

# Depression in primary care: Chile's Programme for Screening, Diagnosis and Comprehensive Treatment of Depression

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In 2001, an initiative to provide effective treatment for people with depressive disorders in primary care clinics was introduced in Chile, the Programme for Screening, Diagnosis and Comprehensive Treatment of Depression (PSDCTD) (Ministerio de Salud, 2001). It was extended to all primary care clinics in the country 4 years later.

The PSDCTD works as follows. The detection of depressive cases is done by any health professional in the clinic during regular consultations. Identified potential cases are referred to a physician within the clinic, who confirms the clinical diagnosis (using ICD-10 criteria). If the depression is severe (defined by the presence of marked suicidality, bipolar disorder or psychosis), the patient is referred to a specialist clinic for evaluation by a psychiatrist. Patients retained for treatment in primary care enter a depression management programme based on clinical guidelines, which stipulate checks every 2 weeks, antidepressant medication (fluoxetine, sertraline or venlafaxine), and individual or group psychotherapy. If there is little improvement with this regimen, a joint assessment with a consultant psychiatrist is arranged and, if necessary, the person may be referred to a specialist clinic for further treatment (about 14% of cases). For those who respond well, monitoring in primary care is maintained for not less than 6 months (Ministerio de Salud, 2001).

During 2001, a total of 18224 persons used this service; the annual total had increased to 125425 in 2005 and approximately 200000 each year thereafter (Ministerio de Salud, 2009). The public expense for this programme grew from US\$893460 in 2002 to US\$33642991 in 2008, more than a 30-fold increase in 6 years!

## Programme's development

At the early stages of the introduction of this policy, scientific research, especially that done within Chile, played an important role, together with a strong and dynamic leadership,

which helped to amalgamate the technical and political will to make the PSDCTD a success.

Scientific research had a major influence, because the results not only indicated the magnitude of the problem within the country (Ministerio de Salud, 1996; Araya *et al*, 2001; Vicente *et al*, 2004), but also provided strong evidence that it was possible to introduce cost-effective interventions within primary care (Araya *et al*, 2003; Gilbody *et al*, 2003). This provided a strong basis for the introduction of the policy. While studies conducted in other parts of the world reported good results from initiatives seeking to improve the effectiveness of treatments for depression (Gilbody *et al*, 2003), having information from studies in Chile was a key factor in persuading political authorities to make a commitment to the programme.

In the 1990s, two studies of the prevalence of mental disorders were conducted, and both showed a high prevalence of depressive disorders. One of these, conducted in Santiago ( $n = 3870$ ) in 1998, found a point prevalence of common mental disorders of 25%, and of 5.5% for depressive episodes only (meeting ICD-10 criteria) (Araya *et al*, 2001). The other was conducted in four cities in Chile ( $n = 2978$ ) and reported a 6-month prevalence of 19.7% for all mental disorders studied and 4.7% for major depressive disorder according to DSM-III-R criteria (Vicente *et al*, 2004). Though these two studies used different methodologies, they came to similar results, adding further credibility to their estimates.

Also in the 1990s, a study of disease burden estimated the impact of different diseases through premature mortality and disability. Mental disorders were among the leading causes of lost years of healthy life in Chile, and depressive episodes were the leading specific cause among adult women (Ministerio de Salud, 1996). This study was coupled with a cost-effectiveness study which showed that the out-patient treatment of depression was the third most cost-effective intervention examined (after treatment of tuberculosis and cervical cancer).

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Later, between 1999 and 2001, a controlled trial in primary care clinics evaluated the effectiveness of a comprehensive multi-component treatment programme for depression, which included: participation in structured group psycho-education (led by social workers and nurses); systematic monitoring of clinical progress; and drug treatment for the most severe cases (performed by general practitioners). This programme was much more effective and slightly more expensive than usual care (Araya *et al*, 2003, 2006). People receiving this 'improved care' programme obtained a recovery rate of 70%, compared with 30% in the 'usual treatment' group.

## Programme's effectiveness

Once the PSDCTD had been launched, an evaluation of its effectiveness was undertaken, based on monitoring a cohort of patients. This cohort showed a significant decrease in the intensity of depressive symptoms at 3 months, in comparison with those who abandoned the treatment (Alvarado *et al*, 2005a). Factors reducing the effectiveness of treatment included comorbidity and psychosocial complications. There was a drop-out rate of 19.5% from the programme within the first 3 months (Alvarado *et al*, 2005b). These results were known by the Ministry of Finance during the budget negotiations of 2004; nonetheless, a further increase in resources was agreed to extend the activities of the programme throughout Chile. Successful experiences with other health programmes (maternal and child health, chronic diseases, and so on) helped to convince policy makers to support the programme, and this was facilitated by the coincidental introduction of a National Mental Health Plan. There were five activities that were critical to the success of the PSDCTD:

- the definition of evidence-based activities that were feasible to be implemented in primary care clinics
- ongoing training of primary care teams, through short courses and ongoing joint consultations (mental health professionals reviewed clinical cases with primary care teams)
- additional resources for the recruitment of mental health professionals and purchase of medication
- better coordination between primary and specialist care (ensuring continuity of care)
- training and ongoing support for local and regional mental health managers (regional and municipal).

A multidisciplinary team at the Ministry of Health led this initiative, advocating for more resources with authorities at the Ministries of Health and Finance, supporting local management teams, as well as negotiating with various

actors involved in implementing the PSDCTD. This team gradually institutionalised the programme (incorporating depression among the country's top health priorities and ensuring the continuous flow of resources), something crucial for the sustainability of this policy.

## Conclusion

The PSDCTD has been active for 8 years and is seen as an example of a successful policy in terms of coverage, effectiveness and sustainability. Chile is one of the few middle-income countries that has implemented a national programme for the treatment of depression in primary care with good results and we believe this experience could be emulated by other countries.

## References

- Alvarado, R., Vega, J., Sanhueza, G., *et al* (2005a) Evaluation of the Program for Depression Detection, Diagnosis, and Comprehensive Treatment in Primary Care in Chile. *Revista Panamericana de Salud Pública*, **18**, 278–286.
- Alvarado, R., Sanhueza, G., Munoz, M., *et al* (2005b) Necesidades clínicas y psicosociales en mujeres que ingresan al Programa para el Tratamiento Integral de la Depresión en Atención Primaria, en Chile [Clinical and psychosocial needs of women in the Programme for Depression Detection, Diagnosis, and Comprehensive Treatment in Primary Care in Chile]. *Revista de Psiquiatría en Salud Mental*, **22**, 83–92.
- Araya, R., Rojas, G., Fritsch, R., *et al* (2001) Common mental disorders in Santiago, Chile. Prevalence and socio-demographic correlates. *British Journal of Psychiatry*, **178**, 228–233.
- Araya, R., Rojas, G., Fritsch, R., *et al* (2003) Treating depression in primary care in low-income women in Santiago, Chile. *Lancet*, **361**, 995–1000.
- Araya, R., Flynn, T., Rojas, G., *et al* (2006) Cost-effectiveness of a treatment program for depression among low-income women in primary care: Santiago, Chile. *American Journal of Psychiatry*, **163**, 1379–1387.
- Gilbody, S., Whitty, P., Grimshaw, J., *et al* (2003) Educational and organizational interventions to improve the management of depression in primary care: a systematic review. *JAMA*, **289**, 3145–3151.
- Ministerio de Salud (1996) *Estudio de Carga de Enfermedad* [Studies of Disease Burden]. Ministerio de Salud.
- Ministerio de Salud (2001) *Guía Clínica para la atención primaria: La depresión, detección, diagnóstico y tratamiento* [Clinical Guidelines for Primary Care: Depression, Detection, Diagnosis and Treatment]. Ministerio de Salud.
- Ministerio de Salud (2009) *Avance Programa Depresión y GES* [Progress Programme for Depression and GES]. Ministerio de Salud.
- Vicente, B., Kohn, R., Rioseco, P., *et al* (2004) Population prevalence of psychiatric disorders in Chile: 6-month and 1-month rates. *British Journal of Psychiatry*, **184**, 299–305.

Time is very slow for those who wait,  
Very fast for those who are scared,  
Very long for those who lament,  
Very short for those who celebrate,  
But, for those who love,  
Time is eternity.

William Shakespeare

A future is not some place we are going, but one we are creating. The paths to it are not found but made and the activity of making them changes both the maker and the destination.

John Schaar