SPECIAL PAPER

Integration of mental health into primary care: a Chilean perspective on a global challenge

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Chile has been successful in integrating mental health and primary care. This paper describes the Chilean mental health service in primary care and the experience of scaling up a depression treatment programme. A new mental health plan is due to be introduced in 2016.

The coverage of mental health services in low- and middle-income countries (LMIC) remains poor (Wang *et al*, 2007) and the evidence on how these interventions can be combined and delivered in primary care remains elusive. Recent research from the PRIME project – the PRogramme for Improving Mental health carE – focuses on the development and implementation of packages of mental healthcare for delivery in primary care and maternal health in five LMIC (Lund *et al*, 2012). A supplement to the *BJPsych* in January 2016 presented district mental healthcare plans from the five LMIC participating in PRIME (see Lund *et al*, 2016). In this special paper we describe Chilean mental health services in primary care and the experience of scaling up a depression treatment programme in primary care in Chile.

Background

Chile has a population of 18 million, with an annual average income per capita of around US$20 000, a Gini coefficient of 0.51, and a life expectancy of 82 years (Comisión Económica Para América Latina y el Caribe, 2015). The national public health system provides services for 72.2% of the population. A network of primary care centres and services was established in 1952; this now comprises a total of around 2000 facilities, including family and community urban centres, rural general health centres and primary care emergency centres. These facilities have implemented many successful public health programmes.

Mental health services in primary care

A conference arranged by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) in Alma-Ata in 1978 and a regional conference for the restructuring of primary care in Latin America held in Caracas in 1990 together had a major influence upon the development of mental health services in the region, whereby asylum-based psychiatric services were transformed into community-based services. In Chile, along with a return to democracy, in 1990 a mental health unit was created within the Ministry of Health. In 1993 a national mental health plan was signed into law, and in 2000 a second plan defined programme priorities and further development of the community-based approach. The Mental Health Action Plan developed by the Pan-American Health Organization and World Health Organization in 2009 recognised the promotion of mental health services in primary care as one of its five priorities, highlighting the impact of primary care in the improvement of healthcare in the region. Chile chose this path to narrow the gap between mental health need and access to treatment. Accordingly, clinical guidelines are now available for mental disorders. Psychologists have been incorporated into all mental health primary care teams, and in 2010, of all mental health consultations in primary care, 54% were undertaken by a mental health professional (34% were undertaken by general practitioners and 9% by social workers). Many centres now receive psychiatric liaison consultations from the psychiatric services based in a general hospital.

Several well-designed epidemiological studies carried out in Chile have shown a high prevalence of mental disorders and psychological problems. For instance, Araya *et al* (2001) reported the 7-day prevalence rate of common mental disorders in the general population in Santiago to be 25%; Vicente *et al* (2004) reported a 6-month prevalence rate of 19.7% in the Chilean general population; and Vicente *et al* (2012) reported a 22.5% prevalence rate of mental disorders in children and adolescents between 4 and 18 years of age. In the WHO Collaborative Project on psychological problems in general healthcare, Santiago had the highest prevalence of mental disorders (52%) among the 15 cities studied (Ormel *et al*, 1994). Depression was one of the most common diagnoses. The highest prevalence of current depression was found in Santiago (29.5%), and the lowest was in Nagasaki, Japan (2.6%) (Ormel *et al*, 1994). In 2004, depression accounted for the second largest burden of disease, after hypertensive disease (Ministerio de Salud, 2008).

Depression treatment programme in primary care

In order to deal with the burden of disease represented by depression, a national programme for the detection, diagnosis and treatment of depression was launched in 2001. This nationwide programme consists of an assistance system that combines medical and psychosocial interventions

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with a plan for the detection, diagnosis, registration, treatment and follow-up of each case. Clinical guidelines have been established that use an algorithm to determine different steps that professionals should take with respect to patients presenting with depression. By 2004, the guidelines had been implemented in primary care clinics throughout the country. This now covers close to 50% of the population affected by depression.

Since July 2005, within the framework of a health reform, the law of Explicit Health Guarantees (GES) gives guarantees on access, opportunity, financial protection and quality of care for a set of prioritised health conditions. Incorporation of mental health conditions into GES has been gradual. Out of 80 health conditions prioritised, only four are mental disorders: schizophrenia, depression, alcohol/drug dependence and bipolar disorder. In 2007, a national plan for the biopsychological and social protection of children aged from 0 to 5 years was implemented, establishing coordination between primary care and community services based in each municipality.

Araya *et al* (2012) assessed the implementation of this programme and concluded that although scientific evidence is important, other factors seem equally relevant, such as effective leadership, strong strategic alliances and a political process to secure its sustainability. They concluded that the lack of evaluation of these interventions might undermine the continuation of the programme.

Furthermore, all these efforts have been hampered by poor detection of mental disorders, and difficulties in the access to care in the case of persons with severe mental disorders and lower income. Again, the impact of interventions for depression or other mental disorders in primary care have not been formally studied, so we remain ignorant as to which are the most cost-effective.

A promising way of dealing with some of these problems is highlighted by Araya *et al* (2012), who compared the effectiveness of a stepped-care programme with usual care to treat depression. The stepped-care intervention included: a psychoeducation group led by a trained non-medical health worker, drug treatment for patients with severe depression provided by trained general practitioners (GPs), structured and systematic follow-up, and psychiatric consultancy to GPs. In terms of the percentage recovered, there was a large and significant group difference in favour of the intervention group at 3 months (34%) and 6 months (40%). This programme was more effective and only marginally more expensive than usual care for the treatment of women in primary care. Women receiving the stepped-care programme had a mean of 50 additional depression-free days over 6 months, relative to patients who received usual care (Araya *et al*, 2003).

As a next step, Rojas *et al* (2007) carried out a randomised controlled trial to compare the effectiveness of a multi-component intervention with usual care to treat postpartum depression in 230 low-income mothers with major depression in primary-care clinics in Santiago. The multicomponent intervention did significantly better across all outcomes (26% difference in favour of intervention group at 3 months). However, the gains faded away with time (Rojas *et al*, 2007).

Conclusion

In summary, Chile has been successful in integrating mental health and primary care. There is still a need for improvement: quality assessments of implemented programmes, training of healthcare teams, and community-based interventions that meet users' needs are warranted. The budget assigned for mental health in Chile represents only around 2% of the health budget, and is very low even when compared with that in other countries in Latin America such as Uruguay and Costa Rica.

A new mental health plan will be introduced in 2016, incorporating as one of its key aspects improvements in mental health service provision, including in primary care. There remains a need for a mental health law.

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