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Guest editorial

Towards integrated primary health care for depressive disorder in the Netherlands. The depression initiative

In the Netherlands, principles of integrated care are seldom applied in the primary care setting, although such a care model might be indicated in diseases and mental disorders of a chronic and complex nature that are prevalent in the primary care setting. For example, in terms of mental health, depressive disorder warrants such an approach due to its high prevalence, chronic course, and burden for patients, health care and society [1–3]. However, treatment of depressive disorder in the primary care setting generally does not occur according to the principles of integrated care [4]. An integrated care model should follow the principles of disease management such as e.g. in disease management programs that have proven effective [5]. Such a program should encompass prevention, diagnosis, treatment according to guidelines, monitoring of treatment, attaining remission and relapse prevention [5]. Attaining implementation of such an integrated care treatment program for depressive disorder, and evaluating its effectiveness, is the goal of the depression initiative [6].

The depression initiative has been launched to integrate treatment for depressive disorder on a nationwide level according to the principles of disease management. It is a program aimed at implementation and evaluation of the multidisciplinary guideline for depressive disorder [7] and the depression standard [8] in primary care, in Mental Health Institutions, and in the general health, occupational health and community setting. The program aims to develop models of collaboration along the lines of an integrated care model in two ways, that are both described in this Journal: by a breakthrough collaborative strategy, and by implementation and evaluation of the (cost) effectiveness of a collaborative care model.

Breakthrough collaborative strategies have been used to support 13 depression breakthrough collaborative teams in attaining goals in implementation that were chosen by the teams. A breakthrough collaborative team consists of a general practitioner (GP) and a multidisciplinary team from a Mental Health Institution. The team decides to work on a certain theme for a year, i.e. improving diagnosis of depression in primary care, or improving monitoring of chronic depression. The Trimbos Institute facilitates the teams in attaining this implementation according to the multidisciplinary guideline for depression as described elsewhere in this Journal [9]. In total 101 health professionals participated in the depression breakthrough collaborative teams, and 536 patients were diagnosed with depressive disorder. The proportion of depressed patients receiving a first step treatment according to the stepped care model, improved during the project, however, this was especially the case for less severe depressive disorders; implementation projects should pay special attention to the quality of care for severely depressed patients. It is presumed that more structured interventions to implement integrated care, and rigorous data assessment for its evaluation, is needed, especially for more severe depressive disorder.

The other model for implementation and evaluation of integrated care for moderately severe major depressive disorder in the primary care setting is collaborative care. This is a highly structured model for collaboration between at least two out of three professionals in the primary care setting, namely the GP, the care manager and the consultant psychiatrist [10]. In the depression initiative, this model has been implemented in 4 regions, with 78 GPs and 2 Mental Health Institutions. GPs as well as Mental Health Institutions are still joining in as this project is continuing. The structure needed for the integrated care approach is provided by an algorithm, developed by the research group, embedded in a web based tracking system for the care managers and GPs. Also, a training carousel for the care managers and GPs is provided, together with structurally embedded possibilities for psychiatric consultation. GPs tend to be happy with the concept of structural monitoring according to an algorithm, provided that the algorithm is distilled from the depression guideline and that structural consultation by trained psychiatrists is provided. This model is described elsewhere in this Journal as well [11].

Both efforts to implement integrated care, as described in the two articles recently published in this Journal [9, 11], face similar factors that can facilitate implementation of integrated care. Both projects seek a link between professionals and patients in the primary care setting, which underscores that primary care is of paramount importance for attaining integrated care for depressive disorders. Also, all professionals involved in both projects are enthusiastic about collaboration

with the depression initiative. Apparently, the concept of integrated care is appealing to them. Furthermore, the use of a web based algorithm to support health care professionals in performing their task according to principles of integrated care is widely accepted in the collaborative care project and seems to be an effective way to overcome the fuzzy structure of the primary care setting. As such, it may be a way to provide the structural support that has been found to be needed in the more severely depressed groups, as assessed in the depression breakthrough collaborative project [9].

However, for both projects, limitations for the implementation of integrated care were found as well. Reimbursement problems do make it difficult to implement this model rapidly on a wide scale and a policy aimed at facilitating reimbursement of integrated care programs such as collaborative care for depressive disorder in the primary care setting is certainly needed. Also, an infrastructure that facilitates early detection of patients with vulnerability to develop depressive disorder, and that facilitates entrance at the primary care setting, is needed. GPs should have the option to choose with which health care professional they work in order to build a chain of care for their patients. Both articles in this Journal aim to identify factors of influence for the implementation, and to give recommendations on micro-, meso- and macro-level for attaining integrated care for depression in the primary care setting.

For further research, it should be taken into account that there are many disruptions in the care for patients with chronic complex conditions, as health care is fragmented. Studying integrated care would require studies aimed at better quality of life, with outcome assessment in terms of professional defined components of care, as well as patient defined components of care. Measuring the impact of the effect requires a monitoring system not only aimed at the primary process of patient treatment, but also on the secondary, organisational process aimed at feedback to improve the disease management system. And patients should be approached in terms of empowerment. People with chronic illness face many tasks in their life. Integrated care should be more goal directed than disability directed, and focus on enhancement of coping and self management of patients.

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