

Use of Mental Health Services in Chile

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Objectives: To address the growing burden of mental illness in Latin America, a better understanding of mental health service use and barriers to care is needed. Although many Latin American countries have nationalized health care systems that could potentially improve access to care, significant barriers to care remain. The authors report the results of a study examining mental health service utilization in the general population of Chile. **Methods:** The data were drawn from the Chile Psychiatric Prevalence Study, a national household survey of 2,987 persons aged 15 years and older conducted in 1992–1999. As part of the survey, psychiatric diagnoses were obtained by using the Composite International Diagnostic Interview, and respondents were asked about their use of general and mental health care services in the past six months and about their experience of barriers to treatment. **Results:** More than 44 percent of respondents reported use of any health care services in the past six months, and 20 percent reported use of mental health services. Of the respondents who met criteria for a psychiatric disorder, a large proportion (62 percent) did not receive mental health care. Increasing severity of the psychiatric disorder correlated with increasing frequency of overall help seeking, but only a small proportion of the respondents with a psychiatric disorder sought specialized mental health services. Regional disparities and inequities in access to care were found. In addition, indirect barriers to mental health care, such as stigma and misconceptions about the course of psychiatric disorders, were important deterrents to service utilization, particularly among persons with lower socioeconomic status. **Conclusions:** To reduce the burden of mental illness in Chile, additional efforts are needed to address both the direct and the indirect barriers to mental health care, including regional inequities in access to care. (*Psychiatric Services* 55: 71–76, 2004)

The burden of mental illness is of growing concern in Latin America. By the year 2020 the proportion of disability-adjusted life years attributable to neuropsychiatric conditions is expected to be 20.6 percent in Latin America (1). To better

understand the mental health needs of the population and to allow better allocation of mental health care resources in Latin America, several studies have been conducted to estimate the prevalence of psychiatric disorders in the community (2–8).

The World Health Organization (WHO) world atlas of mental health resources compiled in 2002 showed a wide disparity between developing and developed countries in the proportions of the health care budget allocated to mental health and in the availability of mental health care resources (9). For example, the proportion of the health care budget allocated to mental health was 1.5 percent in Chile, compared with 11 percent in Canada and 6 percent in the United States. The number of psychiatric beds per 10,000 population was 1.8 in Chile, compared with 19.3 in Canada and 9.5 in the United States.

Utilization of mental health services in Latin America and other developing regions has received only limited attention from researchers. To our knowledge, only three epidemiological studies (3,5,7) using the Composite International Diagnostic Interview (CIDI) (10) have examined rates of mental health service use among persons with psychiatric disorders in Latin American countries. Two of these reports were from Mexico, one representing Mexico City (5) and the other limited to use of services by persons with affective disorders in rural Mexico (7). The third study was from a middle-class catchment area in São Paulo, Brazil (3). Each of these reports suggested a high prevalence of untreated disorders. These studies did not examine determinants of use of mental health care or barriers to care.

Health care in Chile is provided primarily through a public national health service that was established in 1952 as well as through an active private sector. The mental health care

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Table 1

Public-sector mental health service resources per 100,000 population in four Chilean provinces and nationwide in Chile, 2001^a

	Santiago	Concepción	Iquique	Cautin	National total
Psychiatric beds	34.2	4.8	32.4	2.2	21.5
Physicians	801.2	439.3	151.9	158.6	547.3
Primary care physicians	185.8	169.7	61.6	57.0	151.0
Psychiatrists	28.9	5.7	2.9	2.2	17.4
Mobile teams	.3	.4	1.2	.5	.4
Day hospital openings	4.3	7.6	6.2	10.5	5.9
Group home openings	7.7	2.7	12.7	2.0	5.8
Social club openings	6.7	17.1	86.2	17.4	10.2
Day center openings	8.0	11.3	20.5	16.8	10.7
Sheltered workshop openings	4.4	3.0	6.2	2.9	3.6

^a Based on data from the Chilean Ministry of Health

system evolved initially with a focus on inpatient care for severely mentally ill patients. More recent trends have included efforts to encourage deinstitutionalization, increase the use of general medical facilities for psychiatric treatment, and promote psychiatric treatment at the primary care level. In the past decade a formal national mental health care plan was developed to reorganize the delivery of services, and a division within the Ministry of Health was created to assume responsibility for the mental health care budget and the allocation of mental health care resources. Publicly funded inpatient and outpatient mental health services, including services provided in the primary care sector, have been established in each of the 28 health care districts in the country. Primary care facilities responsible for a geographically defined catchment area are widely distributed to provide coverage to small population centers as well as rural areas. In addition to a primary care physician, a nurse, and a social worker, each of these primary care centers has a mental health team funded through national programs, such as the National Program on Depression, that treat mild to moderate cases. Individuals with serious mental illness are managed in nearby psychiatric facilities, which have outpatient clinics. Beyond deinstitutionalization, the goal of the national mental health care plan was to address the growing burden of mental illness by providing services to a wider range of persons in the com-

munity who need psychiatric treatment, not only to those with severe mental illness.

This report draws on data on mental health service use and barriers to mental health care collected as part of the Chile Psychiatric Prevalence Study. The study was conducted in 1992–1999 to determine the prevalence of and risk factors for mental illness in a nationally representative sample.

Methods

Sample selection

The Chile Psychiatric Prevalence Study was based on a stratified household sample of persons aged 15 years and older. In Chile, persons aged 15 years and older are considered adults within the health service system. Four of the 13 regions of the country were sampled to obtain a sampling frame representative of the national population. Within each region the province whose population was most representative of that region of the country was selected. These four provinces represented geographically distinct regions of the country: Santiago, the capital, which is located in the north central region and includes a third of the nation's population; Concepción, the country's second largest city, which is located in the south central region; Iquique, a less populated province located in the north; and Cautin, a less populated province located in the south. As Table 1 shows, the availability of services in the public health sector varied

markedly across these four provinces. In Chile, provinces are subdivided into *comunas*, subsequently into districts, and then into blocks. Within each province, blocks were randomly selected for inclusion in the study. The 1992 national census was used to determine the number of households in each *comuna* and thereby the number of blocks needed. The Kish procedure was used to select one person per household (11).

The department of psychiatry and mental health at the University of Concepción conducted the study between July 1992 and June 1999, with the four sites of Concepción, Santiago, Iquique, and Cautin each being completed sequentially as funding was secured. The response rate was 90.3 percent, and a total of 2,987 persons participated in the study.

Interview schedule

Versions 1.0 and 1.1 of the CIDI were the primary instruments used by the interviewers to conduct the diagnostic interview in the Chile Psychiatric Prevalence Study. The instruments were translated into Spanish by using the protocol outlined by WHO (12), and the translated instruments subsequently became WHO-approved Spanish versions of the CIDI. Validation studies of the Spanish versions reported kappas ranging from .52 for somatoform disorders to .94 for affective disorders (13). Similar procedures were used to develop a validated translation of the section on posttraumatic stress disorder (PTSD) of the Diagnostic Interview Schedule (14), which was also used in the diagnostic interview. The validation study for this section reported a kappa of 0.63 (15).

The psychiatric diagnoses were based on the *DSM-III-R* (16). This analysis focused on one-year prevalence of any psychiatric disorder. The disorders that were included were nonaffective psychosis, major depression, mania, dysthymia, panic disorder, agoraphobia, PTSD, somatoform disorder, alcohol abuse, alcohol dependence, drug abuse, and drug dependence. The severity of a psychiatric disorder was rated with an index based on the diagnosis and the extent of comorbidity (17). The severity index was modified for use in Chile to

account for culturally appropriate clinical presentations and the inclusion of nonaffective psychosis, PTSD, somatoform disorders, and cognitive disorders. A severity score of .5 was assigned to substance abuse and to somatoform disorder. A score of 1 each was given to cognitive disorder, substance dependence, dysthymia, agoraphobia, and generalized anxiety disorder. Panic disorder, PTSD, mania, and depressive disorder each received a score of 2, and nonaffective psychosis received a score of 3. An additive summary score for severity was generated, with cutoff points of 0, 1, 2, and 3.

The interview schedule also included a section on health service use in the six months before the interview. Respondents were asked about their use of any health care services; any mental health care services—which included specialized mental health care and nonspecialized mental health care; and substance abuse services. Specialized mental health care included any inpatient or outpatient services provided by a psychiatrist or a psychologist or formal substance abuse services; nonspecialized mental health care focused on care provided by primary care physicians; and substance abuse services included inpatient and outpatient detoxification as well as attendance at Alcoholics Anonymous. Questions about the use of public- and private-sector services, formal and informal health care, and barriers to care for physical and psychiatric problems were included. For barriers, respondents chose from a list of reasons they might not have sought care.

The institutional review board of the University of Concepción approved the study. All interviewed respondents provided formal informed consent.

Data analysis

The percentages reported here were weighted to account for two factors: the probability that the *comuna*, district, block, household, and respondent would be selected for the sample and the distribution of age groups, gender, and marital statuses in the general population according to the 1992 national census. Because of the characteristics of the sample and the

need for weighting, standard errors were estimated by using the Taylor series linearization method included in the SUDAAN statistical package (18). Chi square and logistic regression analyses were used in the data analysis.

Results

More than 44 percent of the respondents used some form of health care services during the past six months. Approximately 17.7 percent of the population received nonspecialized mental health services during the past six months, and only 5.6 percent of the population received services delivered by the specialized mental health system. During this period 3.3 percent of the population had spent at least one day in a hospital as a result of a psychiatric or a general health condition.

Women were more likely than men to seek any health care services (44.2 percent compared with 39.3 percent; $\chi^2=6.95$, $df=1$, $p<.02$) and to seek nonspecialized mental health services (17.7 percent compared with 11.2 percent; $\chi^2=10.84$, $df=1$, $p<.003$). Gender differences were not found for specialized mental health services. Respondents in different age groups had different rates of service use, with respondents aged 55 to 64 years having the highest rate of use of any health care services (55.5 percent; $\chi^2=20.52$, $df=5$, $p<.005$) and respondents aged 15 to 24 years having the highest rate of use of specialized mental health care (8.6 percent; $\chi^2=9.70$, $df=5$, $p<.006$). In the analysis of marital status, widowed respondents were found to use the most health care services overall (52.5 percent; $\chi^2=14.39$, $df=4$, $p<.02$), and those in a common-law relationship had the highest rate of use of specialized mental health services (9.5 percent; $\chi^2=3.176$, $df=4$, $p<.001$). Education and income did not predict service use. Regional differences were found in health care use, but no differences were found between urban areas and rural areas. Respondents in Cautin had the least use of any health care in the past six months (36.1 percent; $\chi^2=19.26$, $df=3$, $p<.002$), as well as the least use of nonspecialized mental health care (11.1 percent; $\chi^2=13.28$,

$df=3$, $p<.01$). The rate of use of any mental health services was 22.5 percent in Santiago, 18.5 percent in Concepción, 26.1 percent in Iquique, and 12.1 percent in Cautin. The rates of use of specialized mental health services in the four locations were 5.2 percent, 6.8 percent, 5.6 percent, and 3.4 percent, respectively.

The one-year prevalence of mental illness in Chile was 19.3 percent. As Table 2 shows, having a psychiatric diagnosis was predictive of mental health service use but not of use of overall health care services. Although respondents with a psychiatric diagnosis had a higher rate of hospitalization in the past six months (6.4 percent) than those without a psychiatric diagnosis (2.4 percent), the difference was not statistically significant ($\chi^2=3.94$, $df=1$, $p<.06$).

The one-year prevalence of a severity index score of 0 was 74.4 percent, and the rates were 13.8 percent for a severity index score of 1, 5.8 percent for a score of 2, and 5.9 percent for a score of 3. Higher severity index scores were associated with higher rates of mental health service use (Table 2).

When asked to identify someone who could provide assistance with mental health issues, most respondents did not identify alternatives outside the formal health care system. For example, talking with a friend was endorsed by 14.3 percent of the respondents, and talking with a member of the clergy was endorsed by only 2.7 percent of the respondents. In addition, consulting a *curandero*, or folk healer, was endorsed by only 1.2 percent of the respondents.

More than one-fourth of the respondents (26.5 percent) who had a medical consultation in the past six months reported that emotional issues were discussed. Forty-three percent of the medical appointments had not been made to address a psychiatric issue. Of those who did not seek medical attention, 28.5 percent acknowledged that they should have done so for a physical problem and 12.7 percent acknowledged that they should have done so for a psychological problem.

Table 3 lists reasons endorsed by respondents for not seeking treat-

Table 2

Use of services in a representative sample of the general population of Chile who participated in a household survey on the prevalence of psychiatric disorders, 1992–1999

Respondent group	Mental health services														
	Any health care services			All services			Nonspecialized services			Specialized services			Substance abuse services		
	%	SE	p ^a	%	SE	p ^a	%	SE	p ^a	%	SE	p ^a	%	SE	p ^a
All respondents (N=2,978)	44.2	2.3		20.1	1.2		17.7	1.1		5.6	0.6		0.2	0.1	
Respondents grouped by presence of a 12-month psychiatric diagnosis ^b			.20			<.001			<.001			<.001			.08
Without a diagnosis (N=2,349)	43.4	2.0		14.8	1.1		12.9	1.1		3.5	0.6		0.1	0.1	
With a diagnosis (N=629)	46.9	3.7		38.5	3.6		34.1	3.0		13.1	1.8		0.7	0.3	
Respondents grouped by severity index score ^c			.08			<.001			.004			.02			.23
Score of 1 (N=383)	39.4	3.7		20.3	3.6		17.4	3.6		5.0	1.8		0.1	0.1	
Score of 2 (N=189)	48.0	6.6		44.3	7.2		41.9	7.4		9.6	3.2		0.4	0.1	
Score of 3 (N=186)	60.2	7.0		65.0	4.1		57.5	5.0		29.4	5.1		2.1	1.1	

^a Chi square test with df=1 for comparison of respondents with and without a psychiatric diagnosis and df=2 for comparison of respondents grouped by severity index score

^b DSM-III-R diagnoses were generated by the Composite International Diagnostic Interview (10) administered by lay interviewers.

^c Based on severity of the psychiatric diagnosis and extent of comorbidity (18); higher scores indicate more severe disorder. The total number of participants with a severity index score of 1, 2, or 3 exceeds the number of participants with a psychiatric diagnosis because cognitive disorders were not included in the prevalence estimates of persons with a psychiatric diagnosis.

ment for physical or emotional problems. A forward logistic regression was conducted by using the data on each barrier to care to determine which sociodemographic factors were

associated with lower rates of help seeking for emotional disorders. Gender and presence of a diagnosis did not predict endorsement of any of the barriers to care. Respondents with

the lowest level of education were more likely to believe that their problems would resolve on their own. Concern about financial barriers to care was highest in the groups with the lowest levels of education and income. Not knowing where one should go for assistance was noted most frequently among the lowest-income group. Married persons and those with lower incomes were more likely to believe that treatment would not be helpful. Lack of transportation was more frequently endorsed as a barrier to care by married persons. Being preoccupied about what others might think was of greatest concern among those who were married as well as among those with the least education. Low levels of income and education were associated with the belief that consulting a mental health professional was too time-consuming. Concern about others' learning about the consultation was greatest among those with a lower level of education and those who were married. Persons who were younger were more likely to believe that they could solve their problems on their own. Fear of receiving a diagnosis was

Table 3

Reasons for not seeking treatment for physical and mental illness among respondents who acknowledged the need for treatment in a representative sample of the general population of Chile who participated in a household survey on the prevalence of psychiatric disorders, 1992–1999

Reason	Respondents who did not seek treatment for physical illness (N=1,387)		Respondents who did not seek treatment for mental illness (N=347)	
	%	SE	%	SE
Belief that problem will resolve on its own	55.5	3.7	65.7	5
Belief that the respondent could solve the problem him- or herself	52.8	4	60.1	3
Financial burden	35.8	3.2	43.6	3.2
Fear of the diagnosis	33.4	2.1	36.7	2.4
Time constraints	23	2	28.9	3.2
Lack of trust in health care providers	19.8	1.8	22.2	2.8
Belief that treatment would not be helpful	15.4	1.7	27.6	2.6
Concern about what others will think	10	1.7	24.1	4
Lack of knowledge about where to go for help	10.9	1.4	29	3.1
Transportation problems	9.8	2.5	11.4	1.9
Concern that someone may find out	8.5	1.4	22.1	4

highest among the lowest-income group. No predictors were found for lack of trust in mental health care professionals.

Discussion

This study represents the only examination of mental health care service use and barriers to care in a nationally representative sample of the population of a Latin American country. Despite its scope, the study has some limitations that must be considered in interpreting the findings. The psychiatric diagnoses were obtained by using a structured diagnostic instrument administered by lay interviewers. Reporting bias and the lack of a clinical assessment by a mental health care professional may have resulted in misclassification of persons who received treatment as not having a psychiatric diagnosis. The time lag in collecting data from each site could account for regional differences. However, we believed that this interpretation was unlikely because one of the sites in the southern part of the country was the first to participate and the other southern site was the last, yet the results for the two sites were similar. In addition, the limited availability of services in these regions corresponded with the increased rates of untreated illness found for those regions. The interview schedule did not include questions on lifetime use of services or on the use of pharmacologic and psychotherapeutic interventions.

Although utilization of overall health care services in Chile was high, most people with psychiatric disorders did not receive treatment. Approximately 61.5 percent of the respondents who met criteria for a psychiatric disorder in the past year did not receive mental health care. Even among those with the most severe disorders, such as nonaffective psychosis or comorbid disorders, 35 percent did not receive care. Only 13 percent of the respondents with a psychiatric disorder received specialized mental health services, and more than 70 percent of those with severe mental illness, as defined by the severity scale, did not receive care from mental health specialists. These findings are consistent with

the results of regional surveys in Mexico (5) and Brazil (3) that suggested a large gap between the need for treatment and treatment received. Despite the popular belief that alternative sources of health care, such as *curanderos* or the clergy, are frequently consulted in place of or in conjunction with the formal health care system in Latin America, the study findings suggest that, at least in Chile, such alternatives are not commonly used.

The sociodemographic predictors of mental health service use included female gender, being in the age group at risk of the onset of mental illness, and having a common-law relationship. The regional differences in health care use were consistent with the limited availability of both specialized and nonspecialized health care in the poorer southern half of the country (Table 1). These marked differences across the country are consistent with the profound inequities frequently found within developing nations, where services are generally centralized in the capital region and wealthier areas.

The primary direct barrier to mental health care in Chile was the lack of available services. The lack of services was further highlighted by the finding that 29 percent of the respondents reported not knowing where to go to receive assistance. In addition, despite the presence of a national health care plan in Chile, financial barriers precluded many respondents from seeking assistance. To a lesser degree, time constraints and lack of transportation were direct barriers to care. Indirect barriers that discourage treatment were prominent. Most respondents—more than two-thirds of the sample—had the misconceptions that psychiatric illnesses are self-limiting disorders that resolve on their own and that one can deal with these illnesses on one's own. A sizable proportion did not believe that psychiatric treatment could be helpful. Stigma was an important indirect barrier to treatment, as shown by the findings that one-third of the respondents were fearful of receiving a diagnosis of a mental illness and that nearly one-quarter reported concern about what others might

think or that someone would learn about their mental health consultation. Lower socioeconomic status, as evidenced by lower levels of education and income, was highly predictive of endorsement of indirect barriers that reduce the likelihood of seeking help. Although the findings for barriers to care were similar to those of other studies (17), gender was not associated with particular reasons for not seeking professional help.

Similar to findings for other countries (19), use of mental health services was reported by a large percentage of the respondents who did not meet criteria for a psychiatric disorder according to the CIDI. Respondents without a disorder constituted 56.9 percent of those who used mental health services. In comparison, 33.9 percent of the respondents in the U.S. National Comorbidity Study who did not have a disorder received care (20). Such persons could have subthreshold psychiatric disorders that do not meet diagnostic criteria but need to be treated, or they could have met diagnostic criteria at some point but, as a result of successful treatment, no longer do so. In addition, it may be argued that the presence of a national health care service and the reorganization of mental health services to emphasize treatment in the primary care system may have reduced barriers to care for those who have mild conditions that do not warrant attention in specialty care.

If developing countries are to successfully reduce the disability associated with mental disorders, much more emphasis needs to be placed on addressing both the direct and the indirect barriers that persist. WHO (21) has outlined ten recommendations for developing countries to implement in order to reduce the treatment gap in mental health: make mental health treatment accessible in primary care; make psychotropic drugs readily available; shift care away from institutions toward community care; educate the public; involve family, communities, and consumers; establish national mental health programs; increase and improve the

training of mental health professionals; increase links with other governmental and nongovernmental institutions; provide monitoring of the mental health system with quality indicators; and provide additional support for research. ♦

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Psychiatric Services Invites Short Descriptions of Novel Programs

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Text should be 350 to 750 words. A maximum of three authors, including the contact person, can be listed; one author is preferred. References, tables, and figures are not used. Any statements about program effectiveness must be accompanied by supporting data within the text.

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