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Epidemiology of Mental Disorders, Use of Service, and Treatment Gap in Chile

ABSTRACT: *The World Health Organization (WHO) estimates place Chile among the countries with the highest burden of disease from neuropsychiatric illnesses (23.2 percent) in the world. Major depression and alcohol use disorders rank first and second in attributed disability among adults. Nearly one-third of the population over 15 years of age has had a psychiatric disorder in their lifetime and 22.2 percent have had one in the past year. Anxiety disorders are the most prevalent, followed by major depression and alcohol use disorders. Only 38.5 percent of those with a diagnosis receive any kind of mental health service, whether from a specialist or primary care physician. In children and adolescents, the prevalence of any psychiatric disorder is 22.5 percent (19.3 percent for boys and 25.8 percent for girls). These are mainly anxiety and disruptive disorders. Their prevalence is higher among 4 to 11 year olds (27.8 percent) than 12 to 18 year olds (16.5 percent). This difference is mainly a result of disruptive disorders. The prevalence of anxiety disorders is the second highest cause but is less associated with impairment, whereas most children and adolescents with affective disorders are impaired. Only around one-fifth of the subjects in need of services seek some form of assistance. Nearly one-quarter of those using services do not present a psychiatric diagnosis in the past year. Comorbidity occurs in 27 percent of those with a disorder, but only 7 percent have three or more diagnoses. Not addressing the treatment gap in mental health has serious public health implications.*

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The Burden of Mental Illnesses

The burden of mental illnesses has been seriously underestimated by traditional approaches that consider only death and not disability. The World Health Organization's (WHO's) program on the Global Burden of Disease [1] has redefined how this should be evaluated. Now, prevalence, years lived with disability, and mortality are all taken into consideration in order to calculate the disability-adjusted life year (DALY) and the years lived with disability (YLD).

For 2002, neuropsychiatric conditions only explain 1 percent of the deaths in the world but are responsible for 13 percent of the burden of illness and 28 percent of the YLD. The regions of the world differ markedly with respect to the number of DALY and YLD that are due to neuropsychiatric conditions. Estimates of YLD for neuropsychiatric conditions in Chile are not available officially; nonetheless, it is possible to propose that the YLD ranges between approximately 40 percent and 48 percent. Latin America and the Caribbean have estimated YLDs of 40 percent, whereas this figure reaches 48 percent in the United States and Canada. In contrast, all the other regions of the world are below this figure: the YLD in Africa reaches only 19 percent; in the Middle East, 26 percent; in Southeast Asia, 28 percent; and in Europe, 40 percent.

In Chile, according to the 2008 Study of Burden of Illness [2], neuropsychiatric disorders make the greatest contribution (23.2 percent) to the DALY for all age groups (25.9 percent for women and 20.4 percent for men). In Latin America and the Caribbean, the total contribution to the DALY is 22 percent; in the United States and Canada, 30 percent; in Africa, only 5 percent; in the Near East and Southeast Asia, 11 percent; and in Europe, 20 percent. In terms of their contributions to the Chilean DALY, some of the most relevant specific causes for all groups are unipolar depressive disorders (ranking second with 4.5 percent of the total DALY), alcohol dependence (ranking fourth, 3.4 percent), and—complementarily—hepatic cirrhosis (ranking fifth, 3.3 percent). Among men, alcohol dependence is the second most common cause of DALY, hepatic cirrhosis is the third, unipolar depression is in the fifth place, and aggression is in sixth place. Among women, depressive disorders occupy second place, anxiety disorders occupy third place, and aggression occupies fourth place. Schizophrenia is also among the twenty most important causes. The weight of the specific psychiatric disorders is even greater when examining only those that present between 10 and 59 years of age [2, 3].

Neuropsychiatric conditions make a large contribution to both the DALY and the YLD in Chile, reflecting advances in public health and national health care. A reduction in the contribution of neuropsychiatric disorders to the DALY indicates that the country is still primarily engaged in fighting against infectious diseases, which result in high mortality, as compared to many cancerous and cardiovascular illnesses, which present much later in life and have a lower prevalence than many psychiatric disorders. The mental health needs of the population, however, cannot be seen artificially by exclusively analyzing the disorders on axes 1 and 2 of the

DSM-IV (*Diagnostic and Statistical Manual of Mental Disorders*, fourth edition) or ICD-10 (*International Statistical Classification of Diseases and Related Health Problems*, tenth revision). Disorders associated with the epidemiologic transition (e.g., cardiovascular and cerebrovascular illnesses, hypertension, lung and other cancers, and hepatic cirrhosis) have behavioral and mental health components such as changes in the diet and exercise, the moderation of alcohol consumption, and quitting the use of tobacco. Emergent disorders also contribute to the mental health burden of a developing nation and need to be adequately dealt with by health agents because these disorders can result in a variety of psychiatric conditions: homicide, suicide, automobile accidents, substance consumption, HIV/AIDS, child abuse, abuse of women, and other types of violence.

These disorders, which should be of special concern to health care personnel and mental health agents, present risk factors that are associated with behavioral problems, demographic characteristics, and social factors. Demographic risk factors such as age, gender, economic and social level, marital status, ethnicity, and residence in urban versus rural sectors are not easy to modify. However, it is possible to modify variables of individual behavior such as diet, tobacco consumption, prostitution, use of syringes, possession of firearms, and use of seatbelts in automobiles. The social factors require long-term governmental planning in order to intervene in areas such as poverty, unemployment, improved education, gender discrimination, population changes, family structure, work conditions, war, and migration.

Prevalence of Emergent Disorders Related to Mental Health

The Ministry of Health uses basic health indicators that include, for the major groups of causes of death, the so-called external causes. In 2009, these were responsible for 8.9 percent of deaths, similar to the percentage found in 2003. Of these deaths, 25.8 percent were due to transit accidents and 26.4 percent to suicide. The adjusted rate of death by transit accidents for 2009 was 12.4 per 100,000 inhabitants, with a greater weight for men (20.2) than women (5.1), whereas the rate of death derived from self-inflicted injuries reached 12.7 per 100,000 and was nearly four times higher for men (20.8) than women (5.0) [4]. In 2008, the incidence of HIV/AIDS was 12.5 per 100,000, with higher rates in northern Chile, and the rate of mortality from HIV/AIDS reached 2.1 per 100,000 (4.0 for men vs. 0.8 for women). In 2009, 16.1 percent of all newborns were born to mothers under 20 years of age.

With respect to the consumption of substances, the ninth study of the general population carried out by National Commission for Drug Control (CONACE) in 2010 showed an annual prevalence of marijuana consumption of 4.6 percent, confirming a declining tendency observed since 2006 (7.2 percent) and 2008 (6.4 percent). The same trend was observed in the youngest groups: marijuana use by adolescents (12 to 18 years old) dropped from 9.1 percent in 2008 to 5.3 percent in 2010 as did marijuana use by young adults (19 to 25 years old), which fell from 17.9 percent in 2008 to 12.3 percent in 2010. The prevalence of cocaine consump-

tion in 2011 was 0.7 percent, increasing to 1.3 percent among 19 to 25 year olds, whereas the use of cocaine paste reached a prevalence of consumption in 2011 of 0.4 percent [5]. No doubt, alcohol remains the most consumed legal drug in Chile, with adjusted rates of mortality due to hepatic cirrhosis and other chronic liver diseases of 17.2 per 100,000 (31.6 for men vs. 11.8 for women) in 2008.

Prevalence of Psychiatric Disorders in the Adult Population

In Chile, two large studies of psychiatric prevalence were carried out in the 1990s. One of these determined the one-month prevalence in Santiago [6], and the other was a survey of national representation of four regions (Metropolitana, Bío-Bío, Tarapacá, and Araucanía) [7, 8]. The national study was based on the diagnostic criteria of the DSM-III-R and made use of the CIDI (Composite International Diagnostic Interview), which has been widely used internationally for comparative transnational studies that have included Chile [9]. Anxiety and substance abuse disorders are less frequent in Chile than in Canada, Germany, the Netherlands, and the United States. Nonetheless, affective disorders are equally prevalent (see Table 1). The differences in these rates can be explained by the low prevalence of slight disorders in Chile but the relatively higher prevalence of severe or moderate disorders [9].

Nearly one-third of the population has had a psychiatric disorder in their lifetime (i.e., an estimated 3,529,625 people), and 22.2 percent have had one during the previous year (i.e., 2,495,035 people). Anxiety disorders are the most prevalent. Major depressions are one of the most prevalent specific disorders, with 9.2 percent over a lifetime and 5.7 percent within the year. The prevalence of disorders due to alcohol and drug consumption is also high (11 percent and 8.1 percent, respectively). The proportion of the population that presents moderate (5.5 percent) and severe (3.3 percent) disorders is not negligible [10]. Furthermore, within Chile, considerable regional differences occur in the rates of disorders [8]. Major depression is considerably higher in the Metropolitana area, whereas alcohol and drug consumption is greater in Tarapacá. The first case may be related to the fact that the Metropolitana area is the largest urban area of the country, and the second to the location of this area on the border with countries experiencing growing drug traffic.

Prevalence of Psychiatric Disorders in the Population of Children and Adolescents

General Population of Children and Adolescents

In Latin America, research on the prevalence of mental disorders in children and adolescents is limited. One study [11] obtained the prevalence rates of psychiatric disorders in a representative national sample of Chilean children and adolescents, selecting subjects 4 to 18 years of age using a stratified multistage design. The DISC-IV (Diagnostic Interview Schedule for Children, version IV) was used to

Table 1

Twelve-Month Prevalence of Some DSM-IV Disorders in Chile as Compared with Other Countries*

<i>Type of disorder</i>	Canada (<i>n</i> = 6,320)		Chile (<i>n</i> = 2,181)		Germany (<i>n</i> = 3,219)		Netherlands (<i>n</i> = 6,030)		United States (<i>n</i> = 5,384)	
	%	(se)	%	(se)	%	(se)	%	(se)	%	(se)
Mood disorder	4.9	(0.5)	9.0	(1.3)	11.9	(0.5)	8.2	(0.5)	10.7	(0.6)
Anxiety disorder	12.4	(0.6)	5.0	(1.3)	11.9	(0.5)	13.2	(0.7)	17.0	(0.6)
Substance abuse disorder	7.9	(0.5)	6.6	(0.9)	5.2	(0.5)	9.9	(0.5)	11.5	(0.5)
Any disorder	19.9	(0.8)	17.0	(1.8)	22.8	(0.7)	24.4	(1.0)	29.1	(0.7)
<i>Seriousness of the disorder</i>										
None	80.1	(0.8)	83.0	(1.8)	77.2	(0.7)	75.6	(1.0)	70.9	(0.7)
Slight	12.4	(0.6)	8.1	(1.1)	10.8	(0.6)	14.1	(0.6)	13.8	(0.4)
Moderate	3.6	(0.4)	5.5	(0.8)	6.6	(0.4)	4.2	(0.3)	7.0	(0.4)
Serious	3.9	(0.4)	3.3	(0.6)	5.4	(0.3)	6.1	(0.3)	8.2	(0.5)

Source: Adapted from [9].

Notes: *Restricted to some diagnoses, and subjects between 18 to 54 years old; se = standard error.

obtain 12-month DSM-IV diagnoses and was supplemented with questionnaires examining family risk factors, the socioeconomic index, and service utilization. This study reported the DSM-IV 12-month prevalence rates for disorders and the associated sociodemographic correlates, comorbidity, and use of services. A stratified household sample representative of the national population of children (ages 4 to 11) and adolescents (ages 12 to 18) was obtained.

A sample of 1,558 children and adolescents was evaluated, with a response rate of 82.4 percent. The prevalence rate for all disorders was 38.3 percent without impairment and 22.5 percent when the most stringent impairment algorithms contained in the DISC-IV interview [12] were used. The most prevalent diagnostic group was disruptive disorders (14.6 percent) followed by anxiety (8.3 percent) and affective disorders (5.1 percent), including impairment. Substance use disorders in children and adolescents had a prevalence of 1.2 percent. Eating disorders and schizophrenia were relatively rare [11, 13].

In comparison with boys, girls were at greater risk of developing anxiety disorders, mainly social phobia (odd ratio [OR] = 3.4, 95% confidence interval [CI] = 1.3–8.6) and general anxiety disorder (OR = 4.5, 95% CI = 1.8–11.5). No gender difference was found in the prevalence rate for affective disorders when impairment was taken into account. Interestingly, no gender differences were noted for disruptive or substance use disorders [11, 13].

Few statistically significant differences in prevalence rates were noted between children and adolescents, and these differences disappeared in the case of affective disorders. Although, children overall had higher rates of disruptive disorders, this was not the case for each specific disorder. Children had higher prevalence rates of attention deficit hyperactivity disorder (OR = 0.3, 95% CI = 0.1–0.5) and oppositional defiant disorder (OR = 0.3, 95% CI = 0.1–0.6). However, adolescents had higher rates of conduct disorder than children (OR = 3.2, 95% CI = 1.2–8.4). Statistically significant differences were not found between the two age groups for anxiety disorders. In this study, no children—only adolescents—were diagnosed with substance use disorders [11, 13].

The perception of family dysfunction was significantly associated with each category of mental disorder: family structure was related to the mental health of children and adolescents. With the exception of substance use disorders, children living with only one parent had significantly higher rates of mental disorders. Parental psychopathology, but not anxiety disorders or substance use disorders, was a risk factor for affective and disruptive disorders. Interestingly, only substance use disorders were associated with failing to graduate from the equivalent of high school, and social economic status was inversely related to anxiety disorders [11, 13].

Specific Population: Juvenile Offenders

For one specific group, a descriptive, observational, cross-section study was carried out on a sample of adolescent juvenile delinquents between 12 and 18 years

old [14]. Participants were offenders imprisoned in penal or protective institutions. For the sake of convenience, samples of 100 adolescents were chosen and matched in gender and age range with a second group of 100 adolescents that did not show delinquent behavior. A battery of instruments (e.g., DISC-IV, WISC-R/WAIS, Adapted Lifestyle Questionnaire, and Family History Screen) was used to evaluate both groups. The random forest strategy and the language R. 2.8.1 were used to perform a valid multivariate statistical analysis. The two groups differed in intellectual level, number of school failures, number of sexual partners, dissocial disorders, educational levels of the head of household, and last year of school approved. During the 12 months prior to the study, 64 percent of the offenders and 18 percent of the controls presented with a psychiatric diagnosis. Among the offenders, the most prevalent disorders were conduct disorders (46), alcohol abuse (26 percent), and dependence on other substances (18 percent); whereas the control group showed primarily attention deficit and conduct disorders (5 percent each). The groups showed statically significant differences in terms of their intellectual level of functioning: 31 percent of the offenders were ranked as borderline and 34 percent of the controls were classified as low average.

The results given by random forests indicated a predictive capacity of 98 percent for the group of teenagers not committing crimes and 98 percent for the group of teenagers that did commit crimes. The results showed the main predictor for criminal behavior to be the intelligence coefficient of the participants followed by years of education (approved courses), number of hold backs, number of sexual partners, presence of a conduct disorder diagnosis, and education of the head of the household.

Availability of Mental Health Services

The Atlas Project of the WHO has compiled information on mental health contributed by the Ministries of Health of all the member countries (see Table 2) [15]. Chile, unlike more than one-third of the world, has a mental health policy with community care for these problems and legislation that protects, at least partially, the rights of those suffering mental illnesses. According to Atlas Project data in Chile, the health budget is 2.3 percent for mental health, clearly lower than the 6 percent and 11 percent of the United States and Canada, respectively. The primary funding for mental health care is based on public health insurance, which is not available to many people who must finance treatment themselves. Nonetheless, from 2005, depression and the first episode of schizophrenia have been incorporated into the program of explicit health guarantees, allowing broader coverage and assuring an adequate level of care given the preestablished guarantees and guidelines.

Although Chile has more psychiatric beds available than most of its neighbors, the situation in Chile is quite different from that in the United States and Canada. When compared with other countries in the world, the rate of 1.3 beds per 10,000 inhabitants is lower than the median of countries with medium-low incomes and most are in psychiatric hospitals, suggesting that they are used mainly for chronic

Table 2

Selected Results of Countries That Provide Information to the Atlas Project

Country	Budget	Beds	Psychia- trists	Psycho- logists	Social workers	Nurses
Argentina	2.0	6.0	13.3	106.0	11.0	
Bolivia	0.2	0.8	0.9	5.0		
Brazil	2.5	2.6	4.8	31.8		
Canada	11.0	19.3	12.0	35.0		44.0
Chile	2.3	1.3	4.0	15.7	1.5	1.1
Colombia	0.1	1.3*	2.0			0.1*
Ecuador		1.7	2.1	29.1	0.1	0.5
Mexico	1.0	0.7	2.7		0.2	0.1
Paraguay	0.1	0.7	1.8			0.1
Peru	2.0	0.5	2.1	4.0	1.0	6.0
Surinam	4.2	5.2	1.3	0.2	0.6	15.0
United States	6.0	7.7	13.7	31.1	35.3	6.5
Uruguay	8.0	5.4	22.9	15.1	62.0	0.9
Venezuela		2.5	24.0			

Source: Adapted from [15].

Notes: Budget = percent of budget designated for health care; beds = psychiatric beds/10,000 inhabitants; rates of professionals are given per 100,000 inhabitants. *Data not available in the *Mental Health Atlas*.

rather than acute cases. Chile has 4.0 psychiatrists per 100,000 inhabitants. On average, this rate is on par with that of other Latin American countries and far lower than that of the most developed countries. In contrast, there are 15.7 psychologists per 100,000 inhabitants. Mental health care and specialists for children and the elderly are limited and, in most cases, not available. Moreover, there is a wide disparity of resources available throughout the country [16].

Use of Mental Health Services and Treatment Gap

In Chile, in the past decade, most adults with a psychiatric disorder do not seek mental health care [17, 18]. Less than half of those presenting a prevalent disorder (46.9 percent) received any type of health care over the last 6 months, whereas only 38.5 percent received some type of mental health care, whether from a specialist or generalist. The use of specialized services was scant (only 13.1 percent). Although a larger proportion of individuals with severe disorders made use of mental health services, only 24.9 percent received specialized mental health care [16]. The use

of services in individuals presenting with serious mental illnesses in Chile and in developed countries is shown in Table 3 [9]. Currently, in the population of children and adolescents, 41.4 percent of the subjects in need of services sought some form of assistance. Nearly one-fifth (17.8 percent) of those using services did not present a psychiatric diagnosis in the past year. The services most used by those with a diagnosis were services existing in the school context (21.8 percent) and ambulatory mental health services (19 percent). The group presenting disruptive behavior disorders sought help most often.

Based on data during the last decade, gaps in the treatment for specific mental health problems, that is, the percentage of individuals that need but do not receive treatment, is somewhat lower than in other Latin American countries [18] (see Table 4). Nevertheless, these rates remain alarmingly high. More than half of the people with bipolar disorders and nearly half of those with major depression are not treated. The gap of 44.4 percent in the treatment of nonaffective psychosis is greater than in most of the world (32.2 percent) as is that for alcohol consumption disorders (84.8 percent) [19]. Treatment gaps in Chile could be even greater if areas with even less access to care were included in the analysis. In the case of children and adolescents, the gaps are even greater, consistent with the scarcity of health services available for this population.

Reasons for the Lack of Treatment

Despite evidence to the contrary, the population maintains a perception of a lack of treatment effectiveness. Many people also believe that the problem will resolve itself and attempt to manage it without external help. Direct barriers such as financial issues and the insufficient availability of services also interfere with treatment. The lack of knowledge regarding mental illnesses and the stigma associated with these constitute the main reasons that Chileans do not seek treatment (see Table 5) [16, 17].

Gaps in treatment are expected to be greater among people of the lower social classes given their greater risk of having mental illnesses [20] and less relative access to treatment. The indigenous population, specifically the Mapuches, receives virtually no mental health care. In a study done by the authors of this paper [21], only 6.5 percent of those that had psychiatric disorders sought some type of treatment and none saw a mental health specialist despite little evidence that the rates of psychiatric disorders for Mapuches are different from those of other Chileans. Studies examining the stigma of mental health illnesses are lacking, and the level of knowledge in this area is low.

Implications

If the disability, like the economic burden, associated with mental and psychological disorders is to be reduced, it is necessary to identify the *gaps in treatment* and to reduce the delay in access to care, the so-called *treatment delay*. Moreover, some

Table 3

Relationship Between the Seriousness of the Disorder and Treatment in Chile as Compared with Other Countries

	Canada		Chile		Germany		Netherlands		United States	
	%	(se)	%	(se)	%	(se)	%	(se)	%	(se)
<i>Percentage that received any type of treatment</i>										
None (no cases)	3.4	(0.4)	14.4	(1.1)	14.1	(0.8)	7.6	(0.4)	6.3	(0.4)
Slight	10.4	(1.7)	12.3	(2.7)	29.6	(1.6)	13.3	(1.2)	11.3	(1.4)
Moderate	27.7	(4.7)	50.2	(6.3)	38.7	(3.3)	43.0	(3.4)	26.3	(3.2)
Serious	52.3	(5.1)	47.9	(8.0)	67.0	(3.0)	66.3	(2.6)	37.1	(2.3)
Total	7.0	(0.5)	17.3	(1.2)	20.2	(0.8)	13.4	(0.5)	10.9	(0.5)
<i>Of those that received any treatment, percentage receiving specialized treatment</i>										
None (no cases)	46.8	(4.9)	34.5	(7.2)	65.4	(2.5)	43.2	(2.4)	42.3	(4.9)
Slight	40.6	(6.6)	16.4	(8.7)	74.5	(3.7)	41.4	(4.9)	46.3	(6.2)
Moderate	50.8	(7.7)	48.2	(13.9)	68.2	(4.1)	47.3	(4.6)	50.6	(4.6)
Serious	61.6	(8.5)	44.6	(7.7)	79.8	(3.0)	60.0	(3.2)	62.9	(3.2)
Total	50.6	(3.7)	36.5	(4.9)	69.8	(1.7)	48.5	(1.6)	50.0	(2.8)

Source: Adapted from [9].

Note: se = standard error.

Table 4

Gaps in Treatment for Mental Disorders in Latin America and the Caribbean in Terms of Percentage of Individuals That Require Care but Do Not Receive It*

Disorder	Sao Paulo (previous month)	Chile (six months)	Mexico ENEP (previous year)	Mexico City (life)	Rural Mexico (life)	Puerto Rico (previous year)	Average	Median
Nonaffective psychosis	58.0	44.4				9.7	37.4	44.4
Major depression	49.4	46.2	78.2	43.4	66.3	70.0	58.9	57.9
Dystimia	43.8	32.4	81.5	78.5	58.0		58.8	58.0
Bipolar disorder	46.0	50.2	85.7	74.1			64.0	62.2
Generalized anxiety	41.1	44.2	94.7	72.2			63.1	58.2
Panic disorder	47.8	22.7	71.2	70.0			52.9	58.9
Obsessive compulsive disorder		27.6		92.1			59.9	59.9
Alcohol consumption/ dependence	53.3	84.8				76.0	71.4	76.0

Source: Adapted from [19].

Notes: *Colombia World Mental Health (*Colombia WMH*) has published information (previous year) regarding the deficiencies of treatment only for the following: any type of disorder (82.4%); any type of anxiety disorder (95.4%); and any disorder due to substance consumption (92.5%).

Table 5

Reasons for Not Seeking Care for Physical and Mental Illness in Groups That Accept Their Need for Care

Reason	Physical illness (<i>n</i> = 1387)		Mental illness (<i>n</i> = 347)	
	%	se	%	se
Problem was resolved on its own	55.5	3.7	65.7	5.0
I can solve the problem on my own	52.8	4.0	60.1	3.0
Financial burden	35.8	3.2	43.6	3.2
Fear of diagnosis	33.4	2.1	36.7	2.4
Time restrictions	23.0	2.0	28.9	3.2
Do not trust in health care providers	19.8	1.8	22.2	2.8
It is not useful	15.4	1.7	27.6	2.6
Worried about what others will say	10.0	1.7	24.1	4.0
Do not know where to go	10.9	1.4	29.0	3.1
Transport	9.8	2.5	11.4	1.9
Someone could find out	8.5	1.4	22.1	4.0

Source: Adapted from [16].

disorders can be avoided, which suggests that there is a *gap in prevention* as well as a *gap in intervention*. The high rates of disability as a result of neuropsychiatric disorders show that these conditions merit treatment. They are disorders of a significantly high prevalence that should be a top priority on the public health agenda. The onset of mental illnesses during the early stages of life results in a prolonged disability and burden. The course of the illness without treatment is often chronic and debilitating. Solid evidence shows that the treatment is central to and efficient in the reduction of the disability for the individual and the family, improving the symptoms and altering the course of the illness. The degree of the burden of the illness, its economic cost, and the disability associated for both the individual and the family reaches a level that, without aid, would be too costly to pay.

Not dealing with the gaps in treatment has serious implications for public health. Growing poverty, low social levels, and diminished educational attainments are possible consequences derived from not treating mental illnesses. Untreated illnesses can lead to deteriorated family functioning, higher teen pregnancy rates, and greater domestic violence. Psychiatric disorders also have a negative impact on the quality of life, increasing mortality indexes apart from those of suicide. The WHO [22–24] has made recommendations that can be further implemented in Chile in order to reduce the deficiencies in the treatment of mental health:

1) making mental health treatment more accessible through primary care, 2) assuring ready availability of the necessary psychotropic medications in all areas of health care, 3) moving mental health care from institutions and into community care, 4) educating the population, 5) involving families, communities, and consumers in improving the health care system, 6) expanding national mental health care programs, 7) increasing and improving professional training in mental health care, especially for children and the elderly, 8) increasing ties with other governmental and nongovernmental sectors, 9) providing monitoring of the mental health system through quality indicators, and 10) supporting greater investigation.

Although growing in importance, the role of mental illnesses and the use of health services for these problems and for disability in general in Chile are, in our opinion, still undervalued. Studies of psychiatric epidemiology provide relevant information to the authorities that are in a position or condition to designate resources for dealing with the development of an epidemic of mental disorders. Said epidemic can be clearly anticipated in Latin America using existing epidemiologic data of developing actual changes. In addition, new studies are required to, for example, increase or sharpen interest in the need to use services, the presence of medical comorbidity, the prevalence of rates of serious mental illnesses, and the increasingly necessary objective measures of disability.

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