Mental health care before and during the COVID-19 pandemic in public healthcare centers of a Chilean municipality

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Abstract

Introduction

Globally, the COVID-19 pandemic has affected people's mental health care. This study aims to describe mental health care in the first semester of the COVID-19 pandemic of the year 2020 compared to the first semester of the year 2019 in the public health establishments of the commune of Chillán, Chile.

Methods

A descriptive ecological study. The treated cases were analyzed in aggregate, considering the pandemic, amount of admissions, the reason for consultation, sex, and age for the years 2019 and 2020Prevalence, percentages and statistical análisis were evaluated using nonparametric tests.

Results

The prevalence of cases due to admissions to the mental health program in primary health care remained similar between the first semester of 2019 and the first semester of 2020. Most mental health cases concentrate on mood (affective) and anxiety disorders. Statistically significant differences were observed between 2019 and 2020 in the number of mental health admissions for mental and behavioral disorders due to psychotropic substances, harmful use disorders, drug dependence, and personality disorders.

Conclusions

It is a priority for Chile to increase coverage in primary mental health care. The data provided in this study show at an exploratory level that the initial situation of the pandemic could have affected access to timely care for the most vulnerable people with mental disorders.

Main messages

- The COVID-19 pandemic has had repercussions on mental health, raising questions regarding the increase or decrease of care in primary healthcare centers.
- This study contributes to the knowledge of mental health care in public healthcare centers before and during the pandemic, exploring the causes of admission that concentrated the majority of people diagnosed with mental health disorders and the characteristics of the sample by sex and age.
- The study's limitations are related to the exploratory use of aggregate data collected only in the first semester of the pandemic.

Introduction

At the end of 2019, increased cases of atypical pneumonia alerted the World Health Organization to study its clinical presentation, identifying a new coronavirus named SARS-CoV2 [1], declaring on March 11, 2020, the COVID-19 pandemic.

Globally, countries developed different strategies to deal with the spread of COVID-19. With the guidance of the World Health Organization, supported by the scientific world, social distancing, the use of masks, lockdown (quarantine), and, recently, inoculation through vaccines have been the main actions to contain the pandemic [1].

The health emergency has highlighted the relevance of strengthening public health institutions to face infectious diseases and implement political actions, together with an integrated approach to care for the existing interaction between the pandemic and other chronic conditions [2].

However, some international studies [3–7] reported some limitations of mental health care programs during quarantine that restricted community access to specialists in the area. On the other hand, the health emergency centered the priority of health teams on caring for people with suspected symptoms or with COVID-19 disease.

A systematic review indicated that among the consequences of lockdown in some epidemics, such as SARS, MERS, influenza A (H1N1), and Ebola, there is a higher prevalence of psychological distress, affective symptoms, and post-traumatic stress [3].

On the other hand, studies show that domestic violence against children, adolescents, and women has been increasing and is closely associated with pandemic uncertainty and preventive isolation [4,5].

The pandemic has exposed and reinforced pre-existing social inequalities in the prevalence of violence against the most vulnerable populations. Worldwide, significant deficiencies in healthcare systems have been demonstrated in the response and prevention of mental health problems. For example, telephone connectivity and internet access have been accessible mainly in high-income countries or cities. Therefore, there is a vulnerable population of children, adolescents, and families who did not receive mental health care via telephone or through the virtual telemedicine channels implemented during this period [6].

A review of 100 articles [7] identified 48 studies published between March and December 2020, which documented the impact of the COVID-19 pandemic on the increase in assaults against children, adolescents, and women. These studies focused mainly on children's experiences of physical and psychological domestic violence. Ten studies examining child protective services or police found decreased child abuse reports. The authors argue that the decreases were related to stay-at-home orders and the closure of schools and mental health services, which made it difficult for teachers, physicians, psychologists, and social workers to identify violence cases.

The situation in Chile was no different. However, initiatives were created as part of the government's strategies (such as a practical guide on emotional well-being and telephone lines or telematic attention that provided guidance; additionally, universities created other support systems that made it possible to deal with emerging problems and carry out an initial screening in order to provide guidance and referrals), there were two years in which mental health was falling behind [8]. This was worsened by social problems and the sociopolitical context, where families were affected by unemployment, loss of family members, teleworking, and the difficulties that students had to cope with academic demands from their homes, among others [4,5,8].

Prioritizing mental health in the national plan for dealing with the pandemic had the general objective of developing a national strategy that addressed mental health in two ways: strengthening it as a key factor for generating adaptive responses to the pandemic and reducing the impact of the COVID-19 pandemic through prevention, care and strengthening the communities' development capacities [9]. At the local level, the Regional Ministerial Secretariat of Science, Technology, Knowledge, and Innovation of the central-south macro zone, together with researchers from the Catholic University of Maule, Catholic University of the Most Holy Conception, University of O'Higgins, University of Talca, University of Concepción and the University of Bío-Bío, presented a guide of technical

orientations for mental health in pandemics. This document, after identifying a series of shortcomings concerning the population's confidence in the management of the pandemic, suggested a series of actions and measures ranging from an improvement in the communication language of the responsible authorities to the participation of the communities, the detection of vulnerable groups, and promotion and prevention actions in the field of mental health [10].

Mental health care in times of pandemic is a relevant problem at the national level. It is necessary to collect information regarding the prevalence and demand for admissions that have presented the primary health care programs in different public centers, especially at the regional level, in this health emergency context.

During the COVID-19 pandemic, the city of Chillán was put under a three-week lockdown between March and April 2020, only returning during the last week of August of that same year [11]. In addition, in-person classes were suspended in all educational establishments, and many workers carried out their duties from their homes in teleworking modalities [12]. The prolonged lockdown, the job and economic uncertainty, and the radical transformation of daily routines impacted family relationships, generating stressful situations that favored mistreatment and negligence, with impulsive and/or violent behaviors, in a context of a lack of external protection [7,13].

The present study aims to describe mental health care in public health facilities in the commune of Chillán, Chile, during the first semester of the COVID-19 pandemic in 2020, compared to the first semester of 2019. This information could contribute to the development of targeted strategies in the different public health facilities at the regional level, aiming to strengthen mental health care affected by the health emergency.

Methods

Participants

A descriptive ecological study was carried out. In the commune of Chillán, 12 primary healthcare establishments assist patients included in the mental health program. The sample finally considered the aggregate data of the patients admitted in 10 healthcare centers; the remaining two centers were excluded because they did not have complete data on admissions to the mental health program.

The study population was obtained through a census sampling strategy, non-probabilistic, based on secondary data [14] reported by the Monthly Statistical Summaries of series A, REM-A05, admissions and discharges by health conditions and problems, section N of admissions to the Mental Health Program of primary or specialist healthcare by healthcare center for the first period of 2019 and 2020 of the commune of Chillán. Both periods of the first semester were requested to the Ñuble Health Service through the active transparency page [15], selecting only those who entered the mental health program for the first time, aiming to describe the new demand for mental health care considering the impact of the pandemic on the public health system of Chillán.

Selection criteria

The criteria for the inclusion of the centers were the following: public establishments in the commune of Chillán; record of care for men and women; record of age ranges; having records in the Monthly Statistical Summaries on the section of admissions to the Mental Health program in primary or specialist healthcare; record of the motive for admission to the program; and the periods of admission had to be equal in terms of months and season for the years 2019 and 2020.

Healthcare centers that did not belong to the primary or specialist mental health program; data from indigenous peoples; infant-juvenile population data from the National Service for Minors; migrant population; and centers with incomplete databases were excluded.

Variables analyzed from the databases by healthcare center included the number of patients seen in the mental health program during the first semester of 2019 (before the pandemic) and 2020 (during the pandemic) related to the cause of admission for risk factors and mental health conditions requiring assistance for:

1) Violence (victim and aggressor), sexual abuse (victim), and suicidal ideation or attempt.
2) Patients with a mental disorder diagnosis corresponding to mood (affective) disorders such as mild/moderate/severe depression, postpartum depression, bipolar disorder, refractory depression, severe depression with psychosis, and depression with high suicidal risk.
3) Mental and behavioral disorders due to consumption of psychotropic substances (harmful use or alcohol dependence, harmful use or drug dependence, and multiple drug use).
4) Behavioral and emotional disorders of common onset in childhood and adolescence (hyperkinetic disorders, oppositional defiant and oppositional dissocial disorder, childhood separation anxiety disorder, other behavioral and emotional disorders of common onset in childhood and adolescence).
5) Anxiety disorders (post-traumatic stress disorder, panic disorder with agoraphobia, panic disorder without agoraphobia, social phobias, generalized anxiety disorders, and other anxiety disorders).
6) Personality disorder.
7) Pervasive developmental disorder.
8) Number of admissions of assisted patients by sex (male and female).
9) Number of admissions by age range of patients (0 to 19 years old, 20 to 49 years old, 50 years old and older).

It is important to note that the Monthly Statistical Summaries database does not provide specific information on the number of visits per patient. They are only aggregated data by healthcare centers on mental health program admissions in primary or specialist mental health care. The system predetermines the

age ranges, and no information is provided on strategies for focused care by healthcare centers. Neither is more detail provided on more specific types of disorders, e.g., types of personality disorders, types of pervasive developmental disorders, or types of drugs used.

Data analysis

The original information obtained from the report of the Monthly Statistical Summaries on admissions to the mental health program in Chillán healthcare centers was transferred to Excel to construct a database grouped as described in the selection criteria. The figures were double-entered and cross-checked to correct possible typing errors. This database was transferred to SPSS 15.0 software, which included the 10 healthcare centers as a sample.

Subsequently, an exploratory analysis was performed to identify possible coding errors, missing data, and distribution of variables. The descriptive analysis of the variables was performed by measuring the percentage of mental health admissions by sex, age range, and motive for consultation; the prevalence of mental health care admissions concerning total admissions for care in the healthcare facilities; and the median prevalence for both years.

Being aggregate data with a sample of 10 facilities, bivariate analyses were performed with the nonparametric Mann-Whitney U test to compare the prevalence of mental health care in the totality of healthcare centers between the first periods of the years 2019 and 2020. For all tests, a confidence level of 95% was considered ($p < 0.05$).

Results

For the first half of 2019, in the 10 healthcares included, the total number of admissions was 14 264 people, with 8299 people for the first half of 2020, observing a drop of 5965 people in the same period. In the mental health program of the 10 centers, 2498 patients were admitted during the first half of 2019 and 1085 during the first half of 2020.

The prevalence of mental health consultations in relation to the total number of healthcare consultations in the 10 centers accounted for 17.3% in the first semester of 2019 and 13.1% in the first semester of 2020. No statistically significant differences were observed between the first semester of 2019 and the first semester of 2020 for total healthcare consultations in the 10 centers ($p = 0.279$) and total mental health admissions ($p = 0.293$).

Table 1 shows that the proportion of men and women who were seen in the mental health program between the first semester of 2019 and the first semester of 2020 are similar, with no statistically significant differences between mental health care within men ($p = 0.178$) and women ($p = 0.178$) for both periods. However, the proportion of women entering the mental health program overall is higher than that of men, maintaining a ratio of 2:1, i.e., for every two women, one man enters the mental health program.

Concerning age ranges (Table 1), no significant differences were observed in the ranges 0 to 19 years ($p = 0.250$), 20 to 49 years ($p = 0.250$), or 50 years and older ($p = 0.309$), between both periods.

Within total health admissions (Table 2), the most prevalent mental health disorders for both years were anxiety disorders, followed by mood (affective) disorders, personality disorders, and mental and behavioral disorders due to psychotropic substance use. Anxiety disorders and mood (affective) disorders are the most prevalent when analyzing only mental health admissions.

When reviewing the proportion of consultations for violence (victim and aggressor), sexual abuse, and suicide ideation or attempt (Table 2) in relation to the total number of mental health consultations (Table 2), it is observed that they represent a similar percentage between the first period of 2019 and 2020, with no statistically significant differences ($p < 0.05$). If we observe the prevalence of these risk factors in relation to total health care, it can be seen that the low values are maintained throughout the second year. Cases of violence and sexual abuse are the most frequent.

When comparing the specific prevalences of consultations for mental health disorders between the first semester of 2019 and 2020 (Table 3), significant differences were observed in the prevalence of mental and behavioral disorders due to the use

Table 1. Mental health admissions by age and sex of users during the 1st semester of 2019 and 2020.

Variable	Mental health admissions of 2019		Mental health admissions of 2020	
Sex	n (10 centers)	% (10 centers)	n (10 centers)	% (10 centers)
Male	793	31.7	360	33.2
Female	1705	68.3	725	66.8
Age				
0 to 19 years	562	22.5	341	31.4
20 to 49 years	873	34.9	392	36.1
50 or more	1063	42.6	352	32.4

Healthcare in the 10 healthcare centers of Chillán.
Source: Prepared by the authors based on the results of the study.

Table 2. Admissions during the 1st semester of 2019 and 2020 by motive of consultation and proportion of cases in relation to total mental health consultations and their prevalence.

Reason for consultation	Number of admissions in 2019	Number of admissions in 2020	% Total admissions according to mental health care in 2019	% Total admissions according to mental health care in 2020	Prevalence Mental health admissions/ total admissions 2019	Prevalence Mental health admissions/total admissions 2020
Total risk factors and mental health determinants (violence, sexual abuse, suicide)	**63**	**16**	**2.5**	**1.5**	**0.4**	**0.19**
Violence	34	11	1.4	1	0.2	0.1
Sexual abuse	29	3	1.2	0.3	0.2	0.04
Suicide	0	2	0	0.08	0	0.02
Mood disorders (affective)	**427**	**195**	**17.1**	**18**	**3**	**2.3**
Mild depression	123	51	4.9	4.7	0.9	0.6
Moderate depression	215	90	8.6	8.3	1.5	1.1
Severe depression	62	27	2.5	2.5	0.4	0.3
Postpartum depression	2	5	0.1	0.5	0.01	0.1
Total depression	402	173	16.1	15.9	2.8	2.1
Bipolar disorder	25	22	1	2	0.2	0.3
Mental and behavioral disorders due to use of psychotropic substances	**144**	**43**	**5.8**	**4**	**1**	**0.5**
Harmful use or alcohol dependence	80	27	3.2	2.5	0.6	0.3
Harmful use or drug dependence	64	16	2.6	1.5	0.4	0.2
Behavioral and emotional disorders of habitual onset in childhood and adolescence	**110**	**39**	**4.4**	**3.6**	**0.8**	**0.5**
Hyperkinetic disorder	87	34	3.5	3.1	0.6	0.4
Oppositional defiant and oppositional dissocial disorder	18	5	0.7	0.5	0.1	0.1
Separation anxiety disorder in childhood	5	0	0.2	0	0.04	0
Anxiety disorder	**877**	**446**	**35.1**	**41.1**	**6.1**	**5.4**
Post-traumatic stress disorder	20	9	0.8	0.8	0.1	0.1

(Cont.)

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Table 2. Cont.

Reason for consultation	Number of admissions in 2019	Number of admissions in 2020	% Total admissions according to mental health care in 2019	% Total admissions according to mental health care in 2020	Prevalence Mental health admissions/ total admissions 2019	Prevalence Mental health admissions/total admissions 2020
Panic disorder with agoraphobia	18	10	0.7	0.9	0.1	0.1
Panic disorder without agoraphobia	35	39	1.4	3.6	0.2	0.5
Social phobias	6	2	0.2	0.2	0.04	0.02
Generalized anxiety disorders	125	90	5	8.3	0.9	1.1
Other anxiety disorders	673	296	26.9	27.3	4.7	3.6
Personality disorder	**249**	**76**	**10**	**7**	**1.7**	**0.9**
Pervasive developmental disorders	**62**	**34**	**2.5**	**3.1**	**0.4**	**0.4**

Healthcare in the 10 healthcare centers of Chillán.
Source: Prepared by the authors based on the results of the study.

Table 3. Median and comparative prevalence of risk factors, determinants, and mental health disorders.

Reason for consultation	Median prevalences 2019	Median prevalences 2020	P value
Risk factors and mental health determinants	**0.2**	**0.1**	**0.606**
Violence	0.1	0.1	1
Sexual abuse	0	0	0.116
Suicide	0	0	0.3
Mood (affective) disorders	**1.9**	**1.8**	**0.748**
Mild depression	0.6	0.4	0.3
Moderate depression	1.1	1	0.606
Severe depression	0.3	0	0.478
Postpartum depression	0	0	0.3
Bipolar disorder	0.1	0	0.949
Mental and behavioral disorders due to psychotropic substance abuse	**1**	**0.4**	**0.008 a**
Harmful use or alcohol dependence	0.5	0.2	0.171
Harmful use or drug dependence	0.4	0.1	0.001 [a]
Behavioral and emotional disorder of common onset in childhood and adolescence	**0.6**	**0.5**	**0.438**
Hyperkinetic disorder	0.4	0.3	0.699
Oppositional defiant and oppositional dissocial disorder	0.1	0	0.365
Separation anxiety disorder in childhood	0	0	0.151
Anxiety disorder	**6.1**	**5.3**	**0.748**
Post-traumatic stress disorder	0	0.1	0.3
Panic disorder with agoraphobia	0	0	0.652
Panic disorder without agoraphobia	0.2	0.5	0.151
Social phobias	0	0	0.949
Generalized anxiety disorders	0	0.5	0.562
Other anxiety disorders	5.4	4.3	0.438
Personality disorder	**1.4**	**0.6**	**0.019 a**
Pervasive developmental disorders	**0.3**	**0.4**	**0.478**

[a] Test U Mann Whitney, $p < 0,05$.
Assisted patients at the 10 healthcare centers between the first semester of 2019 and 2020.
Source: Prepared by the authors based on the results of the study.

of psychotropic substances ($U = 11.0$; $p = 0.008$), harmful use or drug dependence ($U = 21.0$; $p = 0.001$) and personality disorder ($U = 25.5$; $p = 0.021$). In these cases, prevalences were lower for the year 2020.

Discussion

According to the main objective of this study, we observe that the prevalence of admissions to the primary or specialist mental health program in the first semester of the 2020 COVID-19 pandemic (when the pandemic began in Chile) remains similar to that of the 2019 first semester throughout the different public health establishments in the commune of Chillán. This reveals that the treatment needs associated with mental disorder diagnoses retain the urgency of providing mental health services to decrease the psychological impact on the most at-risk populations who present situations of vulnerability, and existing physical or psychiatric morbidity, in the face of the effects of COVID-19 [16,17].

According to the literature, mental disorders have an increasing prevalence [18], being an event that causes a new form of stress or trauma [19]. However, other studies have shown that strict lockdowns and the prioritization of healthcare for COVID-19 cases affected psychological and psychiatric care, causing an increase in mental health problems and violence in the most vulnerable population [4–7].

Possibly, if the cases follow-up of the periods after 2020 were extended, the difference in mental health care before and after the pandemic would be accentuated, especially when the restrictions on the public's circulation began, incorporating lockdowns and sanitary cordons, which also affected people's circulation in different sectors of the commune.

However, it was observed that some mental health disorders began to decrease their consultation during the first half of 2020, such as mental and behavioral disorders due to psychotropic substances, specifically mental health problems associated with harmful use or drug dependence and personality

disorders. The decline in these cases indicates that mental health admissions could decrease over time due to lockdown-associated restrictions [7], increasing the likelihood and risk of worsening the severity of problematic drug use disorder cases as primary health care decreases and in-home use increases [20].

When comparing the proportion of causes of admission by risk factors and mental health conditions related to violence, sexual abuse, and attempted suicide in the first half of 2020 with that of 2019, a low rate of cases was found in both periods, and no major differences were observed. Although these data are encouraging, it should be considered what the international literature reports [7]. Cases of domestic aggression towards children, youth, and women during the pandemic were mainly affected by difficulties in accessing specialized care, so it should be explored whether the maintenance of this low proportion of causes of admission for this condition in 2020 is because there is a low proportion of cases, and not because admission to the mental health program for those seeking care was affected by the difficulty of access in the context of the pandemic.

In mental disorder diagnoses, we found that mood disorders (17 to 18%) and anxious disorders (35 to 41%) concentrated the largest number of cases by cause of admission, with similar percentages in both periods. A study in China [21] revealed that 53.8% of people rated the psychological impact of the onset of the pandemic as moderate to severe; 16.5% reported depressive symptoms, and 28.8% anxiety symptoms. If these percentages are compared to those of this study, the psychological impact of the onset of COVID-19 is not the same. However, the percentages of admissions of mood disorders (affective) and anxiety disorders before and after the pandemic reported by the mental health programs of Chillán have a similar percentage to that of the Chinese study. That is, the prevalence of these mental health disorders in Chile is high compared to an international level, independent of the pandemic context. Therefore, this indicates the priority that should be given to public mental health care in Chile.

The pandemic had a disturbing impact on people with psychiatric disorders, aggravating their mental health and increasing the risk of depressive symptoms, anxiety, insomnia, and stress reactions [22]. Consequently, there was an increase in negative emotions such as anxiety, depression, and indignation [23], social isolation, fear of contagion, and distress over socioeconomic changes [24,25].

Although in the present study, we did not find significant differences in this type of disorder during the analyzed period in the city of Chillán, it is relevant to maintain surveillance and perform longitudinal analyses of more than one year in more regions of the country to observe the effects of the pandemic on Chileans' mental health.

As mentioned earlier, there is a statistically significant difference in admissions associated with problematic use of psychotropic substances and personality disorders, which could indicate the beginning of a decline in mental health care as a result of the pandemic. Therefore, it is relevant to glimpse the trajectory of the cases over time and to evaluate the hidden problems in public mental health care, considering that the impact of the pandemic is greater in people with previous psychiatric problems and/or history. Possibly such patients were not screened in primary health care and may present a greater severity in their symptoms [16]. There is a high probability that 20% of the world population will develop some type of mental illness during the pandemic. According to this information, depression and anxiety would increase significantly [24–26], making the care of these disorders in the public system more complex, as they already had a high prevalence in the Chilean population before the appearance of COVID-19.

Regarding sex, in both men and women, no statistically significant differences were observed in the number of admissions during the first half of 2020 and 2019. However, in both periods, most of the cases admitted were female. One study in March 2020 [27] found that 53% of women had their mental health adversely affected by the pandemic, compared to 37% of men. Likewise, 57% of mothers had a greater impact as opposed to 32% of fathers. It should be added that in the labor market, one study highlighted that the female labor force was one of the most adversely affected or vulnerable during the COVID-19 health emergency [20]. A literature review found that being female was one of the risk factors that predisposed people to mental health illness [28].

The literature reports greater vulnerability, risk, and impact on women's mental health; the pandemic may have aggravated this. Although this study did not show an increase in the number of admissions in 2020, the fact that the percentage of consultations remained above 60% in women indicates the urgency of monitoring these patients' access to the public healthcare network during and after the pandemic isolation measures. The global situation indicates that the rates of mental health disorders are rising, coexisting in close relationship with marginalization, impoverishment, domestic violence, abuse, work overload, and stress, especially in women's health [4–7,18,29–31].

Based on the above, it is necessary to invest in programs that can handle the increased demand for care for people who develop mental disorders during the COVID-19 pandemic situation and, at the same time, prevent the development of future mental health problems in the population, through support campaigns that help people manage their emotions [16,24]. Programs must emerge from the community with specialized mental health teams [32] Despite orientations and programs offered during the COVID-19 social roundtable: the special accompaniment program named Saludable-Mente [33] and the Ministry of Health recommendations through digital platforms [34,35], they are insufficient to contain community work in mental health.

Although this study is exploratory and has the limitation of analyzing only the situation of mental health care in aggregate and not individual data at the beginning of the pandemic in a Chilean city, it provides background information that allows

understanding of the situation of mental health before and during the health emergency condition in healthcare centers in the southern macro-zone of Chile. This highlights the relevance that mental health interventions have a guaranteed space in the public health system, for which it is necessary to strengthen and guarantee admissions in primary healthcare centers, prioritizing the most vulnerable groups that present symptomatology associated with anxious and depressive features, problematic consumption of psychotropic substances and personality disorders. In addition, it is important to screen and address cases of violence, which may be underreported, as other diagnoses of mental disorders are also included. Finally, it highlights the need for greater coverage of mental health services in the country and the need to strengthen the social capital of the population to reduce the psychological impact of COVID-19 [9].

Conclusions

The number of mental health consultations during the first semester of 2020 does not present great differences compared to the first semester of 2019, before the pandemic, according to the mental health program admissions in primary or specialist healthcare in Chillán.

When identifying the causes of admission that concentrated the majority of patients with a mental disorder diagnosis, they were mood disorders (affective) and anxiety disorders in both semesters.

Although risk factors and mental health conditioning factors did not account for the largest proportion of cases, within this problem, it was observed that consultations related to violence were the most prevalent.

When characterizing the reasons for mental health admissions in the different public facilities in the first semester of 2020 in relation to the first semester of 2019 in the commune of Chillán, it is found that they only presented significant differences towards a decrease in consultations for the year 2020 for cases of mental and behavioral disorders due to consumption of psychotropic substances, along with cases of harmful consumption or drug dependence and personality disorders.

It is a priority in Chile to increase primary mental health care coverage. The data provided in this study show that the need for timely care for the most vulnerable people with mental health disorders remained high both before and at the beginning of the pandemic. Therefore, further studies are needed to investigate the effects of the COVID-19 healthcare emergency on their symptomatology and quality of life.

Notes

Contributor roles

MTMQ and SS wrote and assessed the eligibility of evidence for inclusion and extracted the data. MTMQ and SS developed the database and performed the analyses. All authors (MTMQ and SS) contributed to interpreting the results and writing and editing the manuscript.

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Competing interests

The authors declare that they have no conflicts of interest with the subject matter of this work.

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Ethics

The Monthly Statistical Summaries (2019) databases are available for use. This information was obtained for the first semester of 2020 by request to the Ñuble Health Service through the transparent government page; therefore, it was not necessary to use informed consent, considering that the analyzed data correspond to secondary sources of data on healthcare centers and do not represent private information.

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Atención de salud mental antes y durante la pandemia COVID-19 en centros de salud pública de una municipalidad de Chile

Resumen

Introducción

A nivel mundial, la pandemia por COVID-19 ha afectado la atención en salud mental de las personas. El presente estudio tiene como propósito describir la atención de salud mental en el primer semestre de la pandemia COVID-19 del año 2020, comparado con el primer semestre del año 2019 en los establecimientos de salud pública de la comuna de Chillán, Chile.

Métodos

Estudio ecológico descriptivo. Se analizaron de manera agregada los casos atendidos considerando la pandemia, cantidad de ingresos, motivo de consulta, sexo y edad para los años 2019 y 2020, observando prevalencias, porcentajes y comparación estadística con pruebas no paramétricas.

Resultados

La prevalencia de casos por ingresos al programa de salud mental de atención primaria en salud/especialidad se mantuvo similar entre el primer semestre del año 2019 y el primer semestre del año 2020. La mayor proporción de casos de salud mental se concentran en los trastornos de humor (afectivos) y trastornos de ansiedad. Se observaron diferencias estadísticamente significativas entre el año 2019 y 2020 en el número de atenciones por ingresos en salud mental para los trastornos mentales y del comportamiento debido a consumo sustancias psicotrópicas, trastornos por consumo perjudicial o dependencia como droga principal y trastornos de personalidad.

Conclusión

Es prioritario que en Chile se aumente la cobertura en la atención primaria de salud mental, los datos entregados en este estudio muestran a nivel exploratorio que la situación inicial de la pandemia pudo haber afectado el acceso a la atención oportuna de las personas más vulnerables con trastornos de salud mental.