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Commentary

Depression in primary care: challenges & controversies

Primary health care is in theory best positioned to address the challenges of chronic disease prevention and management. Unfortunately, the delivery of care for chronic diseases in primary health care settings is compromised in most low- and middle-income countries due to lack of funding and an orientation towards acute problems. As the profile of clinical presentation and need of patients in the primary care may be diverse, there is a potential for 'evidence gap' in the applicability of hospital based research, as well as the effectiveness and implementation of interventions[1].

Common mental disorders (CMD) like depressive and anxiety disorders are frequently encountered in the primary care. The prevalence of these disorders varies substantially between primary care settings with a mean of 20 per cent in a study from 14 countries[2]. However, recognition of these disorders is poor, with less than a third of clinically significant cases getting identified[3,4]. Diagnosis of specific psychiatric disorders would be difficult in the primary care because of high rate of co-morbidity amongst various disorders. It has become apparent that a proportion of patients in the primary care do not fit into specific psychiatric syndromes, largely conceptualized using patients seen in the secondary or tertiary care. Many people with depressive symptoms also have other physical or psychiatric disorders. This physical and psychiatric co-morbidity would have implications for the classification, treatment and outcome of the depressive illness[5]. Hence, underdiagnosis and subsequent sub-optimal management lead to persisting symptoms, excess health service use and loss of working ability[6,7].

There is robust international evidence on the efficacy of pharmacological and psychological treatments (notably cognitive-behavioural therapy and interpersonal therapy) for common mental disorders, such as depression, anxiety, and somatoform disorders[8,9]. There is also a growing global evidence base testifying to the cost-effectiveness of these interventions[10,11]. Stepped-care or the collaborative care approach in which interventions are tailored as per the severity of depression and response to the treatment has proven to be an effective mode of treatment delivery. The effectiveness of this approach has been documented both in the developed and the developing world[4]. Structured, stepped-care treatment programme has also been found to be effective in women with major depression in Chile[12]. The socially disadvantaged patients might gain the most from systematic improvements in treatment modalities and delivery of treatment for depression. Western literature also portrays the benefit of collaborative care in the treatment adherence. In countries like India, the effective delivery of these interventions to the primary care population is still a matter of concern. Limited availability of resources, poor recognition of depression and inexperience to use antidepressant medications or psycho-social interventions complicate the existing scenario[4]. Treatment adherence is a major problem in the treatment of depression both in India as well as in the West. Although drugs are commonly considered a critical tool in the treatment of depression, yet the evidence from descriptive epidemiological studies confirmed that about one in three patients could not complete treatment[8]. A study from India also replicated the poor adherence to antidepressant medications. In this randomized control trial only about one third of the participants had completed their treatment[13]. In spite of its magnitude and of its worrisome implications in terms of morbidity and disability, treatment adherence and means to improve the same has rarely been the object of specific research, especially when compared with the vast amount of studies on the effectiveness of antidepressant drugs[14]. Till date, there has not been any

significant research from India specifically focusing on improving treatment adherence.

Keeping this major caveat in mind, in this issue Johnson and colleagues[15] have provided the evidence for effectiveness of enhanced care by community health workers in improving treatment adherence to antidepressant medication in rural women with major depression. Treatment with antidepressant medications was administered by the physician in the primary health care centre. But in the 'enhanced care' an additional input was provided in the form of initial psycho-education, periodic surveillance, support and encouragement to continue treatment. This was conducted by the four community health workers who had experience of working in the community mental health programme. Enhanced care administered through these trained community health workers to rural underprivileged women resulted into more help seeking and less attrition rate but the effect could not be reflected in the outcome of depressive disorder. This research has hinted towards a possibility that simple but systematic input from the health care system could improve adherence to treatment. Moreover the study was intended to examine the effect of enhanced care in a group of subjects who though were more vulnerable but had less access to the health care facility, given the patriarchal social matrix of Indian society[15].

Interestingly, at the end of six months both the adherent and the non-adherent groups of subjects did not differ in terms of either clinical severity of depression or quality of life. Hence, the improvement in the treatment adherence did not translate into enhanced clinical effectiveness. The speculative reasons behind the discrepancy might be many. First, at the baseline, the severity of depression was in the mild to moderate range and all of them were treated with antidepressant medications. However, as per the evidence from the 'stepped-care' intervention, supportive or psycho-educational interventions are adequate for these groups of subjects. And antidepressants are reserved for the most severe depression or for those who do not respond to the psychological interventions[12]. It is likely that the treatment as usual group which has actually received additional input from the research assistant and the community health workers at the initiation was benefitted by the same. Secondly, the clinical profile of the subjects was not assessed thoroughly. So, the study group could be an admixture of first episode and recurrent episodes of depression. The treatment recognized for these is different both in terms of modality and duration. Therefore, a long term follow up assessment is warranted to find out the impact on the clinical outcome. Thirdly, in primary care the diagnosis of depression is difficult and overdiagnosis is a possibility[16]. Adjustment disorder might well be diagnosed as mild depressive episode. And for this group of subjects the treatment as usual with limited duration could be adequate. Presumably, they did not follow up once they felt better with these interventions.

The study had a few other limitations. First, the community health workers who were involved in the study were the most motivated, eager group of local women with a respectable social position. They were trained specially for the purpose of another study for developing a community mental health programme. So the quality, dedication and impact of the intervention delivered by this group of health workers would be hard to generalize[17]. Second, the definition of treatment completers in this study seems arbitrary. The rationale for choosing 8 wk of treatment is not really forthcoming.

In India, the major focus and locus of research is still the tertiary care hospitals. Undoubtedly, hospital based researches serve an important purpose. Psychiatry as a speciality has come a long way from mental hospitals to general hospitals to the community and there has always been an undermining and selective ignorance towards community based research. Hence, much more primary care research is warranted to bridge the 'evidence gap' between hospital and the community based studies.

One important finding of the study was that a significant proportion of women did not seek help or adhere to treatment even after additional input from the health system. The barrier for their treatment seeking needs to be investigated further. Planning and interventions directed against these barriers could potentially improve help seeking. The role of the existing community health workers in identification of common mental disorders (CMD) and their preliminary treatment warrant further research. The authors of this study have justifiably highlighted the significance of involving the community workers in addition to the usual focus on the trained primary care physician[15]. Countries like India with limited high-skilled professional resources could utilize the community health care workers for the treatment of common mental disorders. This study by could be a significant advance with this regard and might encourage others to

delve into primary care studies. But we want to end up with a 'cautious' optimism, taking clue from Voltaire, *"Optimism is the madness of insisting that all is well when we are miserable"*.

Ajit Avasthi* **& Abhishek Ghosh**
Department of Psychiatry
Postgraduate Institute of Medical Education & Research
Chandigarh 160 012, India
**For correspondence*:
drajitavasthi@yahoo.co.in

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