen de manifiesto una serie de carencias y aspectos que necesitan ser claramente mejorados, tales como el tiempo de consulta, la coordinación entre AP y psiquiatría, las listas de espera y la dotación de medios a los centros de salud mental.

Palabras clave:
Depresión. Calidad asistencial. Psiquiatría. Atención primaria. España.

INTRODUCTION

Depressive disorders represent a significant public health problem that affects both the patients and the society as a whole. The reason for this is that together with the functional incapacity that this involves for the patient (maintained impact on health, social functioning and patient's quality of life), it involves an enormous social cost, both in terms of direct as well as indirect costs[1].

Depression affects the patient's quality of life more intensely than other chronic diseases[2] and use of primary care (PC) health services that is three times greater than the mean of the remaining patients[3]. Studies conducted in our setting indicate that approximately 20 % of the patients seen in the primary care consultations have depressive disorder[4,5], while depressive patients make up about 80 % of all the visits to psychiatrist's consultations[6].

Most depressive patients initially request assistance from primary care physicians[1], and it is estimated that only one third of the depressive patients initially go to a mental health specialist[7]. A study that provides data on the perception that the Spanish population has on depression has recently been published in out setting. The results showed that depression could affect more than 25 % of the population and that its incidence would increase, according to 42 % of those interviewed. Furthermore, depression was considered to be among the three general diseases with the greatest incidence, exceeding coronary diseases. Regarding drug treatment, most of those surveyed would not accept treatment less than 1 year long[8].

In relationship with psychiatric care, a reform process was begun in our country in the 1980's. This has contributed to improvement in attention to the mental health problems experienced in recent years. During these last two decades, there have been a series of changes that have meant an increase in mental health care assistance outside of the hospital, so that the number of psychiatric hospitals and psychiatric hospital beds has decreased. Furthermore, an attempt has been made to modify the assistance axis in favor of mental health care units located in the area and made up by specialized multidisciplinary teams who are capable of providing effective support to primary care and attending to the mental health problems of a sector of the population in close relationship with these teams and the rest of the specialized level[9,10]. In turn, the number of health care establishments in PC has increased greatly with the implementation of health care sites. These facts confirm the increasing role of out-patient care and therefore of the primary health assistance in the care of patients with mental disorders in general and with affective disorders in particular.

On the other hand, there have been many changes in the pharmacological tools available to treat depression, above all since the clinical introduction of selective serotonin reuptake inhibitors (SSRI) at the end of the 1980's. These agents, and others introduced afterwards, thanks to their easier management and improved safety profile, have contributed to the improvement of the depressive patient's quality of life and to making the treatment of depression more satisfactory[1,11-12].

This study aims to analyze in what situation health care assistance for depression is found in Spain according to the opinion of the physicians in charge of it, psychiatrists and primary care physicians.

MATERIAL AND METHODS

In the present study, 339 opinion surveys were performed in two differentiated samples of physicians (238 primary care physicians and 101 psychiatrists) (table 1) with self-application of structured questionnaires that included health care, clinical, therapeutical aspects and also those related with care quality. At the end of the questionnaire, there was also a section to obtain information on sociodemographical and work data, such as age, gender, years of professional practice, work site, type of work and mean number of patients attended in the consultation per day. Distribution, assistance in the application and collection of the questionnaires were done during 2002, among physicians of different cites in order to assure the maximum representativeness of the results. The questionnaires used in our study were designed in accordance with those used in previous studies conducted by our group[6].

Statistical analysis

The data have been basically processed with the SPSS, version 11.5 statistical program and sometimes with the Statistix program, version 2.0.

Qualitative variables have been presented in form of percentages and quantitative ones are described with the mean and standard deviation. In the case of the qualitative variables, the chi squared (χ^2) was measured. If the tables were 2×2, Yates correction or Fisher's exact test were used. If the proportions were paired, McNemar test or the Cochran's Q non-parametric test for related samples, according to the situation, was used. When the variables were quantitative, the Student's *t* test or Friedman's non-parametric test was used, according to the cases.

RESULTS

Care aspects

Of all the actual depressive disorders that exist in the population, psychiatrists consider that 51.6 % come to consult

Table 1 Sociodemographic data of primary care and psychiatry professionals

	PC	Psychiatry
Number of physicians	238	101
Gender (%)		
Man	48.9	51.1
Woman	51.1	48.9
Years of practice (%)		
< 6	13.5	27.3
6-15	39.2	30.3
16-30	45.6	34.3
> 30	1.7	8.1
Work center (%)		
Out-patient/health site	93.2	68.0
Hospital	1.3	16.0
Health center and hospital	2.1	9.0
Others	3.4	7.0
Type of work (%)		
Public	86.5	81.0
Private	3.4	6.0
Both	9.7	13.0
Others	0.4	0.0
Age (mean ± standard deviation)	42.1 ± 7.2	41.1 ± 9.6
Patients/day (mean ± standard deviation)	42.5 ± 15.1	12.5 ± 4.9

versus 40 % according to the primary care physician's opinion (PC) ($p < 0.001$).

Depressive patients account for 75.6 % of those who come to the psychiatrist's office and 31.8 % in the case of PC consultations, according to the opinion of both medical groups. Furthermore, in psychiatry, depression is the main reason for consultation in most of the cases (81.2 %) versus only 27.5 % in PC, since in this setting, most of the times it is detected secondarily.

Patients generally arrive to the PC consultation directly, basically by personal decision (53.6 %) or brought by family members (24.4 %). In less frequency, they are referred from the hospital emergency service (7.5 %) or by other ways, such as speciality consultation (14.5 %). In the case of psychiatry, most of the patients seen in the consultation have been referred by the PC physician (58.0 %), 14.2 % coming directly and 10.9 % coming from hospital emergency services, 10.6 % from speciality consultation and 7.7 % from other ways.

The amount of time the psychiatrist dedicates to his/her depressive patients in the consultation differs greatly from that of the PC physician. In the first visit of the patients the specialists spend a mean of three times the time of the PC physician (45.6 ± 12 minutes vs 14.5 ± 9.8 minutes; $p < 0.001$). This is always greater than 15 minutes in the case of the psychiatrists while 70% of the PC physicians spend less than 15 minutes. In the case of check-up consultations, twice the time is used in Psychiatry as in PC (23.7 ± 8.6 minutes vs 11 ± 7.7 minutes; $p < 0.001$), although the differences in time between both medical groups is decreased in regards to the first visit. On the other hand, 86.4 % of the PC physicians consider they need more time to diagnose a depressive patients than any other type of patients.

The main causes for referral of depressive patients to psychiatry by the PC physician, according to the opinion of both groups, are risk of suicide, lack of response to treatment and in case of severe depression. Furthermore, 40.2 % of the psychiatrists consider that the PC physician refers the patient to his/her consultation in most of the cases versus only 3.8 % of the PC physicians who believe this. On the other hand, the main reasons mentioned by PC physicians for not referring depressive patients to the psychiatrist are waiting lists and rejection of the patients to go to the psychiatrist (table 2). However, as can be observed in table 2, the patient's attitude may influence the PC physician in regards to referring him/her to the psychiatry consultation, 85.8 % of the PC physicians state that the patient generally adopts a positive attitude when referred to the psychiatrist.

In the process of referral from primary health care to specialized care, an important aspect to consider is the computer support with which this referral is documented and how the quality of this support is assessed. In spite of

Table 2 Reasons the PC physicians have to not refer depressive patients to psychiatry

	AP (%)
Waiting lists	51.1
Patient's negative attitude toward psychiatrist	42.9
Lack of communication PC-specialist	28.7
Feeling that depressive patients are responsibility of PC	24.1
Patient not satisfied with the treatment received from psychiatrist	21.0
Avoiding that they are labeled as mental patients	17.9
Consideration towards the psychiatrist as they are very busy	6.5

the fact that 85 % of the PC physicians manifest that they refer patients with an attached report, 45 % with request for consultation with specialist, the document information accompanying the depressed patient referral by the PC physician is considered to be fair by the psychiatrist.

In regards to the relationship and collaboration between primary care and specialized care, 60.7 % of the psychiatrists and 58.1 % of the PC physicians estimate that the aspect that needs to be improved the most in these relationships would be communication between both groups. In the following, the aspects mentioned most by the physiatrist are coordination between both groups (22.6 %) and PC physician training (15.5 %). For the PC physicians, other aspects that should be improved would be increasing the performance of joint activities, such as clinical sessions (30.2 %) and the patient's follow-up reports (13.4 %). Comparing this relationship with that which PC and Psychiatry maintain with other specialists, positive results are obtained, both in the opinion of the PC physicians as well as that of the psychiatrists (mean of 1.89 PC and 1.71 psychiatry on a scale of 1 [worse than with other specialists] to 3 [better than with other specialists]).

Table 3 describes the influence of different life events and some categories or groups of individuals in the development of depression, the group of women being the most relevant according to the PC physicians (89 %) and psychiatrists (79 %), together, in the case of the latter group, with that of being divorced/separated (74 %).

Table 3 **Importance of different life events and categories of individuals in the development of depression, according to the consideration of both groups of physicians**

Multiple response	PC (%)	Psychiatry (%)	p
Women	89.0	79.0	< 0.05
Elderly	67.9	48.0	< 0.001
Death of family member	64.3	61.2	NS
Divorces/separation	63.9	74.5	< 0.05
Health problems	42.6	45.9	NS
Low socioeconomic condition	30.8	29.6	NS
Alcoholics	29.8	40.8	< 0.05
Immigrants/marginalized	16.8	23.5	NS
Drug addicts	15.5	17.3	NS
Adolescents	13.1	10.2	NS
Men	7.2	10.2	NS
Work conflicts	6.0	6.5	NS
Children	0.4	1.0	NS

Clinical aspects

Interview with the patient and assessment of the symptoms are the instruments that are always used to diagnose depression according to more than 90 % of the physicians of both groups (fig. 1). The symptoms that mainly lead the physician towards the diagnosis of depression, according to the psychiatrist's and PC physician's opinion, are basically depressed mood state (84.4 % vs 75.6 %; NS), anhedonia (70.8 % vs 36.1 %; $p < 0.001$), decrease of vitality (65.6 % vs 48.7 %; $p < 0.001$) and sleep disorders (45.8% vs 39.1 %; NS). Somatic symptoms are more frequently collected in the PC consultation (34.0 % PC vs 15.0 % psychiatry; $p < 0.001$), and anxiety syntoms are reported more in the psychiatry consultation (38.0 % psychiatry vs 26.9 % PC; $p < 0.05$).

On the other hand, according to the opinion of both groups of physicians, the most common problem to detect a depression syntoms in the consultation, is masking with other symptoms or disease (76.3 % Psychiatry vs 85.7 % PC; NS). Lack of time in the doctor's office would be another important problem in the PC setting (67.4 %).

Therapeutic aspects

Once depression is diagnosed, almost all the physicians, both PC and psychiatrists (94.8 % vs 99 %; NS), state they initiate drug treatment in all their depressive patients. Furthermore, more than 70 % of the psychiatrists use other therapeutic measures such as psychotherapy, counseling or recommendation of health life habits, while only about 50% of the PC physicians apply them (table 4).

Although 93 % of the physicians of both groups consider SSRIs as the antidepressive group of first choice and coincide in the majority use of these as the most frequent antidepressive group and on the use of anxiolytics, there are differences in the frequency of use of the remaining antidepressive drugs (fig. 2). Furthermore, the perception of the efficacy of the different groups of antidepressives is different in PC and psychiatry (fig. 3).

The assessment that both physician groups give to treatment compliance, considered globally (pharmacological and non-pharmacological) is very satisfactory. More than 80% of the psychiatrists and PC physicians consider that pharmacological treatment compliance is good or very good. However, the grading on the compliance of the non-pharmacological treatments is much more unfavorable, since it is only considered good or very good by 29.3 % of the PC physicians and by 46.3 % of the psychiatrists ($p < 0.05$).

The reasons for which treatment non-compliance is attributed vary ostensibly according to the type of physician, the most frequent being adverse events in the case of the

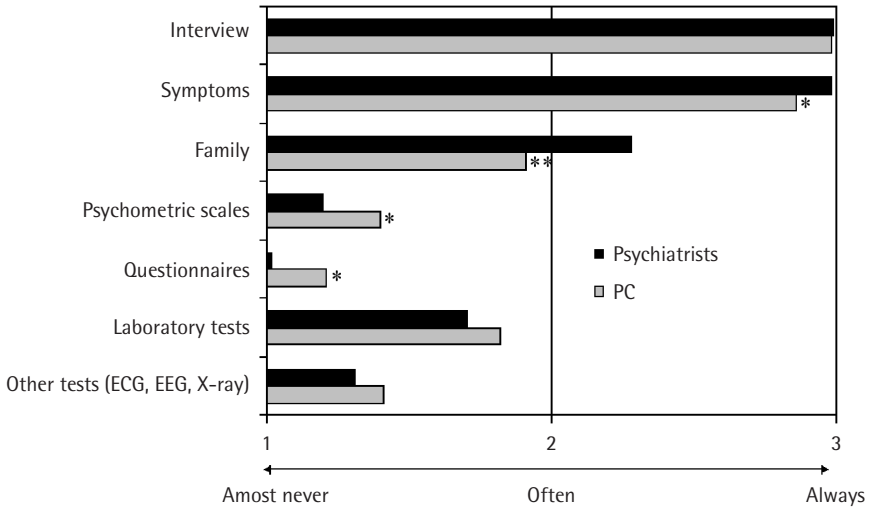

Figure 1 *Use of different diagnostic tools in depression *p < 0.01. **p < 0.001.*

psychiatrist (79.8 %) and long treatment duration for PC (66.8 %) (table 5).

DISCUSSION

Specific weight of the depressive disorders in health care is very high, above all in primary care, in spite of the possible existence of some important values of hidden epidemiology. In our setting, one out of every five patients attended in PC consultation would have a depressive disorder[4-5,13]. In the DEPRES study (Depression Research in European Society)[14] it was stated that 43 % of the depressed patients do not seek help in the treatment of depression and 57 % of those who come to the consultation mostly do so in the primary health care level. Furthermore, it was observed that the seriousness of the depression was related with greater number of doctor's visits.

Table 4 **Most frequent therapeutic actions in PC and psychiatry after diagnosis of depression**

	2002		
	AP (%)	Psychiatry (%)	p
Drug treatment	94.8	99.0	–
Counseling	53.6	84.2	< 0.001
Life and hygiene regimens	52.8	71.9	< 0.01
Referral to psychiatrist	50.1	–	–
Psychotherapy	44.6	80.6	< 0.001
Speak with family members	39.1	91.9	< 0.001
Referral to specialist consultation	3.4	–	–
Sending patient to emergency service	3.4	–	–
Others	2.4	33.3	NS
Hospitalization	–	14.5	–
Electroconvulsive treatment	–	3.3	–

Consultation time has been considered as the main aspect to be improved in health care assistance of depression by the physicians surveyed. Furthermore, it is one of the main problems of the diagnosis of depression for the PC physicians, 80 % of whom estimate that they need more time to diagnose a depressive patients than another type of patient. The results found in our study on mean time used in the consultations coincide with those provided by Pingitore et al.[15], in the USA, in which the length of the first visit of the depressive patient in the PC physician consultation was 32 minutes less than that of the psychiatrist.

Regarding the level of communication and collaboration between primary care and specialized case, and although it is currently considered positive, 60 % of the psychiatrists and PC physicians consider this as the principal aspect to improve in the primary health care-psychiatry relationship. However, both groups consider this relationship equal or better than that maintained with other specialists. In this framework, an important aspect in the referral process from primary care to the specialized care is the computer support with which this referral is documented and how the quality of this support is assessed. This is considered «fair» by the psychiatrist, in spite of the fact that 85 % of the PC physicians state they refer the patient with an attached report.

A more up-dated medical training would explain the fact that the family doctors include data on the examination and

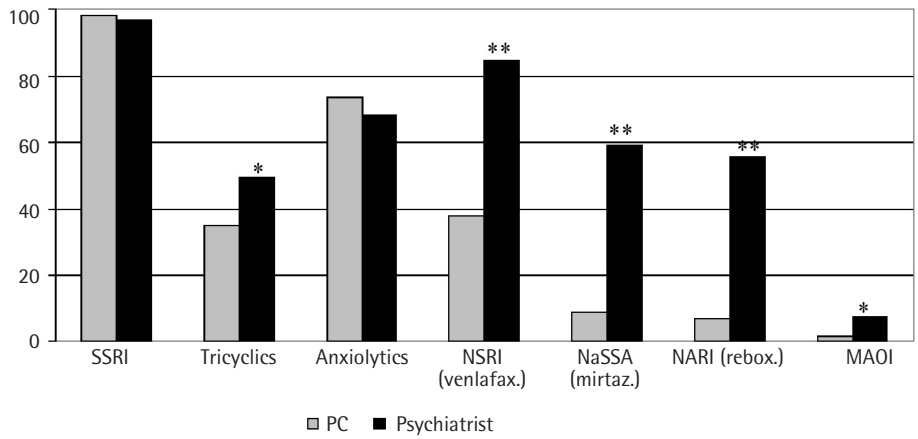

Figure 2 *Frequency of use of antidepressive drugs by psychiatrist and PC physician. *p < 0.05. **p < 0.001. SSRI: selective serotonin reuptake inhibitors; NSRI: norepinephrine serotonin reuptake inhibitors (venlafaxine); NaSSA: noradrenergic and specific serotonergic antidepressant (mirtazapine); NARI: noradrenaline reuptake inhibitor (reboxetine); MAOI: monoamine oxidase inhibitor.*

make a specific according to the opinion of Herrán et al.[16], request more frequently than the general practitioners. These authors observed that on the medical request forms for referral from PC to psychiatry, 34% included data on the psychiatric examination and 97% a diagnostic opinion. On the other hand, in the opinion of most of the referring physicians, data on the psychiatric examination and diagnostic impression is usually specified on the referral medical report form. Both in this study and in other referral studies made in our setting[17,18], it is concluded that it is necessary to improve the referral reports and this would entail an improvement in the communication between PC and psychiatry.

Rejection by patients to go to the psychiatrist may influence the PC physician when they are going to send him/her to the specialist, this being the second most frequent reason the PC physician has for not referring the patient after that of waiting lists. However, the attitude that a depressive patient generally adopts when referred to the psychiatrist is generally positive, according to the opinion of 85.8% of the PC physicians of our study. In a study conducted by Willians in the USA[19] to PC physicians, they stated that more than 25% of their patients rejected the diagnosis and more than half hesitated about going to the psychiatrist when they were referred to the specialist. In our

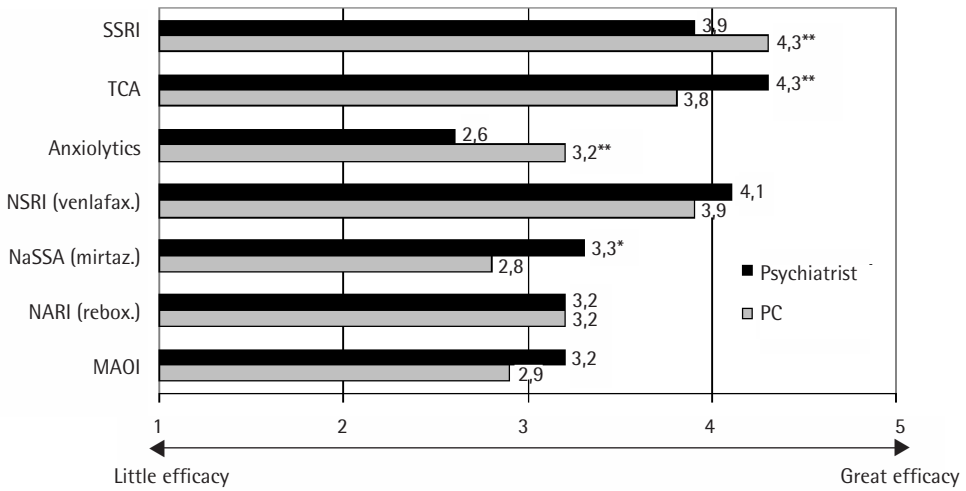

Figure 3 *Assessment of efficacy of antidepressive drugs by psychiatrists and PC physicians *p < 0.01. **p < 0.001. SSRI: selective serotonin reuptake inhibitors; NSRI: norepinephrine serotonin reuptake inhibitors (venlafaxine); NaSSA: noradrenergic and specific serotonergic antidepressant (mirtazapine); NARI: noradrenaline reuptake inhibitor (reboxetine); MAOI: monoamine oxidase inhibitor.*

Table 5 Reasons for treatment non-compliance

	PC (%)	Psychiatry (%)	p
Long treatment duration	66.8	46.5	< 0.001
They believe they do not need it	48.3	40.4	NS
Side effects	47.9	79.8	< 0.001
Non-remission of symptoms	23.1	28.3	NS
Neglect, lack of interest	5.1	7.1	NS
Other reasons	4.2	8.2	NS

setting, García-Testal et al.[18], in a study on referrals of PC to mental health, they observed that 17 % of the patients referred from PC did not go to the first consultation with the psychiatrist.

Several studies have declared that the most relevant life category when suffering a depressive disorder is the female gender[4,5]. This fact is also observed in our study, although according to the opinion of the psychiatrists surveyed, this first place is currently shared with the condition «divorces-separations» (74 %). In this sense, other authors[20] have affirmed that being divorced is associated with greater use of antidepressants. Being elderly is a life category to suffer depression that is more significant for the PC physician than for the psychiatrist. This difference in perception may be justified by the fact that many more elderly subjects are seen in the PC physician consultation than in specialized consultation[15]. From the socio-health care perspective, the greater attention given to geriatric care must also be kept in mind, this group having become the group that uses the most care resources[21]. Other factors that predispose to suffering depressive disorders are very related with old age, such as loss of health, death of family members, work retirement and the consequent decrease in earnings and social prestige, change in residence site and loss of social relationships, etc. All these factors are collected in the Murphy[22] and Emerson et al.[23] studies, that verify the connection between serious life events and depression in the elderly.

There is great coincidence between PC physician and psychiatrists about the symptoms that depression diagnosis is based on, depressed mood state, decrease in vitality, sleep disorders and anhedonia being those most evaluated by both groups, although in different order. However, regarding the latter, there is a large discrepancy between the two groups, since it is much more evaluated by psychiatrists (70.8 %) than by the PC physician (36.1 %). On the other hand, there is greater collection of physical disorders in PC, that perhaps explains why the PC physician needs to conduct more extensive questioning to rule out other diseases while the psychiatrist focuses the consultation directly towards affective disorders.

Evaluation of the symptoms and interview with the patient are the diagnostic instruments used most by the psychiatrist and PC physician. It is striking that the psychiatrists consult the family members of the patient in twice the number of cases as the PC physicians (33 % vs 14.3 %; $p < 0.001$), whom, however, are supposed to be closer to the depressive patient's setting. The routine use of diagnostic and evolution tools, including diagnostic questionnaires and psychometric scales by both groups of physicians as well as the conduction of other diagnostic tests is very limited. Our results follow the line of the study conducted by Depont et al.[24] in a sample of French psychiatrists, in which 79.3% affirmed they made the diagnosis according to «clinical opinion» and very few admitted the use of diagnostic scales or instruments.

In the foreword of the 1982 edition of the White Book «Sociological Studies. Depression in Spain», titled «La depresión en España» (Depression in Spain)[25], López-Ibor commented that at the beginning of the 1980's, there were no «sufficiently accurate clinical criteria for any physician to be able to correctly diagnose the depressive patients, establish an adequate therapeutic plan and evaluate the results, and above all, to distinguish those cases that he/she can treat from those others that are more serious or more resistant to simple treatment that should be referred to the psychiatrist». In fact, in the 1982 study, the «lack of specialized training» was the main problem for the diagnosis of depression, both in psychiatry and in PC, «masking with another symptom» becoming the main problem of diagnosis at the present time for both physician groups. For Lopez-Ibor, the depressive equivalents are those manifestations of the depressive disorders in which the somatic symptoms are present on a first level[26]. These forms of showing depression continue to be the most frequent in the clinical practice and specifically in the PC consultations, where they account for about 50 % of the depressive disorders[27].

Along general lines, the diagnostic barriers reported by the PC physicians in our study coincide with those mentioned by other studies conducted on this type of professional, both in our setting[28] and in other countries of our surroundings[29-31]. In a review realised by Tylee[32], the characteristics that would permit greater likelihood of detecting psychiatric problems in primary care were analyzed. The most relevant were greater knowledge of the symptoms and therapeutic tools, more positive attitudes towards mental disease and improvement of clinical interview skills.

Once the diagnosis of depression was established, 80 % of the PC physicians chose «drug treatment» as the most common action regimen. This fact may be explained by an improvement in the training of the PC physician, with better management of antidepressive drugs and with a larger therapeutical tools from which to choose drugs that are

better tolerated and are easier to use. On the contrary, as occurs from the diagnostic point of view, it stands out that psychiatrists speak more with the family members than the PC physicians do. In the study realised in the USA by Stafford et al.[33], the psychiatrists used counseling in 88.4% of their depressive patients versus 27.8% of the PC physicians.

Practically all the physicians, both PC and psychiatrists, state they establish drug treatment in all their depressive patients. Our results coincide with the data obtained in recent studies, such as that conducted by Tarricone et al.[34], in Italy, in which 98% of the patients were prescribed an antidepressant. In the USA, 37.3% of the individuals were treated with antidepressants in 1987, this going to 74% in 1997[35] and to 89% in the year 2001[36]. Thus, it can be observed how the percentage of patients treated with drugs has been increasing parallelly to the clinical introduction of on the market of new drugs having easier management.

Although we have not found differences between both groups of physicians in regards to percentage of use of anxiolytics (73.4% in PC and 68.4% in psychiatry), it is the second most used drug group in Primary Care. In the Ruiz Doblado et al. study[37], an excessive use of anxiolytics by the PC physician was observed, use up to six times greater of benzodiazepines than antidepressants being observed. On their part, Tarricone et al.[34] report the prescription of benzodiazepine to 84% of the depressive patients. Over 90% of the physicians of both groups state they choose SSRI as the antidepressant of first choice. Several authors of our setting[38,39] propose SSRI as the family of drugs of first choice in primary care.

Therapeutic compliance is a decisive factor in treatment success. In our study, the level of drug treatment compliance has been very favorably assessed by more than 80% of both psychiatrists and PC physicians. This opinion in regards to therapeutic compliance is more optimistic than that obtained in other surveys conducted in our country with PC physicians in 2001 and 2003[40], in which it is estimated that 40% of the patients discontinued therapy in the initial phases and 60% dropped-out in the maintenance phase, the main cause of dropping out being «the belief that they do not need the medication» or «feeling they are cured». In the international setting, a Belgium group, headed by Demyttennaere, has published several articles about this[41-43]. They indicate that between 30% and 60% of the patients do not take the medication as prescribed by the physician and that the first cause of lack of treatment adherence, with 55%, is due to the improvement experienced by the patients, followed by adverse events (23%). According to Khunti[44], from 20% to 59% of the patients dropped-out of the treatment in the first three weeks and up to 68% in the first three months, depending on the type of antidepressive treatment established[45,46]. Peveler et al.[47] evaluated a large population of patients treated with tricyclic antidepressants in PC and observed that 40% dropped-out in the first 12 weeks.

Even though the quality of the health care assistance for depression in Spain is considered good in general terms, it can clearly improve. The assessment of the psychiatrists is more critical than that of the PC physicians in regards to the diagnostic and treatment resources available in PC, approximately 50% of the specialists considering them insufficient. On the contrary, there has been a very positive evolution in the opinion of the physicians about Spanish public psychiatric assistance since 1982, based on the capacity of the Mental Health sites to attend depressive patients[6,21]. The change in attitude of the PC physician regarding depression, together with the evolution of drug treatments, are the two factors which, according to the PC physicians, most positively influence in the improvement of care quality for depression, the latter being the aspect most evaluated by the psychiatrist. Furthermore, the latter considers that the making of a good diagnosis is the main way that the PC physician can contribute best to the treatment of the depressive patient. In fact, until 1997, the most urgent for the psychiatrists was to improve the training of the PC physicians[6].

At present, it is an admitted fact that there are other aspects that greater concern and possibility of improvement than training. Thus, in the opinion of the PC physician, consultation time is the most important aspect, followed by coordination between PC and Psychiatry, waiting lists and social and psychological assistance to the family. From the point of view of the psychiatrist, coordination between PC and the psychiatrist, provision of health care resources in the Mental Health Sites, and consultation time are considered as the main aspects to be improved in health care assistance regarding depression in Spain. On their part, Lopez-Ibor et al.[21], continuing education of primary care physicians, together with better provision of resources, that make it possible to increase the consultation times and promote agile communication flow between both care levels are the main aspects to improve care quality for depression in our country.

CONCLUSIONS

The specific weight of depressive disorders in health care assistance is very high and, above all in primary care, in spite of the possible existence of important values of hidden epidemiology.

Collaboration between primary and specialized assistance levels is considered only as mildly positive. This reveals a lack of mutual satisfaction in the relationships. The psychiatrists consider that quality in filling out the report accompanying the referral of the depressive patient should be improved.

The diagnostic tools used most in the detection of depressive disorders are assessment of the symptoms and interview with the patient, masking with other symptoms being the most important diagnostic difficulty.

Antidepressive treatments used by both groups are increasingly similar so that the SSRI are considered as the drugs of choice by both the psychiatrists and the PC physicians at present. The SSRI are the most used drugs in our country by the primary care physicians and SSRI and venlafaxine by the psychiatrists.

The assessment made by the physicians of current health care assistance to the depressed patient is good, although it affirms a series of deficiencies and aspects that need to be clearly improved, such as consultation time, coordination between PC and Psychiatry, waiting lists and providing of resources to the mental health sites.

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