Detection, diagnosis, and treatment of depression in primary care

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Executive Statement
Mental health problems are one of the main causes of the overall burden of disease, making it imperative that treatment is easily accessible. As with other health problems, primary health care must be the first point of contact to assess and treat, referring to specialist care when needed. However, in most low- and middle-income countries, assessment and treatment for mental health problems are rarely integrated into primary health care. Fifteen years ago, Chile addressed this problem and scaled up the “Programa Nacional de Diagnóstico y Tratamiento de la Depresión (PNDTD)”, or the “National Program for the Detection, Diagnosis, and Treatment of Depression”, operating mainly through primary care. A combination of strong leadership and alliances, scientific evidence and program institutionalization has allowed this program to emerge as an often-cited, successful program in the field of global mental health.

Key message
In most countries, primary care is the foundation of the health system—the majority of the population has access to services, and large proportion of health problems are treated at this level. However, mental health problems are seldom addressed in primary care, creating an enormous treatment gap (the disparity between the large number of people affected by mental disorders and the small number who have access to treatment). The only solution to addressing this treatment gap is integration of mental health care into primary care.

Recommendations
1. Detect depression in primary care settings
2. Treat depression in primary healthcare using general health teams; refer complex cases to specialists
3. Formalize and integrate the PNDTD model of addressing depression in primary care

Introduction
PNDTD became a national program in 2001 with the aim to bridge the large treatment gap for depression in Chile. Studies from the 1990s demonstrated an estimated 5.7% prevalence of depression. At the time, treatment was rarely available, and if it was, it was provided in specialized settings and only in urban areas.

Later, another study reported that 26% of women over the age of 15 had experienced symptoms of depression, and 33% reported a lifetime diagnosis of depression.

Currently, there is still a high prevalence of depression in Chile, and mental disorders are the largest contributor to the burden of disease (disability and mortality) in the country (23.2%). Depression alone accounts for a total of 4.5% of total disability adjusted life years (DALYs) lost.
About the Innovation
PNDTD seeks to increase access to treatment for persons with depression by integrating mental health care into a network of the 500 primary care centers throughout Chile. Each center has one or more local general clinical teams composed of primary care doctors, nurses, midwives, psychologists, social workers and auxiliary nurses.

Any member of the primary care team can detect and refer a potential case of depression to general practitioners. The doctor confirms diagnosis using the World Health Organization ICD-10 criteria, assesses the severity of symptoms and psychosocial risk factors, and enrolls the person in the program. Mild, moderate and severe cases are treated according to pre-established clinical guidelines that include medical visits and assessments, individual or group therapy and psychotropic medication, as needed. Patients are monitored for at least six months, and, if their symptoms do not improve, are referred to specialized community mental health teams. Patients who are suicidal or exhibit psychotic features are also referred. Specialists regularly work with the primary care teams for the evaluation of difficult cases, accompaniment and referral.

Treatment for depression is guaranteed by law for all people over the age of 15 through the Explicit Health Guarantees (GES). This means that any person who lives in Chile and is diagnosed with depression has the right to access care (supportive diagnostic procedures, medical visits, psychological and pharmacological treatment) depending on the severity of the disease, with an established maximum amount of co-payments, regardless of whether the person has public or private health insurance.

“While research evidence for the effectiveness of mental health services in the primary care setting continues to accumulate, low- and middle-income countries should get started on the lengthy process of scaling up by incorporating the elements that led to decisionmaking and implementation of the PNDTD in Chile.”

- Araya et al, 2012
Impact
PNDDT now covers close to 35% of the population affected by depression who are insured by the public scheme affected by depression. Women and people with less education are more likely to access PNDDT, which suggests that the introduction of a universal health program for depression in a middle-income country can substantially reduce the treatment gap and socioeconomic inequalities in mental healthcare.  

Other key impact indicators:

- The relationship between general practitioner visits and psychiatrist visits for mental conditions has been inversed since 1995
- Almost 100% of primary care facilities have at least 1 psychologist (the national average is 2 per clinic)
- PNDDT improves patient outcomes: 70% of individuals treated by PNDDT recovered, compared to just 30% of those receiving usual treatment
- The incremental cost of obtaining an extra depression-free day with the intervention does not exceed 1.04 USD (90% probability)
- The cost of the program is approximately 0.10 USD per person per day

Recommendations

1. **Detect depression in primary care settings**
Because mental health problems are usually undetected or masked by other health problems and symptoms, it is imperative to assess for depression during routine medical visits or any point of contact with the primary care system. Prioritizing risk populations, e.g. pregnant or postpartum women, for screening in primary care is essential.

2. **Treat depression in primary healthcare using general health teams; refer complex cases to specialists**
Fifteen years ago, mental health problems, the greatest burden of disease in Chile, were unaddressed in primary care. However, in Chile and most other countries across the world, primary health centers are the main point of entry to healthcare for the population. Thus, introducing detection, diagnosis, and treatment of depression in primary care allows PNDDT to cover most cases of depression, reducing the social impact of the disorder. Establishing psychiatric liaison services with primary care creates a referral pathway for complex cases (e.g. suicide risk, psychosis, treatment resistance), supports the development of capabilities in primary teams, and guarantees continuity of care.

3. **Formalize and integrate the PNDDT model of addressing depression in primary care**
Through continuous primary care team training programs, referral protocols, and dedicated funding for PNDDT, Chile was able to fully integrate the program into the existing healthcare infrastructure. These steps are essential to ensuring that the innovation becomes a priority for primary care and the entire health system.
Limitations

- High turnover of psychologists and primary care physicians
- Insufficient resources at primary health and specialized levels
- Lack of a comprehensive impact evaluation of the program may hinder scale-up

Acknowledgements


References