Innovation Case Study: Programme for Screening, Diagnosis and Comprehensive Treatment of Depression (PNDTD),

Country: Chile

Objective: To bridge the large treatment gap for depression in Chile.

Innovation: Nationwide integration of detection and treatment of depression into primary care.

Project Type: Programme

SUMMARY

PNDTD was introduced in 2001 and became a national program in 2003. It functions in a network of 500 primary care centres throughout Chile. Each centre has a general clinical team composed of primary care doctors, nurses and auxiliary nurses, with specialist supervision for severe cases and access to psychologists in primary care.

1. Detection of depression is carried out by any health professional in the primary health care clinic during regular consultations.
2. Possible cases are referred to a primary care physician for further assessment and diagnosis. Severe cases are referred to a mental health specialist.
   - Confirmed cases enter a depression-management program with checks every two weeks, antidepressant medication and individual or group psychotherapy. Monitoring is maintained for at least six months. If the persons’ symptoms do not improve, he or she is referred to a specialist.

IMPACT SUMMARY

- Randomized control trials have shown positive service user outcomes with a recovery rate of 70% compared with 30% for those receiving usual treatment; [1] and that the program is cost-effective. [2]
- The number of full-time psychologists in primary care increased by 344% between 2003 and 2008. [3] This has resulted in more than a 5-fold increase in visits to primary care for a mental health condition while visits to psychiatrists remained relatively stable. [4]

“In primary care, there have been many attempts at introducing mental health programs, but they did not have the financial or political backup...This was different...a program with a clinical protocol, financial and political support, [and] itemized resource allocation.”

- Head, Primary Care Division, Ministry of Health, Chile [5]
### PART 2: INNOVATION

#### INNOVATION DETAILS

Any member of the primary care team can detect and refer a potential case of depression to the program. [5]

- Referrals are seen by General Practitioners and/or Psychologists who confirm the diagnosis according to ICD-10 criteria; assess the severity of symptoms and psychosocial risk factors; and, if required, enrol the person in the program.
- If depression is severe, the person is referred to a mental health specialized unit for a psychiatric assessment (7% of cases).
- If depression is of moderate or mild severity, the person is seen and followed up in the primary care setting according to pre-established clinical guidelines that include frequent consultations and assessments, individual or group therapy, and psychotropic medication, as needed.
- If follow up assessments show little progress or clinical deterioration, a joint assessment by a team leader and a psychiatrist is undertaken and adjustments to treatment are made.
- Patients responding well to treatment are followed up for at least 6 months before discharge.

#### COLLABORATION

**Funders**

- The program is funded by public and private health insurance schemes. Around 80% of the population are covered by public health insurance which is funded by the Ministry of Health.
- The original trials were funded by the US National Institutes of Mental Health (NIMH).

**Partners**

- Ministry of Health, Chile
- Universidad de Chile
- University of Bristol, UK

#### IMPLEMENTATION

**Key Drivers**

Four key drivers have been identified that facilitated the scale up of the programme to the national level: [5]

1. **Scientific evidence**
   - To show that depression (or indeed any other pressing problem) is or should be an important public health priority and there are cost-effective solutions locally
   - All information needed to be disseminated proactively, succinctly, quickly, and in a language understandable by policymakers.

2. **Teamwork and leadership**
   - A group of widely respected and politically “friendly” professionals joined together by a common goal, acting as leaders in a team effort
   - Leaders capable of communicating effectively with decision makers
   - Leaders with a capacity to detect emerging opportunities and react accordingly
   - Leaders capable of negotiating political agreements at all levels
• Individuals with at least basic technical knowledge, capable of preparing and defending a solid proposal
• Trustworthy individuals capable of forming alliances with strategic partners and ensuring these new resources are on fixed contracts

3. Strategic alliances
• With key individuals occupying positions of political power at the Ministry of Health
• Across sectors with strategic partners
• That can persist over time
• With other units by which the program can be co-owned, especially those with more power within the organization

4. Program institutionalization
• Using well recognized models of health care delivery within the Ministry of Health
• Placing the program among other well established primary care programs
• Finding and introducing personnel (psychologists) widely available and at an affordable cost with potential to lead the program locally
• Fence ringing any new and essential financial resources

Key challenges
• Establishing mental health as an important issue in the political agenda.
• Incorporating a new cadre of health professionals (psychologists) into the primary care budget.
• Incorporating new activities into the existing workload of health professionals in primary care, who are often overloading with activities for other programs.
• Overcoming the initial resistance from mental health specialists of primary health care workers treating depression.

CONTINUATION
The existence of the programme for depression allowed health guarantees related to schizophrenia and substance abuse disorders to be approved in Chile in 2005. These programs were implemented using the existing resources in primary care made available through the depression program. More recently, health guarantees for bipolar disorder were approved. This includes a significant role for primary care in the identification of cases.

The Ministry of Health in Chile is currently considering increasing the coverage of the depression program to children younger than 15.

IMPACT DETAILS

EVALUATION METHODS
A series of clinical trials have been conducted in Chile testing the approach. After the program was implemented, routine monitoring and evaluation has been conducted.
## IMPACT OF INNOVATION

### Programme Cost-effectiveness or budget
- Clinical trials have shown the approach has been shown to be cost effective with the incremental cost of obtaining an extra depression free day $1. [2]
- In 2005 the budget was US $6 million. [5]

### Impact
- The approach has been shown to improve patient outcomes in a series of trials. People on this program achieved a recovery rate of 70% compared to 30% for those receiving the usual treatment. [1]
- The number of full-time psychologists in primary care increased by 344% between 2003 and 2008.[3] This has resulted in more than a 5-fold increase in visits to primary care for a mental health condition while visits to psychiatrists remained relatively stable. [4]
- The programme has grown steadily since its inception in 2001. In 2007 more than 170,000 patients started treatment.[4] The program now covers close to 50% of the population affected by depression.
- Women and those with less education are more likely to use the programme, showing that the introduction of universal health programmes for depression can reduce substantially the gap and socio-economic inequalities in access to health care in middle income countries. [6]

## REFERENCES