NEW LEGISLATION TO PROTECT AND PROMOTE HUMAN RIGHTS OF PEOPLE WITH MENTAL DISORDERS

KEY ACHIEVEMENTS

1. Broad sensitization around mental health issues and rights (govt, policy-makers, professionals and the general public);
2. Incorporation of provisions related to people with mental disorders into the draft of the Charter of Rights and Duties of Patients;
3. Incorporation of provisions related to people with mental disability into the draft legislation that amends Law on the Social Integration of Persons with Disability
4. The drafting of provisions in both laws allowing: persons with mental disability to have the same rights as any other patient; • right to have legal representation; • right to appeal involuntary treatment and hospitalization; • creation of an independent review and monitoring body – the Commission for the Protection of Persons with Mental Disorders; • improved rights related to prevention and rehabilitation, education and work which can be applied to people with mental disability.
5. Sensitization to achieve the approval of the Charter of Rights and Duties of Patients approved by Parliament (government and legislators)
6. Approval of the Charter of Rights and Duties of Patients by Chile's Health Commission in July 2007

NEXT STEPS

1. Implementation of the provisions of the Charter of Rights and Duties of Patients related to persons with mental disorders
2. Sensitization to achieve the approval of the legislation that amends Law about Social Integration of Persons with Disability and implementation of the provisions related to persons with mental disability
3. Amendments of other laws to improve human rights protection of persons with mental disability. According to a comprehensive review of Chilean legislation, two priorities were set:
   + Better protection in procedures around issues related to capacity of people with mental disabilities
   + Better protection from discrimination and exploitation in employment.

Potential partners and donors interested in supporting the WHO Project 'Strengthening Mental Health Systems, Improving People's Health' or any aspects of the implementation of the mental health law and reform in Chile should contact the World Health Organization:
Dr Alberto Minoletti ● Dr Juan Manuel Sotelo Figueiredo ● Dr Jorge Jacinto Rodriguez ● Dr Javier Vasquez ● Dr Michelle Funk
THE PROJECT
The coming into force of the Presidential Decree for Psychiatric Hospitalization in 2001\(^1\) had several positive outcomes for people with mental disabilities, including, for example: the establishment of a National Commission for the Protection of People with Mental Illness, with the participation of consumers, families and professionals; the implementation of a campaign to inform and educate mental health workers about the rights of people with mental disabilities who are admitted to psychiatric hospitals; strict regulations concerning the then common practice of psychosurgery for mental disabilities associated with violent behavior; and inspection of at least some psychiatric facilities. However the provisions of the decree and mechanisms in place to protect the human rights of people with mental disabilities are still insufficient.

- There is no judicial protection or guarantees in relation to involuntary admission and treatment in psychiatric facilities. The National Commission for the Protection of People with Mental Illness is not really independent from the Ministry of Health, nor does it have judicial or quasi-judicial functions of a review body.
- There is no periodic review of legal capacity/guardianship and consent to make a treatment decision. It is very easy to declare a person with mental disability incompetent and to appoint a guardian. There is no provision to ensure legal counsel and appeal procedures.

In addition, there is also no legislation in Chile to:

- Ensure parity between mental and physical health, and the resources allocated to the former are still much lower (between 2 to 2.5%) than to the latter, both in public and private sector.
- Promote the development of community-based treatment facilities.
- Protect people with mental disabilities from discrimination and
- Facilitate access to subsidized housing, education and sheltered work.

**The goal of this project** is to improve the rights of people with mental disabilities in the country consistent with international human rights treaties ratified by Chile and existing international/regional mental health standards. The specific objectives are to:

- Include human rights oriented provisions in relation to mental health within the Charter of Rights and Duties of Patients and the law for the Social Integration of People with disability.
- Revise the current mental health decree for Psychiatric Hospitalization in the longer term
- Train multidisciplinary professionals on the human rights of people with mental disabilities: lawyers, journalists, police, physicians, social workers, psychologists, nurses, occupational therapists.
- Empower consumer and family organizations.
- Sensitize leaders from Government, Parliament and the Judiciary.

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\(^1\) Changing the regulations issued in 1927 required a decree signed by the President of Chile and the Minister of Health, thus avoiding a longer process in Parliament.
MAJOR MILESTONES

■ April 2002: The Ministry of Health, through the Mental Health Program of PAHO/WHO, requests technical support to disseminate the international human rights norms and standards applicable to persons with mental disabilities. PAHO/WHO and the Ministry conducted the first national training workshop on the human rights and fundamental freedoms of persons with disabilities with the participation of relevant stakeholders from the governmental sector, civil society and organizations of users. PAHO/WHO made several recommendations to the Government on the reform of existing regulations and practices related with the human rights of persons with mental disabilities.

■ June 2002: Follow up recommendations of the national training workshop mentioned above, PAHO/WHO submit preliminary comments on international human rights norms and standards on mental health to be incorporated into the first draft law on the rights and duties of patients, currently draft Charter on the rights and duties of patients.

■ October 2005: The Ministry of Health, through the Department of Mental Health, requests technical support from WHO to improve Chilean legislation on mental health and human rights.

■ January 2006: a new government was elected in Chile.

■ February 2006: WHO HQ and PAHO work with Professionals from Ministry of Health to identify the priorities and actions for the technical cooperation. The two main strategies defined are to:

  o 1) Incorporate mental health issues into the draft legislation amending the Law for Social Integration of People with Disability that had been sent to Parliament on May 2005;

  o 2) Introduce a section related to mental health into the draft "Charter of the Rights and Duties of Patients". This Charter had been on standby in the parliament since 2001

■ April 2006: The new government announces their intention to revise both draft laws.

■ Beginning of May 2006: Dr Minoletti and colleagues meet with Minister of Health, Dr. Soledad Barría, to discuss the need to incorporate protective provisions for people with mental disabilities in the Charter of Rights and Duties of Patients. She supports the idea of proceeding with an analysis of Charter with a view to the possible incorporation of provisions related to the rights of people with mental disabilities into the Charter. The Minister also stated her willingness to advocate for this law to be given priority in Parliament.
May 2006: Official request sent to WHO from the MOH to review the draft *Charter of Rights and Duties of Patients* and the draft legislation that amends *Law for Social Integration of People with Disability*. WHO/PAHO international network of experts review both draft laws and sends their comments to Chile.

June 2006: *Workshop for Mental Health Leaders* (series of roundtables with users, families, mental health professionals and lawyers from across the country; 30 to 40 participants) is held to empower participants so that they can advocate for the rights of people with mental disabilities and lobby the Executive and Parliament.

July 2006: The draft for the *Charter of Rights and Duties of Patients* is submitted to legislature. With the support of the minister of health and members of the drafting team, a section about the rights of persons with mental and intellectual disability is included in the draft. The principal provisions of this section are the following:

- Persons with mental disability have the same rights as all other patients (being treated with respect and dignity, freedom of communication, access to information, informed consent, confidentiality, etc.).
- Right to have legal representation.
- Regulation of involuntary admission and irreversible treatments
- Right to appeal involuntary treatment and hospitalization.
- Creation of an independent review and monitoring body in each of the 13 regions of the country

The draft sent to parliament is approved in general and sent to the Chamber of Deputies to be reviewed by the Health Commission.

September 2006: *A new draft for the amendment of the disability law is submitted to legislature*. This draft includes strengthening provisions around prevention and rehabilitation, education and work, which are equally applicable to people with mental disability. A specific article is devoted to protect the rights of persons with mental disability, with special emphasis on:

- rights to dignity, sexuality, forming a family, and developing capacities through rehabilitation
- protection against discrimination, violence, abuse, and treatment and research against the person’s will.

August to October 2006: *Lobby with Legislature*: Face to face and telephone conversations are held with members of the parliament, from different political parties, in order to sensitize them to the rights of persons with mental disabilities and the need to legislate in order to protect them.
■ **September and October 2006: Public opinion mobilization:** A media professional is hired for 3 months, around the date of the national debate, in order to facilitate the inclusion of news about the rights of persons with mental disabilities in the media. Several reports about this subject appeared on TV, radio and newspapers.

■ **October 11, 2006:** On the occasion of World Mental Health Day, 250 people participated in a **one-day national debate**, where the two draft legislations were analysed with the technical assistance of WHO and PAHO. The participants were representatives from similar organizations and institutions as the June 2006 workshop but from different regions of the country and not only the leaders but also persons from local groups and programs.

■ **October 2006 to January 2007: Comprehensive review of Chilean legislation:** Pr Maria Soledad Cisternas (a legal professional at Diego Portales University) is hired to review different legal documents from the perspective of the rights of persons with mental disabilities or mental disability, in order to elaborate a legal basis to improve the current legislation. Using the “WHO Resource Book on Mental Health, Human Rights and Legislation” and other tools as a guidance, the following legislations were reviewed:

- The Political Constitution of the Chilean Republic;
- The Law 19.284 about Social Integration of Persons with Disability;
- The Draft legislation that amends Law 19.284 about Social Integration of Persons with Disability;
- The Law 18.600 about Mental Disability and its amendments;
- The Draft legislation about Rights and Duties of People in Health Services;
- The Draft legislation about Anti-Discrimination;
- The Civil Code and the Civil Procedures Code;
- The Penal Code and the Penal Procedures Code;
- The Health Code;
- The Law 18.700 about Popular Suffrage;
- The Law 20.066 about Domestic Violence;
- Regulations about health, housing, employment, social security, and disability.

■ **July 2007:** Chile's Health Commission approves the **Charter of Rights and Duties of Patients** containing relevant sections related to the rights of people with mental and intellectual disabilities.
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- Pr Christian Courtis (ITAM-Departoamento de Derecho, Mexico).

- Pr Maria Soledad Cisternas (Diego Portales University).
LINKS TO OFFICIAL DOCUMENTS

- The draft Charter of Rights and Duties of Patients

  http://sil.congreso.cl/pags/index.html  (Boletín # 4398-11)


  http://www.minsal.cl/ici/s_1/u_14/REGLAMENTO%20DE%20INTERNACION%20PSQUIATRICA.pdf  (last accessed 17 July 2007)


  http://www.minsal.cl.  (last accessed 17 July 2007)

- Political Constitution of the Republic of Chile (1980)

  http://www.camara.cl/legis/masinfo/m6.htm  (last accessed 17 July 2007)


- Draft legislation that amends Law 19.284 about Social Integration of Persons with Disability (2005)


  (last accessed 17 July 2007)

- Law 18.600 on Mental Disability and its amendments (1987)


- Draft legislation on Anti-Discrimination

- The Civil Code (revised in 2000)

  http://www.paginaschile.cl/biblioteca_juridica/codigo_civil/codigo_civil_de_chile.htm  (last accessed 17 July 2007)

- The Health Code (1967)

  http://www2.udec.cl/farmacia/reglam/codsan.pdf  (last accessed 17 July 2007)
Mental Health Improvements for Nations’ Development
( WHO MIND )

The country summary series:
Chile

Progress for Mental Health & Human Rights

Draft Patient Rights Charter submitted to legislature

Workshop for Mental Health Leaders

MOH, WHO and PAHO define priorities

Discussion with Minister of Health on MH and Patient Charter

MOH requests support to WHO to improve legislation affecting rights of people with mental disabilities

PAHO/WHO submit comments for integration into Patient Charter

MOH requests support from PAHO/WHO to disseminate HR norms

1st Workshop on HR

timeline
THE CONTEXT
Chile is located in the south western coast of South America. It has a population of 16.124 million people (13% of which is rural; World Bank 2006), with a density of 21 people/km² and an annual population growth of 1.3% for 1994-2004 (WHO, 2006b). Its capital is Santiago.

The largest ethnic group is Mestizo (two-thirds), the other ethnic groups are European and Native American. The largest religious group is Roman Catholic (70%), the other religious groups are Evangelical and Protestant Christian. The main language used in the country is Spanish.

The adult literacy rate is 95.6% for men and 95.8% for women (2004; UNESCO, 2006²).

The proportion of the population under the age of 15 years is 25.5% (World Bank, 2006), and the proportion of population above the age of 60 years is 11.3% (WHO, 2006b).

The life expectancy at birth is 74 years for males and 81 years for females (WHO, 2006b).

Chile is an upper middle income group country (based on World Bank 2004 criteria³).

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The main sector of employment and revenue is services (83% of female and 53% of male employment in 2000-2004; WDI, 2006)

The per capita total expenditure on health (at international dollar rate) is 707$, which represents 6.1% of GDP per capita (2003; WHO, 2006b).

The general government expenditure on health as % of total government expenditure is 12.7% (2003; WHO, 2006b).

The per capita government expenditure on health is 345 international $ (2003; WHO, 2006b) [ratio 0.49], with the remainder almost equally filled in by private prepaid plans (27.6%) and user fees (out-of-pocket: 23.6% of total expenditure on health).

![Figure 4: Sources of health financing for general health in Chile (2003; WHO, 2006b)](image)
② CONTEXUAL FACTORS INFLUENCING MENTAL HEALTH NEEDS AND SERVICES

- **Poverty** / Economic situation of Chile: "As the fastest growing economy in the region during 1990–2004, with an average annual per capita growth rate of 4.1 percent, Chile has become a benchmark for reform in the Latin American region, doubling its income since 1990. Chile now has the second lowest headcount poverty rate in the Latin America and the Caribbean (LAC) region, after Uruguay " (World Bank, 2006).

**Figure 5**: Population below the national poverty line in Chile (1990, 1996 and 2003 national survey; from World Bank development doc, 2006b, p. 15 Official poverty lines (national): Chile, 1990-2003 (percent) and World Development Indicators, 2006.

**Figure 6**: Poverty levels and poverty gaps\(^5\) in Chile (2000) and Latin America & Caribbean (1999), international poverty lines (IPL) at $1 and $2 (World Development Indicators, 2006).

(Source: [http://devdata.worldbank.org/wdi2006/contents/Section2.htm](http://devdata.worldbank.org/wdi2006/contents/Section2.htm) [table 2.7.: Poverty]).

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\(^5\) The poverty gap is the mean shortfall from the poverty line (counting the non-poor as having zero shortfall), expressed as a percentage of the poverty line. This measure reflects the depth of poverty as well as its incidence.
Human Development Index (HDI)\(^6\) (Country HDI 2004 = 0.859, ranking 38/177):

While figure 7 shows HDI trends over time, figure 8 shows how, in this specific national context, GNI relates to health and social indicators of development (how much economic wealth is transformed into development at the population level).


![Development Diamond (Year)](http://devdata.worldbank.org/AAG/chl_aag.pdf)

From figure 7 we can see how well Chile has performed since 1975, with a consistent increase on the Human Development Index. This parallels the HDI for the region but remains above it. The development diamond (figure 8) shows that Chile is achieving very good outcomes in all aspects of development, in keeping with the average performance of its income group (upper middle income), except for life expectancy for which it is doing even slightly better than the average. Chile has achieved the fastest growing economy in Latin America and the Caribbean for the past 15 years and this has been accompanied by huge improvement on a number of social indicators.

- **Impressive improvement in social indicators since the 1990s**: "Social indicators, including enrollment in primary education, youth literacy, infant mortality and life expectancy have improved, reaching levels close to advanced economies. Chile is the only country in Latin America to have achieved all the Millennium Development Goals: by 2000, with poverty, extreme poverty and indigence headcounts falling to less than half

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\(^6\) The Human Development Index (HDI) is an indicator, developed by UNDP, combining 3 dimensions of development: a long and healthy life, knowledge, and a decent standard of living (see figure below).


their 1990 levels” (World Bank, 2006).

- **Historical background of State violence and human rights violations:** During the military dictatorship, between 1973 and 1990, many people were murdered, disappeared, tortured, incarcerated, sent to concentration camps and exiled by the armed forces. Approximately 800,000 people were directly affected by these human right violations and many of the survivors still have physical and mental sequelae. These 'politically' motivated human rights violations have dominated the human rights agenda.

- **High prevalence of Alcohol Abuse and Dependence:** Chile has a historical tradition of excessive alcohol drinking (wine and other beverages) with many physical and mental consequences for the drinkers and their families. Fifteen percent of the population over 15 are problem drinkers and one third of them meet the criteria for alcohol dependence.

- **Increase in Illicit Drugs Abuse:** Over the last 20 years there has been a steady increase in the percentage of people consuming illicit drugs, mainly marijuana and cocaine. Twenty years ago only a few people consumed illicit drugs, while 2.02% of the population over 12 declared to consume them during the last month in 1994 and 3.02% in 2004. There has also been an increase in the number of crimes associated with illicit drug traffic.

- **Domestic Violence:** is highly prevalent in all socioeconomic levels. One half of women and one half of children report that they are victims of verbal or physical violence from their sexual partners or their parents, respectively.

- **General Health System Reform**

The challenges of the demographic and epidemiological transition experienced in Chile (the percentage of adult population and the burden of non-communicable diseases have increased significantly) and the inadequacies of the health system prompted a global health system reform in 2005. The main principles of this reform were: right to health, equity, solidarity, efficiency in the use of resources, and social participation in health. National health objectives and goals for the year 2010 were formulated. Regional health authorities were created; the 28 public health districts (Servicios de Salud) were given more autonomy; health superintendence was created for the regulation of public and private providers; Importantly also, a national Public Health Plan is being developed with the social determinants of health approach very prominent in its design. Regional public health plans are also being formulated. The most visible step of this reform has been the implementation of a system of treatment of health problems with guarantees for access, opportunity, quality and financial protection. Among the 56 health problems with guarantees, three mental health problems have been included so far: schizophrenia (since 2005), depression (since 2006) and substance abuse and dependence (since 2007).

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10 Servicio Nacional de la Mujer Chile (SERNAM). http://www.sernam.cl/basemujer/index.htm

3 BURDEN OF MENTAL DISORDERS AND TREATMENT GAP

Epidemiological studies have shown a high prevalence of mental disorders in Chile. Approximately one-third (31.5%) of the population has had a lifetime psychiatric disorder, and 22.2% have had a disorder in the past 12 months. The most common lifetime psychiatric disorders were agoraphobia (11.1%), social phobia (10.2%), simple phobia (9.8%), major depressive disorder (9.2%), and alcohol dependence (6.4%). 38.5% of persons with mental disorders utilize mental health services (34.1% nonspecialized and 13.1% specialized). (Vicente et al., 2006).

Figure 9: Treatment gap for people with mental disabilities in Chile

Figure 10: The most common lifetime psychiatric disabilities
Coordinating Structure

The Mental Health Department at the Sub-Secretary of Public Health develops policy, plans, programmes, legislation and regulation. The Mental Health Unit in the Sub-Secretary of Health Care Networks supports the health districts on the implementation of programmes and coordinates national networks. The Mental Health Professionals at the Health Districts support health and mental health public facilities on the implementation of programmes and coordinate local public networks. The Mental Health Professionals situated in the Regional Health Authorities contribute to the implementation of the Public Health Plan and to the authorization and regulation of public and private mental health facilities; for example, they supervise involuntary admissions and coordinate the 4 existing Regional Commissions for the Protection of Persons with Mental Disorders.
Legal framework, policies and programmes

Legal framework


- The reform of the 'Law for the Social Integration of Persons with Disability' has been under discussion in the Chilean Congress since 2005. This draft law aims to protect the human rights and fundamental freedoms of persons with disabilities. It promotes the equalization of opportunities; non-discrimination; protection of vulnerable groups (children, women and older persons); recognition of sign language as the mean of communication for deaf persons, and the inclusion of persons with disabilities in areas such as education and work (among others).

- The draft law "Charter of Rights and Duties of Patients", which has been under discussion in the Chilean Congress since 2001, has recently been re-submitted to parliament (July 2006). The main objective of this charter is to establish the rights and obligations of persons who are receiving health care, including those persons who have been admitted as patients in public or private health institutions. This instrument includes provisions on basic rights and freedoms; informed consent; privacy issues; and obligations of patients (among others).

The National Mental Health Plan of 2000. There is no separate mental health policy document as the vision, principles and strategies have been included in the national mental health plan. The implementation of this plan has achieved major improvements for the mental health services in Chile through:

1. The facilitation of the exchange of information and economic resources between the public health and the financial sectors.
2. The implementation of community based services, which are progressively offering an alternative to traditional mental health care that is provided by psychiatric institutions.
3. The increasing role of primary health care centers in mental health: since 2000, there has been a significant increase in the number of people who have access to good quality mental health care without discrimination in primary health care settings, as well as in the number of people who are able to access psychotropic medications.

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13 Boletín No. 2727-11 sobre Derechos y deberes de las personas en materia de salud, Câmara de Diputados del Congreso, Chile [Rights and duties of persons in health"], National Congress, Chile. Available from: http://sdi.bcn.cl/partners/consenso/conferencial/ProyectoLeyDebDer

14 Between 1999 and 2004, the budget for psychiatric hospitals decreased from 57% to 33%; and the budget for community based services increased from 43% to 67%
People with mental disabilities can now be treated in ambulatory services, day hospitals, different community mental health services, general hospitals, and sheltered homes and residences.

The principal mental health programmes that are being implemented in the public sector as part of the National Plan are the following:

1. **Depression**: This programme includes psychotropic medications and psychosocial interventions for persons 15 years and older. Approximately 90% of persons are treated in primary care, and 10% are referred to specialist care due to the severity of their disorder.\(^\text{15}\)

2. **Schizophrenia**: Specialist care for persons any age with this diagnosis. Medications have been improved (including atypical antipsychotics), and people increasingly have access to psychosocial rehabilitation.

3. **Substance abuse and dependence**: A joint programme between the Ministry of Health and the National Illicit Drugs Council that offers ambulatory and residential services of different levels of intensities. Each type of service provides individual, group, family and community interventions.

4. **Integral Health programme for victims of military dictatorship**: There is one specialized mental health multidisciplinary team in each of the 28 health districts to treat the most severe psychological sequelae. They can also access the general health and mental health programmes.

5. **Domestic violence**: This programme focuses on women and children, and is carried out mainly in primary health care facilities. The programme has important intersectoral links with other services.

6. **Attention deficit/hyperactivity disorder**: There is a programme in place for children who have been referred from the school system, which is being implemented in primary health care facilities.

7. **Forensic psychiatry**: Short and medium-stay forensic inpatient units are available both in mental hospitals and in prisons. The general mental health system is being reinforced in order to provide people with mental disabilities who are caught up in the justice system with forensic evaluation, ambulatory and inpatient care, psychosocial rehabilitation, and sheltered homes.

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\(^{15}\) Escuela de Salud Pública, Universidad de Chile (2002). Evaluación de la Efectividad del Programa para la Detección, Diagnóstico y Tratamiento Integral de la Depresión en Atención Primaria. [Link](http://www.minsal.cl/ici/s_1/u_14/estdepre.pdf)
Financing:

No data is currently available concerning the sources of financing for mental health or the proportion of mental health services provided by public versus private health care providers as the present information system does not allow for this calculation.

Human Resources for Mental and General Health

Mental health professionals per 100,000 population in Chile are as follows: Psychiatrists (4.7); mental health nurses, include psychiatric nurses (1.7); psychologists doing clinical work (12.3); social workers in mental health (1.7); and occupational therapists in mental health: (3.1) (Minoletti A, Saxena S y col 2006).

<table>
<thead>
<tr>
<th>Mental Health Professionals</th>
<th>General Health Professionals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrist</td>
<td>Physicians</td>
</tr>
<tr>
<td>Mental health nurses</td>
<td>Nurses</td>
</tr>
<tr>
<td>Social Workers</td>
<td>Occupational therapists in mental health</td>
</tr>
<tr>
<td>Psychologists (doing clinical work)</td>
<td>Physicians</td>
</tr>
<tr>
<td>Occupational therapists in mental health</td>
<td>Nurses</td>
</tr>
</tbody>
</table>

**Figure 12:** Human Resources for Mental Health and general Health in Chile (2004).
Table 1: Training and work for mental health professionals in Chile

<table>
<thead>
<tr>
<th>Human Resources</th>
<th>Training in MH available in Chile</th>
<th>Currently working in Chile</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Degree courses</td>
<td>Density (per 100,000 population)</td>
</tr>
<tr>
<td></td>
<td>CPD(^{16}) (No./training yrs)</td>
<td></td>
</tr>
<tr>
<td>Mental Health workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>3 years (after MD)</td>
<td>4.7</td>
</tr>
<tr>
<td>Neurosurgeons</td>
<td>3 years</td>
<td>N/A</td>
</tr>
<tr>
<td>Neurologists</td>
<td>3 years</td>
<td>N/A</td>
</tr>
<tr>
<td>Psychiatric nurses</td>
<td>No formal training to become psychiatric nurse, however, see 'General nurses' below</td>
<td>12.3</td>
</tr>
<tr>
<td>Psychologists</td>
<td>2 years (after 5 yr general psychologist degree)</td>
<td>3.1</td>
</tr>
<tr>
<td>Occupational therapists</td>
<td>No formal training in MH for OT (Training to be an OT is 5 yrs during which good undergraduate MH training is provided)</td>
<td>1.7</td>
</tr>
<tr>
<td>Social workers in MH</td>
<td>No formal training in MH for social workers</td>
<td>N/A</td>
</tr>
<tr>
<td>Traditional healers</td>
<td>No formal training in MH for traditional healers</td>
<td>N/A</td>
</tr>
<tr>
<td>Other health or MH workers (auxil staff, non-doctor/non-physician PHC workers, paraprof psychosocial counsellors)</td>
<td></td>
<td>7.5</td>
</tr>
<tr>
<td>General Health Workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Doctors</td>
<td>7 years</td>
<td>0.7</td>
</tr>
<tr>
<td>(General) Nurses</td>
<td>5 years</td>
<td>1.7</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>No formal training in MH for pharmacists</td>
<td>N/A</td>
</tr>
</tbody>
</table>

\(^{16}\) Continuing Professional Development.

\(^{17}\) Informe WHO-AIMS sobre Sistema de Salud Mental en Chile [WHO-AIMS report]. OMS y Ministerio de Salud, Santiago, Chile, 2006

\(^{18}\) Informe WHO-AIMS sobre Sistema de Salud Mental en Chile [WHO-AIMS report]. OMS y Ministerio de Salud, Santiago, Chile, 2006

\(^{19}\) MD or general nurses working in MH facilities or private practice.
Mental Health Facilities and Services

Figure 12: The global shape of mental health services: WHO Model vs Chile

Table 1: Number of mental health facilities in public sector (Chile 2006)

<table>
<thead>
<tr>
<th>Health Districts</th>
<th>PHC Centers w/ psychologists</th>
<th>Community MH Centers</th>
<th>Psychiatric Outpatient Centers</th>
<th>Day Hospitals</th>
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<td><strong>TOTAL</strong></td>
<td><strong>671</strong></td>
<td><strong>42</strong></td>
<td><strong>55</strong></td>
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<td><strong>18</strong></td>
<td><strong>25</strong></td>
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</table>
Description of public services at each level of care

- Long Stay Facilities & Specialist Services

There are 4 public and 1 private mental hospitals in Chile. They are located in the central part of the country (3 in Santiago and 2 in Valparaiso Region), where half of the Chilean population live. They have a total of 1453 beds, divided in 480 short-stay beds, 112 medium-stay, 781 long-stay and 80 forensic. They provide acute hospitalization for health districts that do not have an inpatient unit in a general hospital or if the unit in the general hospital does not have enough beds. Since 2001 there cannot be admissions to long-stay units.

Hospital admissions:
In the years 2005 and 2006 there were 4,820 and 4,986 discharges respectively from these hospitals (the information system registers discharges but not admissions). These discharges are mainly from short-stay beds.

- Psychiatric Services in General Hospitals

- Inpatient: There are 18 psychiatric units in public general hospitals. They are distributed throughout the whole country, covering 12 of the 13 regions. Each of these units has, on average around 20 beds, but this varies from a minimum of 6 to a maximum of 60 beds, with a total of 397 beds throughout the country. The average stay per patient is 20 days. In the years 2005 and 2006 there were 6,178 and 6,320 discharges respectively from these units.

- Outpatient: Psychiatry has been incorporated in almost all secondary level outpatient centres along with other medical specialties. Most outpatient centres are placed in large high technology general hospitals. All health districts have at least one psychiatric outpatient centre with the exception of 2 districts that have completely shifted the secondary level outpatient care toward mental health community centres. There are 55 psychiatric outpatient centres in the country. In the year 2004, a total of 130,869 persons were attended to in these facilities.

Most health districts have also implemented day hospitals, with a national total of 42. They provide intensive ambulatory care from 9 am to 5 pm, several days a week, as an alternative to inpatient treatment when the person has a supporting family. In the year 2004, a total of 2,497 persons were received in these facilities, with an average length of care of 45 days (without weekend days).
### Community Mental Health Services

- Mental health community centres: These are secondary level ambulatory facilities within the territory of a municipality and are more decentralized than psychiatric outpatient centres. They are staffed by a multidisciplinary team (psychiatrist, psychologist, social worker, occupational therapist, nurse, nursing aid and community agents). In the year 2004, a total of 47,291 persons were attended to in these centres.

- Day centres: They are oriented towards psychosocial rehabilitation and recreational activities. Some of them are administrated by family organizations. Their staff is similar to mental health community centres, with the exception of psychiatrists who seldom work in these facilities. In 2004, a total of 1,821 persons were received in these centres, with an average length of care of 68 days (without weekend days).

- Sheltered homes and residences: These are for persons with mental disability who do not have the support of their family. A sheltered home is for people with some skills who need partial support and can function adequately by themselves in several types of activities (maximum number of residents in a home = 8 and total number using these homes in 2004 = 665). A sheltered residence is for people who need support 24 hours a day and seven days a week (maximum number of residents in a home = 14 and total number using these homes in 2004 = 177).

### Mental Health Services through Primary Health Care

- **Major Health Centers**: As part of the health reform, primary care is changing towards a family health model. The traditional primary care centres (urban and rural general health centres) are transforming into family health centres. They are all staffed by general physicians and a multidisciplinary team (dentist, nurse, obstetric nurse, social worker, nutritionist, psychologist and nursing aid). They carry out most of the mental health activities in primary care and in 2006 they received a total of 327,714 new persons with mental disabilities.

- **Minor Health Centers**: Rural health posts reach out to the most distant and isolated places of the country. They are usually staffed by a nursing aid and receive the visit of a multidisciplinary professional team (general physician, nurse, obstetric nurse, dentist, and psychologists in some places) at least once a week.

Major and minor centres are organized through a network of facilities all over the Chilean territory. The types and numbers of facilities are the following:
Table 2: Types and Numbers of Primary Health Care Facilities in Chile 2007

<table>
<thead>
<tr>
<th>Type of PHC Facility</th>
<th>Principal characteristics</th>
<th>Number</th>
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</thead>
<tbody>
<tr>
<td>Family health centre</td>
<td>Multidisciplinary teams, each one working with a sector of the population and applying a family health approach</td>
<td>81</td>
</tr>
<tr>
<td>Community family health centre</td>
<td>A small decentralized version of the family health centre with participation of community agents.</td>
<td>72</td>
</tr>
<tr>
<td>Urban general health centre</td>
<td>Multidisciplinary professionals working with the total population and applying an individual approach (in a large city)</td>
<td>258</td>
</tr>
<tr>
<td>Rural general health centre</td>
<td>Multidisciplinary professionals working with the total population and applying an individual approach (in a small rural town).</td>
<td>145</td>
</tr>
<tr>
<td>Rural health post</td>
<td>A small health centre placed in an isolated rural area and usually staffed only by a nursing aid.</td>
<td>1171</td>
</tr>
<tr>
<td>Primary care emergency service</td>
<td>A physician based centre for mild and moderate health emergencies, working at nights and on weekends.</td>
<td>141</td>
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<tr>
<td>Total Number of PHC facilities</td>
<td></td>
<td>1868</td>
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</table>

**Informal Community Care**

- **Traditional Healers**: According to the policy of the Ministry of Health concerning health and native people, health facilities should develop an intercultural approach. This implies, among other things, that facilities should respect the diagnosis of traditional healers, articulate referral and counter-referral procedures with them, and facilitate access to traditional healers when the users ask for this. Some mental health teams are applying this policy with aymara population in the North of Chile and mapuche population in the South of the country. No quantitative information about these activities is available.

- **NGOs**: There are few NGOs working on mental health in Chile. Seven NGOs work on psychosocial rehabilitation for people with mental disabilities, and they run a variety of programmes such as day centres, sheltered homes and sheltered workshops. Some of them receive funding from the health districts. The largest of these NGOs carries out a very successful community programme, supported by charitable funds, with 11 sheltered homes (97 persons used these homes in 2004) and several rehabilitation services. Four NGOs work with persons with mental health sequelae resulting from human rights violations committed during the military dictatorship. There are also around 40 NGOs working with persons with substance addiction, mainly through residential therapeutic communities.
Mental Health Consumers/Users or Family associations: Approximately 8,000 people participate in users groups in the country, and around a similar number of relatives participate in family groups. Slightly more than 50% of the users groups are oriented towards mutual-help for substance addiction. Thirty-one percent of major primary health care facilities declare working with user groups and 15% with family groups, while 64% of specialist outpatient centres state that they work with user groups and 65% with family groups (WHO-AIMS 2004).
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url: http://www.who.int/globalatlas/default.asp (last accessed 24/03/2007).


