

# Autism and ADHD prevalence in Chile through Bayesian prevalence analysis, machine learning and clinical record data linkage

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## **Preface**

This dissertation is the result of my own work and includes nothing which is the outcome of work done in collaboration except where specifically indicated in the text.

The dissertation does not exceed the word limit for the respective Degree Committee.

Word count: xxx TODO (including footnotes, but excluding tables, appendices, and bibliography)

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# 1 Abstract

The prevalence of autism and ADHD in Chile has not been well characterised and therefore the unmet need of affected children without school-based support is unknown. This investigation aims to quantify the prevalence of autism and ADHD in Chilean children and understand the characteristics of children with autism through analysis of 3 million school records and linkage to 1,300 supplementary clinical records. Found using frequentist age- and sex-adjustment, a lower bound on the prevalence of autism is 0.46% with male to female ratio of 6.00:1 and a lower bound on the prevalence of ADHD 1.50% with male to female ratio of 1.94:1. Autism prevalence peaks in 6-8 year-olds and ADHD in 9-11 year-olds. For both autism and ADHD, prevalence is lower among Mapuche students than non-Indigenous students and is lower among students at urban schools than rural schools. Multiple correspondence analysis of categories in clinical autism diagnosis data for Servicio de Salud Araucanía Sur showed ethnicity, age and commune of residence were important in distinguishing between patients with autism. Probabilistic linkage of school records and clinical autism diagnoses identified an unmet need of 1,132 students with autism in Servicio de Salud Araucanía Sur that were not accessing school-based supports. This equated to an updated autism prevalence of 1.22% with male to female ratio of 4.15 for Servicio de Salud Araucanía Sur. Projecting this finding across Chile, the national prevalence of autism is estimated to be 1.31%, there is an unmet need of up to 25,903 students not accessing school support with females disproportionately affected. Bayesian prevalence projection found credible intervals of autism prevalence for each Chilean health service. Collectively, these findings are a first step to creating a rich, national picture of autism and ADHD support in Chile.

## 2 Introduction

### 2.1 Chilean health context

Chile is a high income country in Latin America with a population of 19.7 million, GDP of US\$15,356 per capita, and US\$2,699 per capita annual health care spend (1,2). Chile has a dual health care system with most people accessing care in the public health system that is partly funded by the Government through the Fondo Nacional de Salud (National Health Fund, FONASA), a social insurance fund (3). Approximately 15% of the population, mostly those of middle and high income, pay for private insurance through Instituciones de Salud Previsional (Social Security Institutions, ISAPRE) (3). All workers also pay a mandatory health contribution of 7% of their income which funds both FONASA and ISAPRE services (3). FONASA defines four coverage groups based on income with those in groups A and B having low income and receiving 100% subsidised care, and groups C and D having low to middle income and receiving 90% and 80% subsidised care respectively (3). Care is delivered through 29 Servicios de Salud (health services) that cover catchment areas within Chile's 16 regions, see Table 1 (4). The public and private systems have various additional pay-per-service options which creates high out-of-pocket expenses that effectively redistribute wealth with those in the top income quintile paying on average 7.0% of monthly household expenditure on out-of-pocket healthcare and those in the bottom quintile paying 3.9% (5,6). Many conditions are not covered by ISAPRE services meaning high needs and high risk patients are overrepresented in the public system (3). The public system is stretched thin with wait times of up to 1.6 years and 2 million people on specialist waiting lists in 2022 (3).

Chileans accessing public health care are on average poorer than those accessing private care with 17.2% below the poverty line in 2013, and they are less likely to access specialist medical services (7). Chile has considerable income inequality with a Gini Index of 44.9 in 2020 (8). In 2014, 21% of inequality was due to spatial inequalities, of which 50% was due to differences between communes meaning inequality in Chile has high granularity (9). Income is highest in the regions of Magallanes y Antártica Chilena, Santiago, Antofagasta and Aysén del Gral. Ibañez del Campo, see Figure 1 (10).

Chile has a large Indigenous population with nearly 10% of Chileans self-identifying as Mapuche and approximately 2.4% belonging to other Indigenous groups (11). Sandoval, Portaccio and Albala found life expectancy at birth of Indigenous Chileans as a whole group is seven years shorter than for non-Indigenous Chileans and 8.3 years shorter for Mapuche people as a group, and suggest lack of access to health services as a possible cause (12). Sandoval and Portaccio separately note that accurate analysis of Chile's health context

Table 1: Chilean health services by region

Region	Health services
Antofagasta	Antofagasta
Arica y Parinacota	Arica
Atacama	Atacama
Aysén del Gral. Ibañez del Campo	Aisén
Bío-Bío	Arauco
Bío-Bío	Biobío
Bío-Bío	Concepción
Bío-Bío	Talcahuano
Coquimbo	Coquimbo
La Araucanía	Araucanía Norte
La Araucanía	Araucanía Sur
Libertador Bernardo O'Higgins	Libertador B.O'Higgins
Los Lagos	Chiloé
Los Lagos	Osorno
Los Lagos	Reloncaví
Los Ríos	Valdivia
Magallanes y Antártica Chilena	Magallanes
Maule	Maule
Metropolitana de Santiago	Metropolitano Central
Metropolitana de Santiago	Metropolitano Norte
Metropolitana de Santiago	Metropolitano Occidente
Metropolitana de Santiago	Metropolitano Oriente
Metropolitana de Santiago	Metropolitano Sur
Metropolitana de Santiago	Metropolitano Sur Oriente
Tarapacá	Iquique
Valparaíso	Aconcagua
Valparaíso	Valparaíso San Antonio
Valparaíso	Viña del Mar Quillota
Ñuble	Ñuble

## Net income from main job

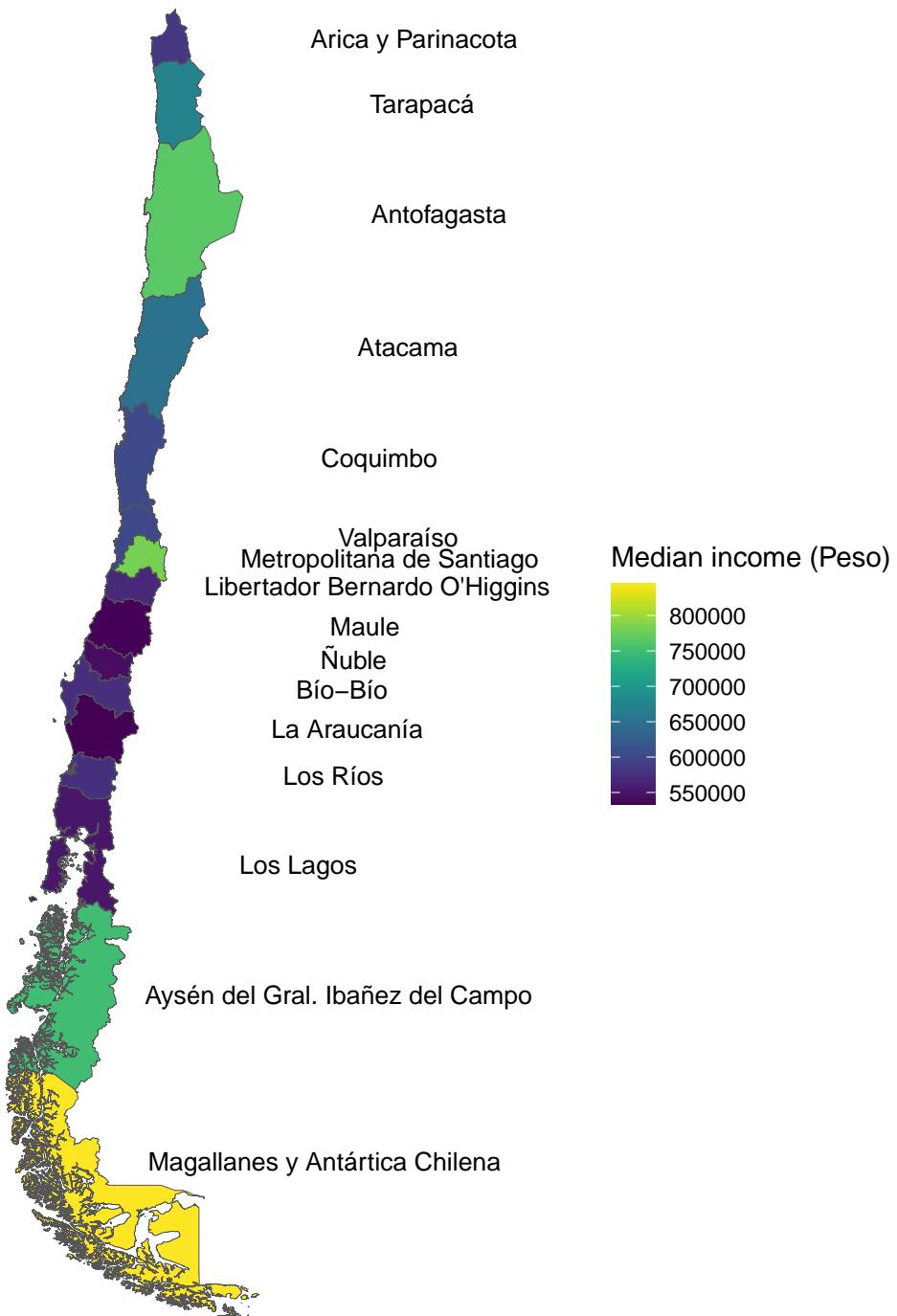


Figure 1: Net income from main job in Chile in 2021 by region, from the INE's Supplementary Income Survey (10).

## Percentage of population living in rural areas

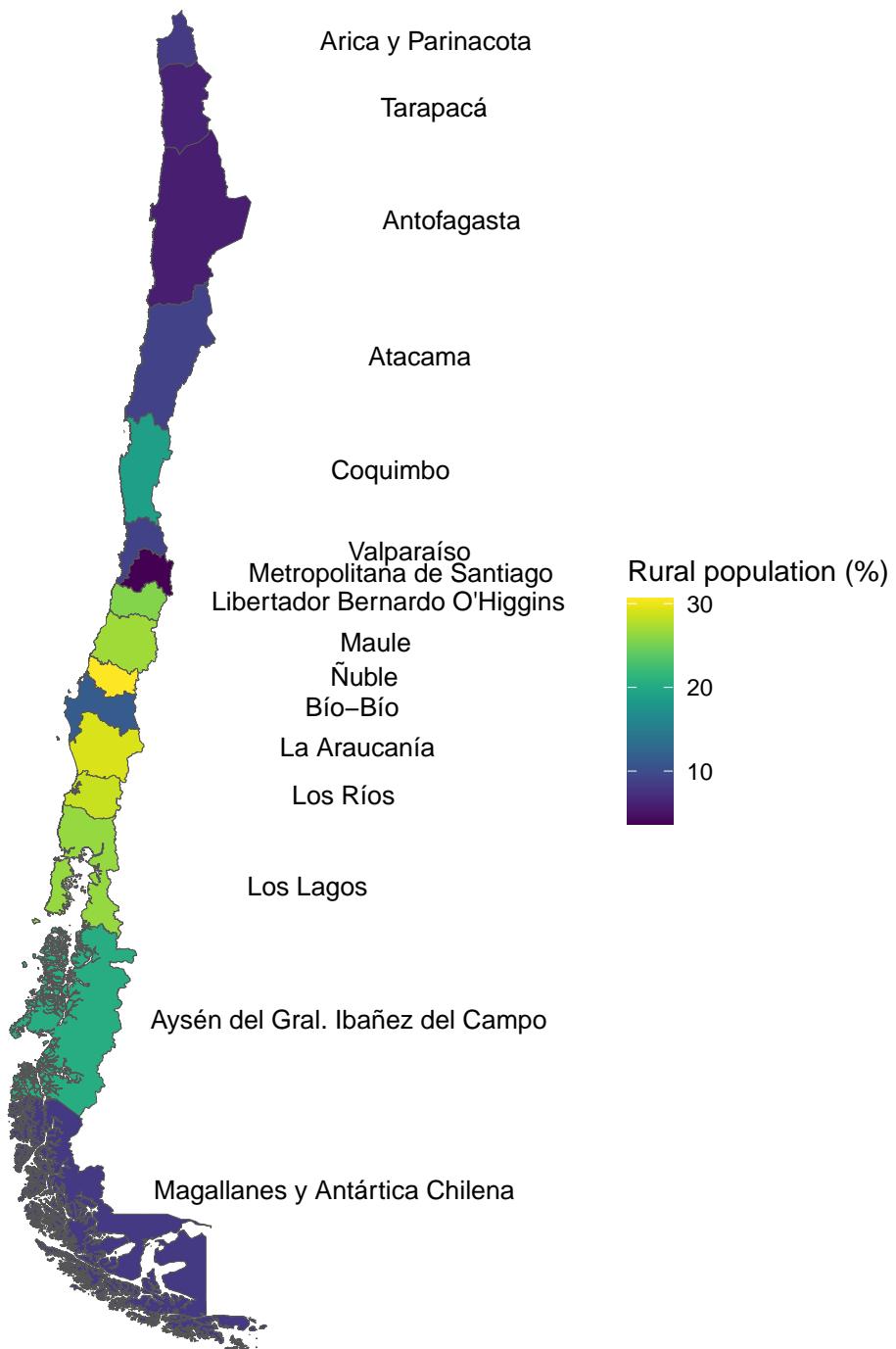


Figure 2: Percentage of population living in rural areas in Chile in 2017 from 2017 census (13).

for Indigenous groups is difficult because ethnicity is not required on death certificates (11). Large population health studies with self-reported ethnicity data are therefore particularly valuable in Chile.

Approximately 12% of Chile's population lives in rural areas; the regions of Ñuble, La Araucanía and Los Ríos have particularly high prevalence of rural dwelling, see Figure 2, and approximately 7 million people live in Santiago, Chile's largest city (13). Núñez and Manzano identified a lack of availability of rural health clinics as a barrier to accessing healthcare in Chile (6).

Chilean policy encourages children with special education needs and disabilities, including autism and ADHD, to be educated in mainstream schools and the Government provides funding to enable this (14). For each child with a registered disability that is integrated into a regular public school, the Ministerio de Educación (Ministry of Education) provides funding through the Subvención de Educación Especial Diferencial (Differential Special Education Grant, SEED) (15). SEED is provided for students with severe physical or mental disabilities, including autism and ADHD, that require education adjustments such as specialist classes or small class sizes (16). Specialists in the SEED network of providers conduct external assessments of students that apply for SEED funding to determine whether they have a special educational need. Chile's schooling system comprises 44% state-funded schools, 51% state-subsidised private schools and 5% non-subsidised private schools (14). Students in non-subsidised school are not eligible for SEED (15). Approximately 5% of Chilean students are registered as having special needs and there is evidence that they have not been completely successfully integrated into public schools as they experience higher rates of bullying and violence, and teachers report not feeling equipped to meet their needs (14). This may prompt some students with less severe needs to choose not to access support as it would single them out as different from their peers. The Programas de Integración Escolar (School Integration Programme, PIE) was established in 2013 to improve integration of students with special needs into public schooling (17).

## 2.2 Autism

Autism, or Autism Spectrum Disorder (ASD) describes a range of developmental conditions that cause significant challenges to functioning and include persistent social difficulties and restrictive or repetitive behaviours (18). The ICD-10 codes F84.0 and F84.1 describe autism and the code F84.2, F84.3, F84.4, F84.5, F84.8 and F84.9 describe other pervasive developmental disorders closely related to autism (19). Autism is diagnosed through specialist or caregiver assessment of behaviour, cognitive function and developmental milestone attainment and generally uses standardised screening tools (20). The Autism Diagnostic Interview-Revised (ADI-R) and the Autism Diagnostic Observation Schedule (ADOS), the gold standard autism diagnostic tools, have been translated into Spanish, and the Modified Checklist for Autism in Toddlers (M-CHAT), Autism Screening Questionnaire (ASQ/SCQ), Autism Behaviour Checklist (ABC), Social Responsiveness Scale (SRS), Autism Detection in Early Childhood (ADEC), the Childhood Autism Rating Scale (CARS), the Structured Observation for Autism Screening (OERA), and the Autism Mental Status Examination (AMSE) have been validated in Chile (21). Roman-Urrestarazu showed that a 10 question version of the Quantitative Checklist for Autism in Toddlers (Q-CHAT-25) is valid for use in routine health checks in primary health clinics in Chile (22).

The worldwide population prevalence of autism is estimated to be 1-2% (20), and if this prevalence holds true for Chile it represents a burden of disease of approximately 200,000 – 400,000 people. Given autism is typically diagnosed in early childhood (23), much of this burden falls on schools. Very little research has been conducted on the prevalence of autism in Chile. Yáñez et al found autism prevalence of 1.95% (95% CI 0.81-4.63%) in their small study of 272 children in Estación Central commune of Servicio de Salud Metropolitano Central and Santiago commune of Servicio de Salud Metropolitano Occidente, both in Santiago (24). They used consecutive sampling of children attending optional checkups at clinics that primarily treat low to middle income families which is not fully representative of Chile's broader population, therefore their prevalence estimate is likely to contain selection bias. Their figure may be an underestimate as participants were aged 18-30 months which is well below the UK's median diagnosis age of 55 months (23) and the CDC's recommended peak prevalence assessment age of 8 (25). Thus Yáñez et al. may have missed children with less severe autism symptoms and hence underestimated prevalence.

Some data on autism prevalence is available for other Latin American countries. The estimated prevalence

of autism was 0.17% (95% CI 0.015 - 0.019%) among 254,905 children aged 3-9 in Venezuela in 2008 (26). Prevalence of autism in Buenos Aires between 2010 and 2017 was estimated as 1.03% from 22,750 clinical records (27). In Ecuador in 2015, prevalence of autism diagnosis among 51,000 students aged 5-15 was 0.11% and prevalence of suspected autism was 0.21%, with these low estimates thought to be due to children with disabilities having low school attendance rates (28). The older prevalence calculations are likely to be underestimates as the prevalence of known autism diagnoses has been increasing for the last 20 years, though this is thought to be due to more appropriate diagnostic approaches and the true prevalence has remained similar (29). To the best of our knowledge, this investigation is the largest study of autism prevalence in Chile and Latin America to date. It is important to find the prevalence of autism in Chile and quantify the population that does not have full school support to ensure people can access the interventions they need to live healthy and fulfilling lives.

It is also valuable to understand the distribution of autism cases in Chile and the characteristics of people that do have diagnoses to identify population groups that are under-diagnosed or under supported. The autism prevalence is known to differ by age, sex, socio-economic status, ethnicity and geography (20,30). Individuals with more severe symptoms are more likely to be diagnosed earlier (23) and autism prevalence increases as children age, reflecting the condition's long diagnostic window (30).

Loomes, Hull and Mandy's meta-analysis of male-to-female odds ratios of having autism showed three males are diagnosed for every female in childhood and adolescence (31). This difference is thought to be due to a combination of sex-linked causes, differences in symptom presentation, and bias of diagnostic tools toward traits that are more commonly observed in males and may be masked in females (20,31). Giarelli et al. found that females are more likely than males to meet autism diagnostic criteria but not have a documented diagnosis and that there is no significant difference in mean diagnosis age between female and male children that already had a documented autism diagnosis (32).

Research on the relationship between autism prevalence and socio-economic status is conflicting. Two US studies found high socio-economic status was associated with up to 2.2 times higher prevalence, thought to be due to easier access to diagnostics (33,34), while a French study found the highest prevalence was in the most deprived areas (35) and Roman-Urrestarazu et al's study of UK school students found higher prevalence among those who had ever been eligible for free school meals, an indicator of low SES (30).

Roman-Urrestarazu et al. also found differences in autism prevalence across ethnicities in UK school students; after adjusting for sex, age band and location and in comparison to students from White backgrounds, students from Roma/Irish Traveller, Asian and Other backgrounds were significantly less likely to have autism, and students from Chinese, Black and un-classified backgrounds were more likely to have autism (30). These differences likely reflect a combination of true prevalence differences, differing access to diagnosis and cultural factors that impact awareness of autism (30). Bailey and Arcaíuli's literature review found no significant difference in the actual prevalence of autism between Australian Indigenous and non-Indigenous people but did find Indigenous Australians were less likely to have a diagnosis of autism, and suggest lack of access to diagnosis services, mis-diagnosis and different cultural understandings of disability as probable causes (36).

A systematic review by Zeidan et al. found no difference in autism prevalence between rural and urban areas when using pooled estimates but note that one component study in India found higher prevalence in rural populations and another in Taiwan found higher prevalence in urban populations (37).

## 2.3 ADHD

ADHD is a neurodevelopmental condition and is characterised by severe inattention and hyperactivity (38). It is described by the ICD-10 codes F90.0, F90.1, F90.8 and F90.9 (19). Like autism, ADHD is typically diagnosed in childhood, using similar diagnostic tools (38). Fioravante, Lozano-Lozano Martella noted in their 2022 article that Chile does not have a standardised, objective ADHD diagnosis process and recommend combining diagnostic instruments such as the Conners Comprehensive Behaviour Scale, Conners Parent Scale, the Strengths and Difficulties Questionnaire (SDQ-Cas) and the Diagnostic and Statistical Manual Version 5 (DVM-V) diagnostic criteria (39). ADHD and autism often occur together and Salazar et al. estimate that 59.1% of people with autism have a co-diagnosis of ADHD (40).

The prevalence of ADHD in Chile was estimated to be 10.0% by de la Barra et al. using data on 1,570 school students in Cautín (La Araucanía region), Santiago, Iquique (Tarapacá region) and Concepción (Bío-Bío region) between 2007 and 2009 (41). They found no significant differences by sex or age and found prevalence was higher in children aged 4-11 than in adolescents (41). They also note that their findings differed from the established literature that shows higher prevalence in males than females and among people with low socio-economic status (41). Assuming applicability across all ages and regions, de la Barra et al.'s estimate represents a burden of disease of nearly 2 million people in Chile. In an earlier publication on what is presumably a subset of the same data, Vicente et al. reported ADHD prevalence of 12.6% in 792 students in Santiago (42).

ADHD prevalence varies by other socio-demographic features. It is now considered to be more common in people with low socio-economic status but is less well diagnosed in this group (43). The prevalence of ADHD among Indigenous people is typically found to be lower than in non-Indigenous people; Borges e Azevêdo et al. found it to be 4.3% among Karajá children in Brazil (44). A study in Vietnam found ADHD prevalence of 7.7% overall, comprising 14.9% in urban areas and just 6.7% in rural areas (45). Finding up-to-date estimates of ADHD prevalence stratified by socio-demographic factors is important to understand differences in access to school supports and thus address inequities.

## 2.4 Prevalence analysis techniques

Analysing the population prevalence of a condition can be considered either a population-level task in which the population is assumed to have a particular distribution and inference is made on its mean, or an individual-level task in which the condition is observed in individuals and this informs calculation of the population prevalence, as proposed by Ince et al. (46). They illustrate a hierarchical binomial model of population prevalence, from which frequentist or Bayesian estimates can be made and their Bayesian estimate of population prevalence uses a conjugate beta prior to find the exact formula for the posterior predictive distribution (46). Downing et al. demonstrate a powerful application of Bayesian prevalence analysis to incomplete, multi-source data in their opioid-dependence study (47). Their study combined opioid treatment data with opioid-related mortality, hospitalisation and arrest datasets and fitted a multi-source Bayesian regression model to extrapolate the prevalence observed in the treatment data to the broader population (47). Bayesian methods are particularly useful when prior information about the condition's prevalence exists, when data is incomplete or has patchy coverage, when some indication of the likelihood of output values is needed, when sample sizes are small, or when frequentist approaches are insufficient to model the complexity of the system under study (48).

## 2.5 Machine learning

Machine learning provides an increasingly valuable suite of tools in population health research and clustering techniques are well suited to understanding the complexity inherent in epidemiological datasets (49). Multiple correspondence analysis (MCA) is a descriptive, unsupervised machine learning technique that is well suited to categorical data (50). It uses Euclidean distances to cluster data points based on similarity of categorical feature values, without making assumptions about features' distributions (50). MCA is most useful in exploratory analysis of large datasets to find feature categories that group together and associations are often assessed visually (49,50). Costa et al. used MCA to explore the relationship between healthy aging and categorical variables describing 1,051 patients' cognition, health, lifestyle and demographic features (50).

## 2.6 Probabilistic record linkage

Probabilistic record linkage is a technique for joining two datasets that do not share a common feature that uniquely identifies individuals in each dataset (51). It was proposed by Fellegi and Sunter in 1969 (52) and refined by many since then, such as Enamorado, Fifield and Imai who parallelised the algorithm to improve efficiency, added category frequency information to calculations of pair weights and accounted for uncertainty in the merging processes (51).

Probabilistic record linkage generates all possible record pairs across both datasets, compares the similarities

of each pair's values for each common feature and calculates their weight, typically using an expectation maximisation (EM) algorithm that includes consideration of the relative contributions of each feature and their categories' relative frequencies (52–54). Pairs are then allocated as a link, a non-link or a possible link based on user-defined thresholds for the pair weights (52). The similarity comparison is also user defined with Jaro-Winkler distance being common for character features such as names and exact matches being common for numeric features (51,53). R's RecordLinkage package uses Contiero et al.'s EM algorithm, EpiLink, to calculate pair weights (53,55). Blocking can be used to improve efficiency by requiring a perfect match on some pre-specified features and therefore reducing the total number of pairs to be considered (53).

Enamorado, Fifield and Imai recommend using probabilistic rather than deterministic models to merge large datasets because probabilistic models allow the certainty of matches to be quantified and deterministic models do not, meaning the latter are prone to bias due to measurement error (51). They also recommend blocking the data before running the matching algorithm to reduce the number of false matches identified, especially when the overlap between datasets is low (51).

A simulation study by Hejblum et al. validated the use of probabilistic linkage for matching anonymised clinical records using data on patients' diagnoses (56). They found the Fellegi-Sunter method underperformed compared to their proposed Bayesian method because it is not well suited to one-to-one matching and does not distinguish between the feature values of matches – it weights 0-0 matches the same as 1-1 matches - which in a clinical data context where missingness is common would cause overweighting of low information matches (56).

### 3 Aims

This project aims to better understand the prevalence of autism and ADHD in children in Chile. To that end, its objectives are to:

1. Find a lower bound on Chile's prevalence of autism and ADHD and assess variation across sex, health service, SES, ethnicity and rurality from school data using a frequentist method.
2. Identify common characteristics of Chilean children with autism from clinical data using machine learning clustering.
3. Link Chilean school data and clinical data to obtain accurate autism prevalence and unmet need estimates in one health service, and project estimates across all health services using Bayesian prevalence prediction.

### 4 Methods

#### 4.1 Deviation from research protocol

This investigation differed substantially from the research protocol provided at Appendix B. The protocol intended to investigate autism prevalence in the Cambridgeshire region using clinical data from the Cambridgeshire and Peterborough NHS Foundation Trust and school data from the UK Department for Education's National Pupil Database. Unfortunately this clinical data was found to be of insufficient size and quality to conduct the proposed investigation and while this school data was of high quality, it had previously been well analysed by Roman-Urrestarazu (30,57). Therefore school and clinical data from Chile were used instead as they were of high quality and autism and ADHD prevalence is under-researched in Latin America. The available data from Chile did not have fields on age at autism diagnosis and it was therefore not possible to progress the research protocol's first aim of using machine learning to analyse autism diagnosis age. Instead, machine learning has been used to analyse characteristics of patients with autism. The protocol's second aim of linking school autism diagnoses with clinical diagnoses was adapted and appears here as supplementation of the Chilean school data diagnoses with clinical diagnoses. Additional aims and analysis that were appropriate to the Chile data were developed and are detailed in Section 3 above and the rest of this section.

## **4.2 Data management**

The statistical software package R was used to clean, link, analyse and visualise data. R analysis scripts and version control were managed in GitHub and are available at <https://github.com/delatee/Autism-diagnosis-age-ML>. Raw data was not uploaded to GitHub. All data was stored on local devices and will be deleted at conclusion of the project.

## **4.3 Data collection**

See Figure 4 for an illustration of the data sources and how they were combined through the analysis detailed below.

### **4.3.1 School data**

This research used data from the Chilean Government's Ministerio de Educación that was provided under a freedom of information request and Chile's Law 21545 (58). This dataset contained anonymised records of 3.6 million students in all Chilean schools in 2021. It was collected and curated by the Chilean Unidad de Estadísticas (Statistics Unit), Centro de Estudios (Study Centre) and Ministerio de Educación and is housed in the Sistema de Información General de Estudiantes (General Student Information System, SIGE). It included data on school type and location, student characteristics, academic performance, special needs and monthly school fee contributions. This dataset will be referred to as the school data.

The school data showed whether students access SEED funding, and if they did it provided the disability under which they qualified for funding. The school data included four groups of students who had autism but were recorded in this dataset as not having autism: students with autism who attended private schools which are not eligible for SEED; students with autism who chose not to apply for SEED; students with autism who applied for SEED but were found to not be sufficiently severely affected to receive SEED; and students with autism who received SEED but for a different disability as only one can be recorded, perhaps one that more severely affects them. The number of students in each of these groups was unknown and these groups were analogous for students with ADHD. Thus all estimates of autism and ADHD prevalence from this dataset alone were likely to be underestimates of the true population prevalence.

### **4.3.2 Clinical data**

This research also used data from Chile's Servicio de Salud Araucanía Sur (South Araucanía health service, SSAS), obtained under a freedom of information request. These data were collated from secondary care clinical records, particularly from mental health community care services. They comprised clinical records for public sector specialist health visits of patients aged 6-18 with a primary diagnosis of autism between February 2014 and December 2021 for all communes in the SSAS catchment. Figure 3 shows the communes in the SSAS and Servicio de Salud Araucanía Norte (North Araucanía health service, SSAN) catchments. The clinical records included wage deducted health insurance contributions from Chile's Fondo Nacional de Salud (National Health Fund, FONASA), from which a colleague previously inferred socio-economic status of patients' families. The majority of records were for patients resident in the SSAS catchment area and they did not include any records for privately provided healthcare. These data will be referred to as the clinical data.

For a subset of the clinical data, those for appointments provided by Villarrica Hospital in the Villarrica commune of Chile's La Araucanía region, patients' autism diagnoses were manually validated prior to this investigation. Validation involved a neurologist and a psychiatrist in the SEED network of providers checking the clinical records against central health records to confirm individuals did have autism, adding secondary and tertiary diagnoses where relevant, and adding demographic information including ethnicity, rurality of residence, existence of another disability and experience of foster care status where available. Most patients in this subset were resident in Loncoche, Pucón and Villarrica communes in the SSAS catchment area. These data will be referred to as the validated clinical data, see Figure 4 and the rest of the clinical data that was not validated will be referred to as the remaining clinical data.

## La Araucanía communes by health service



Figure 3: Communes in the La Araucanía region, with Servicio de Salud Araucanía Sur (SSAS) communes in green and Servicio de Salud Araucanía Norte (SSAN) communes in blue (60).

### **4.3.3 Additional data**

Chile's 2017 census data, held by the Instituto Nacional de Estadísticas (National Statistics Institute, INE), was used to create a standard population of Chile's age and sex distribution from projections for 2021 of population size by age and sex (59). It was also used to obtain projections of the population of youth aged 0-14 in 2021 by region and the percentages of the population living in rural areas in 2017 by region (13).

Data from the INE's Encuesta Suplementaria de Ingresos (Supplementary Income Survey, ESI) of 2021 (10) was used to obtain the nominal median income by region in 2021.

For mapping, shapefiles of administrative areas were obtained from The Humanitarian Data Exchange of the United Nations Office for the Coordination of Humanitarian Affairs (60). Additional region and commune naming information was taken from the R package 'chilemaps'.

## **4.4 Aim 1: Use school data and frequentist method to find a lower bound on autism and ADHD prevalence, and assess socio-demographic variation**

Using the school data, the crude prevalence of autism and ADHD were found. Frequentists methods were used to find the age- and sex-adjusted autism and ADHD prevalence among Chilean school students. Variation in prevalence across age, sex, commune, SES, ethnicity and rurality was assessed by comparing confidence intervals.

### **4.4.1 School data preparation**

The school dataset was restricted to students aged 6-18 as of 30th June 2021 to capture children of school age in Chile. No restriction on sex was necessary as it contained only females and males. Students' commune of residence was mapped to their respective health service catchment areas. Two issues due to boundary changes were corrected. Firstly, the commune now called Tocopilla which falls across the Antofagasta and Tarapacá regions was formerly two communes, Tocopilla in Antofagasta and Pozo Almonte in Tarapacá. The old names have been retained to ensure appropriate region mapping and they were mapped to Antofagasta and Iquique health services respectively. Secondly, the communes recorded as belonging to the former Ñuble sub-region of the Bío-Bío region were mapped to their corresponding communes in the recently formed Ñuble region.

Commune of residence was missing for 4078 students (0.13%). The commune of their school was imputed as most students were likely to go to school near their place of residence.

Students' age as of 30th June 2021 was mapped to age-bands of 6-8, 9-11, 12-14 and 15-18, preserving the divide between primary and secondary school as secondary school starts at age 12 in Chile, and with a larger final band as fewer students were expected to be diagnosed older and the 18 years old group may be small due to students leaving schooling. Students' ethnicity was mapped to being a member of the Mapuche Indigenous group, being a member of another Chilean Indigenous group, or not being a member of an Indigenous group based on their recorded ethnicity which can take at most one value. The 6859 students (0.22%) with ethnicity recorded as 'no registry' were mapped to not being a member of an Indigenous group.

Students' school fee status was mapped to a proxy socio-economic status feature. Students with free schooling were given SES of 1 indicating low status as families with low SES are entitled to schooling rebates. Students paying Chilean Peso \$1,000-\$100,000 monthly were given SES of 2, indicating medium status, and students paying more than \$100,000 monthly were given 3 to indicate high status. For school fee status, 49973 students (1.64%) were coded as 'No information' and 29 students (0.00095%) were missing school fee values and these were re-categorised as 'No information' to reflect their unknown school fee status. No other features of interest for this analysis had missingness.

### **4.4.2 Crude prevalence**

The crude prevalence of autism and of ADHD were calculated as the count of cases divided by the relevant population size. Grouping features of sex, health service of residential commune, monthly school fee as a

proxy for SES, ethnicity and school's rurality were used, and calculations were made by sex and age band as calculating by single year ages resulted in too many counts of less than 20.

#### **4.4.3 Frequentist age and sex adjustment**

Nationally and for each grouping feature, prevalence was standardised by age and sex using direct standardisation following the method presented by Fay and Feuer (61). The 2017 Chile census projections of the distribution of people by age and sex in 2021 was used as the standard population. Gamma confidence limits were calculated at the 95% level using chi-squared distributions. The adjusted prevalence rates were multiplied by their respective population sizes to give adjusted prevalence counts which were rounded to integers, therefore losing a small amount of precision.

Ethnicity analysis compared individuals from the Mapuche Indigenous group to those from other Indigenous groups or with no Indigenous group and used data from the La Araucanía, Aysén, Biobío, Los Lagos, Los Ríos, Magallanes and Región Metropolitana de Santiago regions only as these regions were collectively the five regions with the largest Mapuche populations and the five regions with the highest proportion of Mapuche people in their population.

### **4.5 Aim 2: Use clinical data and machine learning to identify autism diagnosis characteristics**

The machine learning technique of multiple correspondence analysis for categorical data was used to explore the feature categories in the validated clinical data that explain its variance. The features examined were sex, age band, ethnicity, commune of residence, rurality of residence, health insurance contribution level, other disability status and foster care status.

#### **4.5.1 Clinical data preparation**

The full clinical dataset was cleaned to ensure internal consistency in feature values and translated into English where appropriate. Patients were categorised as having autism if any of their diagnosis codes were in ICD F84-F89 for any appointment. No restriction on sex was necessary as these data contained only females and males. The clinical data included economic data in the form of patients' family's health insurance contribution level. Values taken were 'FONASA-A', 'FONASA-B', 'FONSAS-C' and 'FONASA-D' which are respectively larger contributions to this public health fund and were assumed to map to increasing socio-economic status, and 'Private health insurance' which indicates contributions to a private health insurance provider rather than the public fund and was therefore assumed to map to the highest socio-economic level.

For multiple correspondence analysis, only the validated clinical dataset was used as it contained additional demographic fields not present in the remaining clinical data. In the validated clinical data, patients' age as of 30th June 2021 was mapped to age-bands of 0-2, 3-5, 6-8, 9-11, 12-14 and 15-18. Students below school age were retained for MCA to more fully explore the variation in the autism patient data. The validated clinical dataset had many values for ethnicity, other disability status and foster care status that were recorded as 'no information'. For other disability status and foster care status, additional features were created with the 'no information' values imputed as 'no disability' and 'no foster care' respectively, as it is likely that patients who did have another disability or had experienced foster care would have this recorded.

The validated clinical data was aggregated to patient level. First, only appointments for patients resident in a commune in the SSAS catchment area were included. Then appointments were aggregated to patient level by selecting each patient's most recent commune of residence and rurality status, and most common health insurance contribution level, hospital and medical specialty of appointment. For ethnicity, Mapuche was selected if present in any of that patient's appointment records, then Chilean if present, then Foreign if present and else 'No information' was selected. Similarly, other disability and foster care status were selected as 'Yes' if recorded for any appointment, then 'No' was selected if present, then 'No information' if no status was recorded for any appointment.

#### **4.5.2 Multiple correspondence analysis**

The machine learning technique of multiple correspondence analysis (MCA) was conducted using R's FactoMineR package with the number of output dimensions equal to the number of input features. MCA was an appropriate technique to use here because the small clinical dataset contains primarily categorical features which MCA is designed to handle.

Data-led analysis was used to identify features in the small clinical dataset that explained the variance in this patient-level data. Initially, all available features with suspected association with autism were included in MCA, specifically: sex, age band, commune of residence, health insurance contribution level as a proxy for SES, ethnicity, rurality of residence, other disability status and foster care status. Hospital and medical specialty of appointment were not included as they were not thought likely to be associated with autism diagnosis. The data grouped well into having information about other disabilities and about foster care and not having information about each, therefore the MCA was rerun with the disability and foster care features exchanged for their respective imputed versions. This identified age, commune and ethnicity as important for explaining the variance, so the MCA was rerun using only these three features.

#### **4.5.3 Alternative machine learning approaches**

Other machine learning techniques including component factor analysis (CFA) and principle component analysis (PCA) were also considered to cluster patients with autism. Both are powerful methods for uncovering the latent structure of data, however CFA typically requires ordered categorical variables and PCA requires continuous variables. As the commune feature, an unordered categorical variable, was thought to be important to explain variation between patients with autism and therefore needed to be included in analysis, using CFA or PCA would require one-hot-encoding of commune which would reduce the appropriateness of these tests.

### **4.6 Aim 3a: Use machine learning to link school and clinical records**

The school data and clinical data were linked using manual and probabilistic record linkage.

#### **4.6.1 School data preparation**

For data linkage, the school data was restricted to students with autism that were living in communes in the SSAS catchment in 2021 to maximise comparability with the clinical data. A false empty record was added to the school dataset before linkage that allowed the algorithm to correctly match on SES. This false record was only used during linkage, did not match to any patient records and was removed before comparing matched and unmatched records. This will be referred to as the SSAS school data, see Figure 4.

#### **4.6.2 Clinical data preparation**

For data linkage, the full clinical dataset was used. It was restricted to appointments for individuals resident in communes in the SSAS catchment as the data is believed to be complete for this catchment area only. It was also restricted to patients aged 6-18 as of 30th June 2021 to maximise compatibility to the school data. Appointment year was not restricted in order to retain more data and thus maximise linkage opportunities, and only patients of female and male sex were present. Patients with familial socio-economic level of FONASA-A were interpreted to have low SES and given proxy status of 1 (equivalent to students with free school fees); patients with FONASA-B, FONASA-C and FONASA-D were interpreted to have moderate SES and given 2 (equivalent to students paying \$1,000-\$100,000 monthly for state schooling); and patients with private health insurance were interpreted to have high SES and given 3 (equivalent to students paying more than \$100,000 monthly).

The clinical dataset had no missingness in the features of interest for data linkage.

The clinical data was aggregated to one row per patient per commune in the SSAS catchment, to maximise the opportunity for matching patients that had moved within this health service. Most patients lived in only one commune in SSAS during the study period. Aggregation used the most common SES value for each patient. The resulting dataset will be referred to as the patient data, see Figure 4.

#### **4.6.3 Selection of features for matching**

The features available for matching that occurred in both the SSAS school data and the patient data were sex, date of birth, commune of residence, and the proxies for socio-economic status – monthly school fees in the SSAS school data and mode health insurance contributions in the patient data.

#### **4.6.4 Manual record linkage**

The SSAS school and patient data were blocked on sex and date of birth to improve match quality and reduce runtime. As both datasets were from trusted, large-scale data collections, it was reasonable to assume sex and dates of birth were highly accurate in both datasets, and it would not have been reasonable to accept any proposed matches that did not agree on either sex or date of birth.

Two versions of manual record linkage were tried. First, the SSAS school and patient data were merged with perfect matches required on sex, date of birth, commune of residence and proxies for SES. Second, the SSAS school and patient data were merged with perfect matches required only on sex, date of birth and commune of residence, as the proxies for SES were known to be approximate and therefore requiring perfect matches on SES was not reasonable.

#### **4.6.5 Probabilistic record linkage**

The machine learning technique of probabilistic matching was used to link the SSAS school and patient data. All possible pairs of blocked matches across these two datasets were generated and agreement weights were calculated for each feature using expectation maximisation, then aggregated into a weight for the pair. Records with missing values were retained as this linkage method is robust to missingness. The similarity comparison method was exact matching for commune of residence, diagnosis with autism and socio-economic status; there was no value in using a string comparison method for commune of residence as all commune names were already standardised and two communes having similarly spelled names did not increase the likelihood of a match between those communes. Linkage was implemented using R's RecordLinkage package. This included consideration of the average frequencies of categories in each feature and estimated errors rates were supplied: the default estimated error rate of 0.01 was supplied for the commune of residence and diagnosis with autism features as they were expected to be fairly accurate features, and an estimated error rate of 0.1 was supplied for the socio-economic status feature to reflect that it was a loosely defined proxy.

No specific weight value was set as a cut-off to define matches. Instead, pairs were selected based on high weight to create a 1-1, bipartite, matching between SSAS school records and patients. These matches were examined to ensure each patient that lived in multiple communes had matched to only one SSAS school record.

#### **4.6.6 Alternative record linkage methods**

Record linkage using Bayesian methods in which matched status is modelled, as developed by Sadinle (62) and refined by Stringham (63), was considered for record linkage here. This technique is typically more complex and has longer runtimes than probabilistic matching but can more easily enforce one-to-one matching and is particularly well suited to matching names. As the datasets in this investigation did not include names, there was limited benefit from using Bayesian linkage methods.

Record linkage using machine learning to classify matched and unmatched pairs, as explored by Pita et al, was also considered as it is generally thought to be more accurate than probabilistic matching alone (64). However this was not pursued because the datasets under investigation had very few common features to match on, meaning machine learning algorithms would have few options to trial, and there were no known true matches with which to assess the accuracy of machine learning models.

#### **4.6.7 Comparison of matched and unmatched records**

For the SSAS school and patient datasets, each record was classified as either matched or unmatched based on whether it appeared in the bipartite matching. The discrete Kolmogorov-Smirnov test was used to compare

matched and unmatched records within each dataset for each of the features used for matching, excluding date of birth which had too many categories to have meaningful results. Missing values in the socio-economic status feature were omitted before testing as the Kolmogorov-Smirnov test is not robust to missingness.

Permutation tests were then performed for each of the features tested in each dataset by permuting the matched status 2000 times and recomputing the discrete Kolmogorov-Smirnov test for each permutation. The p-values for the Kolmogorov-Smirnov tests on the observed data were then compared to the distributions of p-values for the permuted data to determine the significance of the observed results.

## **4.7 Aim 3b: Accurately estimate autism prevalence and unmet need, project estimates across health services using Bayesian prevalence prediction**

An updated estimate of autism prevalence in SSAS was made and projected across health services. Unmet need was calculated and projected nationally. Bayesian random effect models were used to predict autism prevalence across health services for several priors.

### **4.7.1 Updated autism prevalence estimation**

The patient data was de-duplicated to a single row per patient with the commune of their matched record chosen if they had multiple communes of residence. The unmatched patients were aggregated to counts per age and sex group. The full school dataset was restricted to students resident in SSAS, then was aggregated to counts per age, sex and autism status group. It was assumed that the patients that did not match to the SSAS school data, which only includes students with SEED for autism, do exist in the larger school data of students resident in SSAS but they did not have a diagnosis of autism in the school data because they did not receive SEED or did not receive it for autism. Thus the count of students with autism for each age and sex group in the restricted school data was increased by the number of unmatched patients in that age and sex group, and the number of students without autism was decreased by the same amount. This effectively reallocated the appropriate number of SSAS students recorded as not having autism to having autism and retained the school data sample sizes. This will be referred to as the linked data, see Figure 4.

The crude and age- and sex-adjusted updated prevalence of autism for SSAS was calculated from the updated counts in the linked data, following the same method as in sections 4.4.2 and 4.4.3. The adjusted prevalence delta was calculated as the difference between the adjusted updated prevalence for SSAS (from the linked data) and the adjusted prevalence for SSAS (from the school data only). It represented the prevalence of clinical autism diagnosis without SEED for autism in SSAS. Unmet need for SSAS was calculated as the adjusted prevalence delta multiplied by the number of students in SSAS.

### **4.7.2 Prevalence projection**

The adjusted updated national prevalence of autism was calculated as the adjusted national prevalence (from the school data only) plus the adjusted prevalence delta (found for SSAS). This assumed the delta was nationally applicable.

Prevalence was projected for each of the health services other than SSAS by adding the adjusted prevalence delta to the adjusted prevalence (from the school data only) for each health service. This projected the prevalence of individuals with a clinical autism diagnosis that did not access SEED across the health services. It assumed that all SSAS patients existed in the school data and were recorded in this dataset as resident in SSAS communes. Estimated confidence intervals were calculated for the projections by finding a band around the projection that was the maximal of either the width of the 95% gamma confidence interval for each health service's adjusted prevalence (from the school data only) or the width of the confidence interval for the adjusted prevalence delta.

### **4.7.3 Bayesian prevalence analysis**

Bayesian prevalence analysis of autism was conducted for the school data by health service. Bayesian methods were appropriate here because they allowed calculation of prevalence with incomplete data. Here two different

types of data, school records and patient appointments, were combined and both were known to be incomplete. Bayesian analysis is robust to this messiness and allowed plausible prevalence predictions to be made. It also provided information about the likelihood of these predictions given the observed school data.

To conduct the Bayesian analysis, a random-effects model was constructed with the random effect on health service as follows.

Set

$$y_i = \text{adjusted count of autism cases in health service } i$$

$$n_i = \text{number of students in health service } i$$

$$\theta_i = \text{prevalence of autism in health service } i$$

For each health service  $i$ , the model formula was

$$y_i | (n_i, \theta_i) \sim \text{Binomial}(n_i, \theta_i)$$

With

$$\theta_i \sim \text{Beta}(a, b)$$

And posterior distribution

$$\theta_i | (y_i, n_i) \sim \text{Beta}(y_i + a, n_i - y_i + b)$$

Fitting a binomial model required integer valued counts of autism cases. As adjusted case counts were used throughout, the adjusted counts had to be rounded to integer values which caused a small amount of precision to be lost. This likely caused the posterior credible intervals to be slightly wider but was not expected to have a large effect on findings.

#### 4.7.4 Prior selection

Four priors for  $\theta_i$  were used when fitting the Bayesian prevalence model. First, a conjugate beta prior common to all health services was constructed with the national age- and sex-adjusted prevalence of autism in the school dataset and its standard deviation used respectively as the mean and standard deviation of the prior. This prior was suitable because the national adjusted prevalence in the school data provided a lower bound on the plausible prevalence of autism in Chile.

Second, a conjugate beta prior specific to each health service using the health service specific age- and sex-adjusted autism prevalence in the school data and their standard deviations as the prior means and their standard deviations respectively. This prior was suitable because it extended the previous prior to each of the random effect categories and it reflected the students known to be receiving SEED for autism. On its own this prior was expected to give uninformative posteriors because it was effectively duplicating the information in the sample data. However it was used here as a health service specific lower bound on the plausible prevalence of autism that can then be compared to the projected prevalence values.

Third, a conjugate beta prior specific to each health service with the health service specific projections of adjusted updated prevalence from data linkage and their standard deviations from their maximal 95% confidence intervals as the prior means and prior standard deviations respectively. This prior was suitable as it captured the extra information provided by the linkage and thus represented all individuals with clinical autism diagnoses, not only those that received SEED for autism. Additionally, this prior had narrow standard deviations which modelled a plausible upper bound on the prevalence of autism in each health service.

Fourth, a uniform prior specific to each health service with the adjusted autism prevalence from the school data for each health service as its lower bounds and the adjusted projected prevalence from data linkage for each health service as its upper bounds. This prior was suitable because it captured the information from both the school and clinical datasets, without specifying where within these bounds the true prevalence values were likely to be.

#### 4.7.5 Markov chain Monte Carlo sampling

Bayesian prevalence modelling used the JAGS (Just Another Gibbs Sampler) R package which uses Markov chain Monte Carlo (MCMC) sampling to produce posterior density distributions when given the above priors and adjusted prevalence observations. A burn-in period of 2000 samples was used to ensure models converged, then 2000 iterations were used to model the posterior densities. Visual inspection of trace plots showed no evidence of a lack of convergence,  $\hat{r}$  values were less than 1.1, effective sample sizes were reasonably large and median estimates had at least two significant figures unaffected by Monte Carlo standard error.

## 5 Results

Figure 4 shows the school and clinical data and how they contribute to the three aims of this investigation. The school data is used to address aim 1, finding a lower bound on autism and ADHD prevalence and understanding their variation, see sections 5.1 and 5.2. The validated clinical data for patients resident in SSAS is used to address aim 2, identifying common characteristics of children with autism, see sections 5.3 and 5.4. Linkage of school and clinical data is used to address aim 3, obtaining and projecting accurate autism prevalence estimates, see sections 5.5, 5.6 and 5.7.

### 5.1 School data

Table 2: Count and percentage of features' values in the school dataset. Metro. is short for Metropolitano and these health services are all in Santiago.

Feature	Available values	Count (%)
Sex	Female	1,487,224 (48.66%)
	Male	1,569,082 (51.34%)
Age band	6-8	748,406 (24.49%)
	9-11	767,350 (25.11%)
	12-14	749,693 (24.53%)
	15-18	790,857 (25.88%)
Health service	Aconcagua	46,840 (1.53%)
	Aisén	19,890 (0.65%)
	Antofagasta	119,378 (3.91%)
	Araucanía Norte	36,651 (1.20%)
	Araucanía Sur	132,242 (4.33%)
	Arauco	31,318 (1.02%)
	Arica	44,609 (1.46%)
	Atacama	58,743 (1.92%)
	Biobío	71,411 (2.34%)
	Chiloé	30,908 (1.01%)
	Concepción	109,502 (3.58%)
	Coquimbo	141,152 (4.62%)
	Iquique	69,935 (2.29%)
	Magallanes	28,031 (0.92%)
	Maule	182,352 (5.97%)
	Metro. Central	122,576 (4.01%)
	Metro. Norte	180,230 (5.90%)
	Metro. Occidente	277,282 (9.07%)
	Metro. Oriente	182,798 (5.98%)
	Metro. Sur	200,984 (6.58%)
	Metro. Sur Oriente	236,817 (7.75%)

Table 2: Count and percentage of features' values in the school dataset. Metro. is short for Metropolitano and these health services are all in Santiago. (*continued*)

Feature	Available values	Count (%)
O'Higgins		161,335 (5.28%)
Osorno		40,266 (1.32%)
Reloncaví		79,767 (2.61%)
Talcahuano		54,678 (1.79%)
Valdivia		66,206 (2.17%)
Valparaíso		78,598 (2.57%)
Viña del Mar		172,456 (5.64%)
Ñuble		79,351 (2.60%)
School fee	Free \$1,000-\$10,000 \$10,001-\$25,000 \$25,001-\$50,000 \$50,001-\$100,000 \$100,001+ No information	2,190,359 (71.67%) 1,120 (0.04%) 36,477 (1.19%) 206,952 (6.77%) 270,875 (8.86%) 300,521 (9.83%) 50,002 (1.64%)
Ethnicity	Mapuche Other Indigenous group No Indigenous group	176,302 (5.77%) 35,779 (1.17%) 2,844,225 (93.06%)
Rurality	Rural Urban	238,948 (7.82%) 2,817,358 (92.18%)
Accesses SEED	Yes SEED No SEED	339,968 (11.12%) 2,716,338 (88.88%)
Autism	Yes autism No autism	14,549 (0.48%) 3,041,757 (99.52%)
ADHD	Yes ADHD No ADHD	46,224 (1.51%) 3,010,082 (98.49%)

The school dataset contained records for 3,056,306 Chilean students aged 6-18 in 2021, see Table 2. Of these, 1,487,224 (48.66%) were female and the rest were male. Students were evenly distributed across age bands and fairly evenly distributed across communes with generally more students in the metropolitan Santiago communes. Most students received free schooling and after this value, the proportion that paid for schooling increased with monthly school fees. 176,302 (5.77%) students were Mapuche and 2,844,225 (93.06%) did not belong to an Indigenous group. 238,948 (7.82%) attended a school in a rural area. A special needs code was recorded for 339,968 (11.12%) students, indicating they accessed SEED funding in 2021. Of these students, 14,549 (4.28%) received SEED for autism and 46,224 (13.6%) received SEED for ADHD.

## 5.2 Frequentist prevalence estimation

The national crude prevalence of autism in the school data was 0.48% (0.47-0.48%). After using frequentist methods to adjust for the age and sex distribution of the 6-18 year-old population of Chile in 2021, the national adjusted prevalence of autism was 0.46% (0.46-0.47%). The national crude prevalence of ADHD was 1.51% (1.50-1.53%) and the national age- and sex-adjusted prevalence was 1.50% (1.48-1.51%). The crude prevalence of autism and ADHD varied with age, as shown in Figures 5 and 6. Autism prevalence was highest in 6-8 year-olds and decreased with age while ADHD prevalence peaked in 9-11 year-olds then decreased. Both conditions showed a small increase in prevalence for age 18. See also Supplementary Tables 17 and 18.

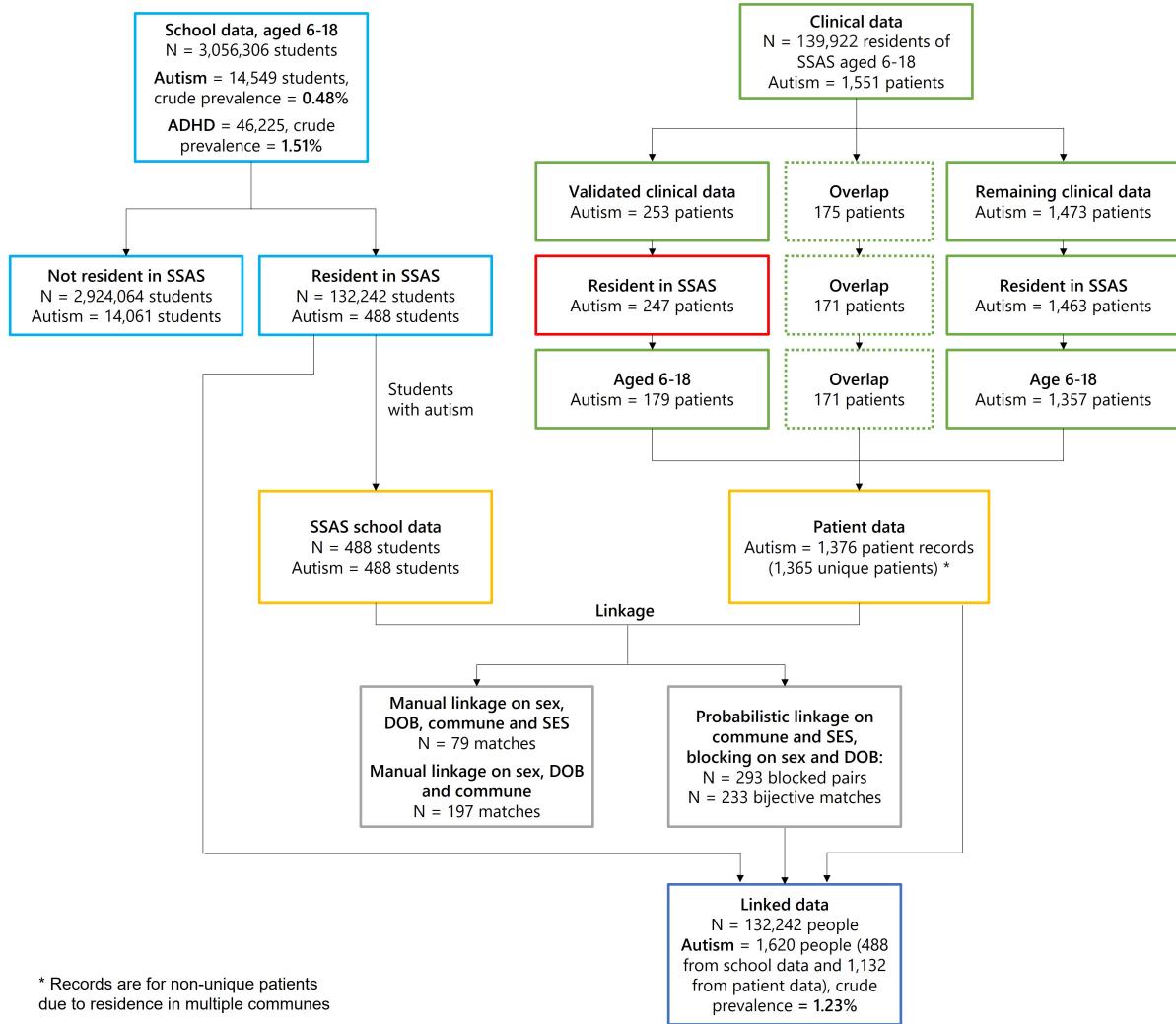


Figure 4: The datasets used in this investigation, their size (N) and the number of people with autism and ADHD and their crude prevalence where applicable. Light blue shows the school data which was used to calculate lower bounds on autism and ADHD prevalence, and subsets of the school data for students resident in Servicio de Salud Araucanía Sur (SSAS) and those that were not. In the school data, autism and ADHD indicate students that accessed SEED for autism and for ADHD respectively. Green shows the clinical data and its subsets of validated and unvalidated clinical data and autism here indicates clinical diagnoses. Validation involved confirming autism diagnosis against central clinical records, adding 2nd and 3rd diagnoses, and adding demographic data. Red shows the validated clinical data for patients resident in SSAS that was used for multiple correspondence analysis. Yellow shows the subsets of school and clinical data used for data linkage; the patient data was the combination of validated and unvalidated clinical datasets and some patients were represented in both these datasets, shown by the dotted overlap boxes. Grey shows the matches resulting from three linkage approaches. Dark blue shows the result of data linkage and was used to calculate updated estimates of autism prevalence.

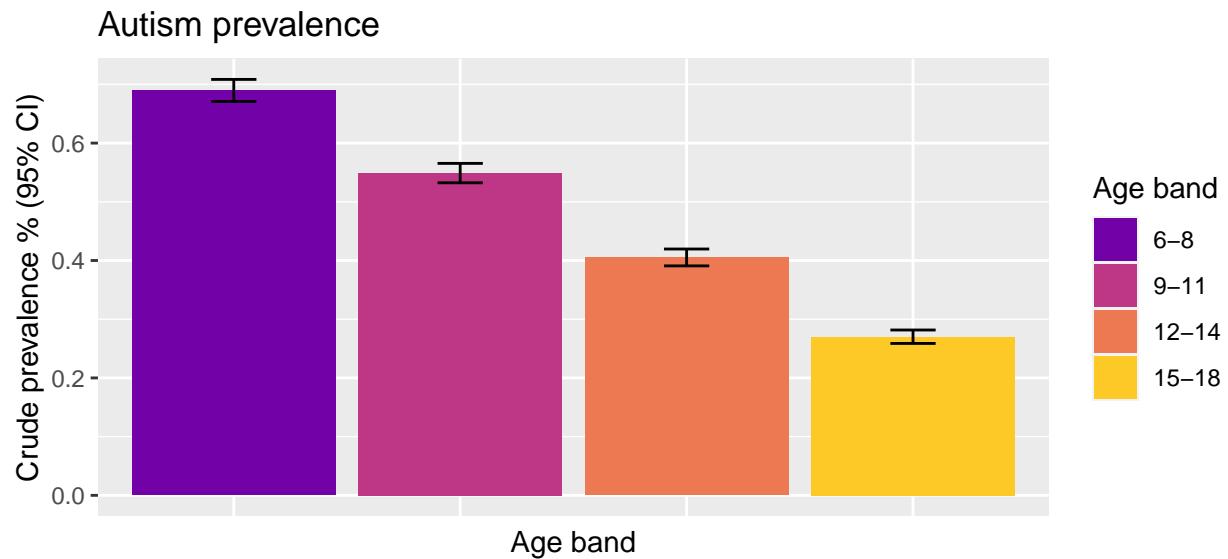


Figure 5: Crude prevalence of autism in school data by age band. Bars show 95% normal confidence intervals.

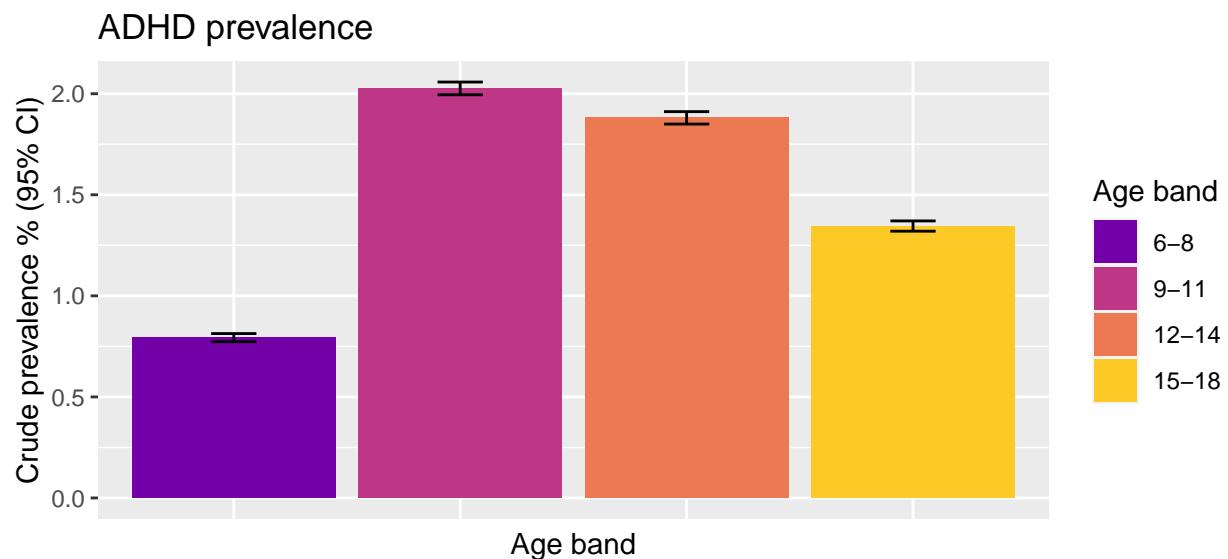


Figure 6: Crude prevalence of ADHD in school data by age band. Bars show 95% normal confidence intervals.

Disgregated by sex, autism prevalence in the school data was 0.13% (0.13-0.14%) for females and 0.80% (0.79-0.82%) for males, with male to female ratio of 6.02:1, see Figure 7 and Supplementary Table 19. Among females, the age- and sex-adjusted autism prevalence was 0.13% (0.13-0.14%) and among males it was 0.79% (0.77-0.80%), thus giving an adjusted male to female ratio of 6.00:1. ADHD prevalence was 1.01% (1.00-1.03%) for females and 1.98% (1.96-2.01%) for males, with male to female ratio of 1.96:1, see Figure 8 and Supplementary Table 20. After adjustment, the prevalence of ADHD was 1.01% (1.00-1.03%) for females and 1.97% (1.94-1.99%) for males with adjusted male to female ratio of 1.94:1.

Given the prevalence of autism and ADHD in these data were likely to be underestimates, the age- and sex-adjusted prevalence values can be considered a lower bound on the true prevalence of autism and of ADHD in Chile.

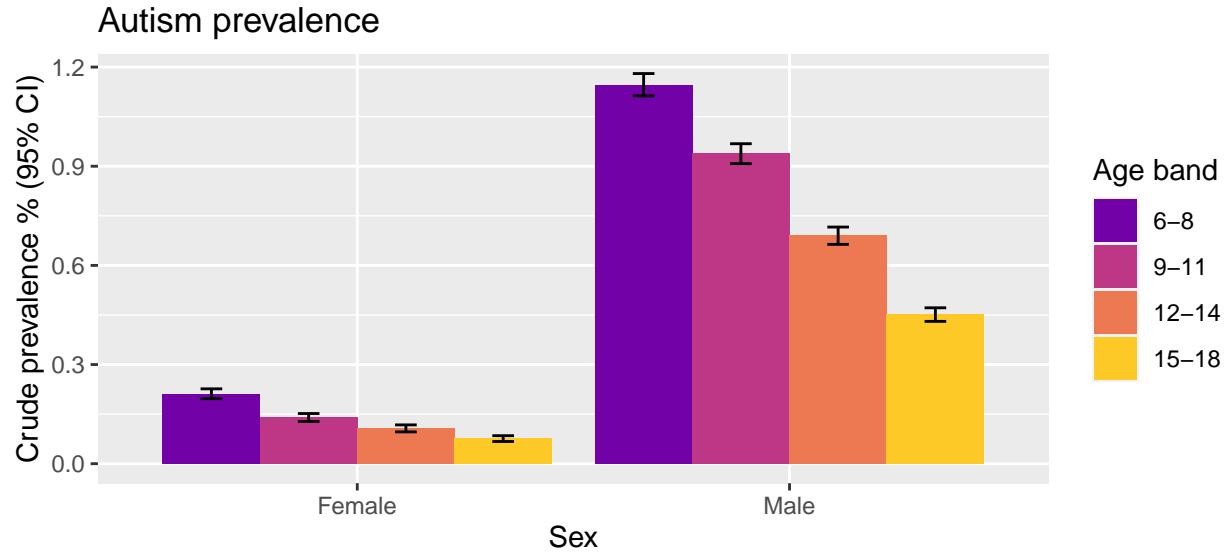


Figure 7: Crude prevalence of autism in school data by age band and sex. Bars show 95% normal confidence intervals.

Table 3: Crude and age- and sex-adjusted autism prevalence by health service in Chile school data. Crude prevalence has 95% normal confidence intervals and adjusted prevalence has 95% gamma confidence intervals.

Health service	Crude prevalence (95% CI)	Adjusted prevalence (95% CI)
Aconcagua	0.44 (0.38, 0.50)	0.43 (0.37, 0.50)
Aisén	0.75 (0.63, 0.87)	0.75 (0.63, 0.90)
Antofagasta	0.84 (0.79, 0.89)	0.83 (0.77, 0.88)
Araucanía Norte	0.30 (0.24, 0.36)	0.30 (0.24, 0.38)
Araucanía Sur	0.37 (0.34, 0.40)	0.37 (0.34, 0.41)
Arauco	0.73 (0.64, 0.83)	0.72 (0.62, 0.82)
Arica	0.61 (0.54, 0.68)	0.61 (0.54, 0.70)
Atacama	0.31 (0.26, 0.35)	0.31 (0.27, 0.37)
Biobío	0.43 (0.38, 0.48)	0.42 (0.37, 0.47)
Chiloé	0.45 (0.38, 0.52)	0.43 (0.36, 0.52)
Concepción	0.78 (0.73, 0.84)	0.77 (0.72, 0.83)
Coquimbo	0.41 (0.38, 0.45)	0.40 (0.36, 0.43)
Iquique	0.45 (0.40, 0.50)	0.43 (0.38, 0.49)
Magallanes	0.83 (0.72, 0.94)	0.83 (0.72, 0.96)

Health service	Crude prevalence (95% CI)	Adjusted prevalence (95% CI)
Maule	0.31 (0.28, 0.33)	0.30 (0.28, 0.33)
Metro. Central	0.42 (0.38, 0.46)	0.42 (0.38, 0.46)
Metro. Norte	0.29 (0.27, 0.32)	0.29 (0.26, 0.31)
Metro. Occidente	0.36 (0.34, 0.38)	0.34 (0.32, 0.36)
Metro. Oriente	0.30 (0.28, 0.33)	0.30 (0.27, 0.33)
Metro. Sur	0.41 (0.39, 0.44)	0.40 (0.37, 0.43)
Metro. Sur Oriente	0.37 (0.34, 0.39)	0.36 (0.34, 0.39)
O'Higgins	0.43 (0.40, 0.47)	0.42 (0.39, 0.46)
Osorno	0.44 (0.38, 0.51)	0.43 (0.37, 0.51)
Reloncaví	0.42 (0.38, 0.47)	0.42 (0.37, 0.47)
Talcahuano	0.84 (0.76, 0.92)	0.81 (0.74, 0.90)
Valdivia	0.31 (0.27, 0.35)	0.30 (0.26, 0.35)
Valparaíso	0.69 (0.63, 0.74)	0.68 (0.62, 0.74)
Viña del Mar	0.67 (0.63, 0.71)	0.66 (0.62, 0.70)
Ñuble	1.32 (1.24, 1.40)	1.29 (1.21, 1.37)

Table 4: Crude and age- and sex-adjusted ADHD prevalence by health service in Chile school data. Crude prevalence has 95% normal confidence intervals and adjusted prevalence has 95% gamma confidence intervals.

Health service	Crude prevalence (95% CI)	Adjusted prevalence (95% CI)
Aconcagua	2.08 (1.95, 2.21)	2.04 (1.91, 2.19)
Aisén	2.23 (2.03, 2.44)	2.17 (1.97, 2.40)
Antofagasta	1.00 (0.94, 1.06)	0.98 (0.93, 1.04)
Araucanía Norte	1.33 (1.22, 1.45)	1.29 (1.18, 1.43)
Araucanía Sur	1.42 (1.36, 1.49)	1.38 (1.32, 1.45)
Arauco	1.64 (1.50, 1.78)	1.64 (1.50, 1.81)
Arica	1.14 (1.04, 1.24)	1.12 (1.02, 1.24)
Atacama	0.49 (0.44, 0.55)	0.49 (0.43, 0.56)
Biobío	2.27 (2.16, 2.38)	2.26 (2.15, 2.38)
Chiloé	2.96 (2.77, 3.15)	2.87 (2.68, 3.07)
Concepción	2.94 (2.84, 3.04)	3.00 (2.89, 3.11)
Coquimbo	1.98 (1.91, 2.05)	2.00 (1.92, 2.08)
Iquique	1.49 (1.40, 1.58)	1.50 (1.40, 1.60)
Magallanes	3.07 (2.87, 3.27)	3.06 (2.85, 3.29)
Maule	1.19 (1.14, 1.24)	1.15 (1.11, 1.21)
Metro. Central	1.53 (1.46, 1.59)	1.49 (1.43, 1.57)
Metro. Norte	1.42 (1.36, 1.47)	1.42 (1.36, 1.48)
Metro. Occidente	1.09 (1.05, 1.13)	1.12 (1.08, 1.17)
Metro. Oriente	1.22 (1.17, 1.27)	1.20 (1.15, 1.26)
Metro. Sur	1.42 (1.37, 1.48)	1.41 (1.35, 1.46)
Metro. Sur Oriente	1.56 (1.51, 1.61)	1.53 (1.48, 1.58)
O'Higgins	1.73 (1.66, 1.79)	1.69 (1.63, 1.76)
Osorno	1.05 (0.95, 1.14)	1.02 (0.92, 1.13)
Reloncaví	1.02 (0.95, 1.09)	0.99 (0.92, 1.07)
Talcahuano	3.07 (2.93, 3.22)	3.02 (2.87, 3.18)
Valdivia	1.08 (1.00, 1.16)	1.06 (0.98, 1.15)
Valparaíso	1.19 (1.12, 1.27)	1.19 (1.11, 1.27)
Viña del Mar	1.17 (1.12, 1.22)	1.15 (1.10, 1.20)

Health service	Crude prevalence (95% CI)	Adjusted prevalence (95% CI)
Ñuble	2.12 (2.02, 2.22)	2.11 (2.00, 2.22)

Considering school data by health service, shown in Table 3, the adjusted prevalence of autism was significantly higher in Ñuble at 1.29% (1.21 - 1.37%) than other health services with non-overlapping confidence intervals. Adjusted prevalence was lowest in Metropolitano Norte at 0.29% (0.26 - 0.31%) and Araucanía Norte at 0.30% (0.24- 0.38%). Autism prevalence peaked in the 6-8 age band across all health services except Chiloé and Magallanes where it peaked in the 9-11 band, see Supplementary Table 21 and Supplementary Figure 41.

ADHD prevalence also varied across health services, as shown in Table 4. Prevalence was significantly lower in Atacama than other regions at 0.49% (0.43 - 0.56%). Magallanes, Talcahuano, Concepción, Chiloé, Biobío, Aisén, Ñuble, Aconcagua and Coquimbo all had adjusted prevalence of 2.00% or higher and there was a significant gap between these health services and those with lower prevalence. There was also a significant gap separating Magallanes, Talcahuano, Concepción and Chiloé as the highest prevalence health services. See also Supplementary Table 22 and Supplementary Figure 42.

Table 5: Crude and age- and sex-adjusted autism prevalence by monthly school fee (Peso) in Chile school data. Crude prevalence has 95% normal confidence intervals and adjusted prevalence has 95% gamma confidence intervals.

School fee	Crude prevalence (95% CI)	Adjusted prevalence (95% CI)
Free	0.57 (0.56, 0.58)	0.55 (0.54, 0.56)
\$1,000-\$10,000	0.71 (0.22, 1.21)	0.69 (0.29, 3.25)
\$10,001-\$25,000	0.20 (0.15, 0.25)	0.20 (0.16, 0.27)
\$25,001-\$50,000	0.30 (0.28, 0.33)	0.32 (0.29, 0.34)
\$50,001-\$100,000	0.39 (0.36, 0.41)	0.40 (0.37, 0.43)
\$100,001+	0.05 (0.04, 0.05)	0.05 (0.04, 0.06)
No information	0.50 (0.44, 0.57)	0.46 (0.40, 0.52)

Table 6: Crude and age- and sex-adjusted ADHD prevalence by monthly school fee (Peso) in Chile school data. Crude prevalence has 95% normal confidence intervals and adjusted prevalence has 95% gamma confidence intervals.

School fee	Crude prevalence (95% CI)	Adjusted prevalence (95% CI)
Free	1.65 (1.63, 1.67)	1.62 (1.60, 1.64)
\$1,000-\$10,000	0.18 (0.00, 0.43)	0.11 (0.01, 2.74)
\$10,001-\$25,000	1.06 (0.95, 1.16)	1.05 (0.94, 1.17)
\$25,001-\$50,000	1.59 (1.54, 1.65)	1.65 (1.59, 1.72)
\$50,001-\$100,000	1.90 (1.84, 1.95)	1.90 (1.84, 1.96)
\$100,001+	0.22 (0.21, 0.24)	0.23 (0.21, 0.25)
No information	1.21 (1.11, 1.31)	1.22 (1.13, 1.33)

For school fees, which were used here as a proxy for SES, autism prevalence was highest among students that received free or low fee education, though the sample size for students that paid \$1,000-\$10,000 monthly was very small, see Table 5. ADHD prevalence was variable across school fee levels, with the \$1,000-\$10,000 band having low prevalence and very few cases, see Table 6. For both autism and ADHD, prevalence was very low among students paying more than \$100,000 monthly, suggesting students from wealthier families may not

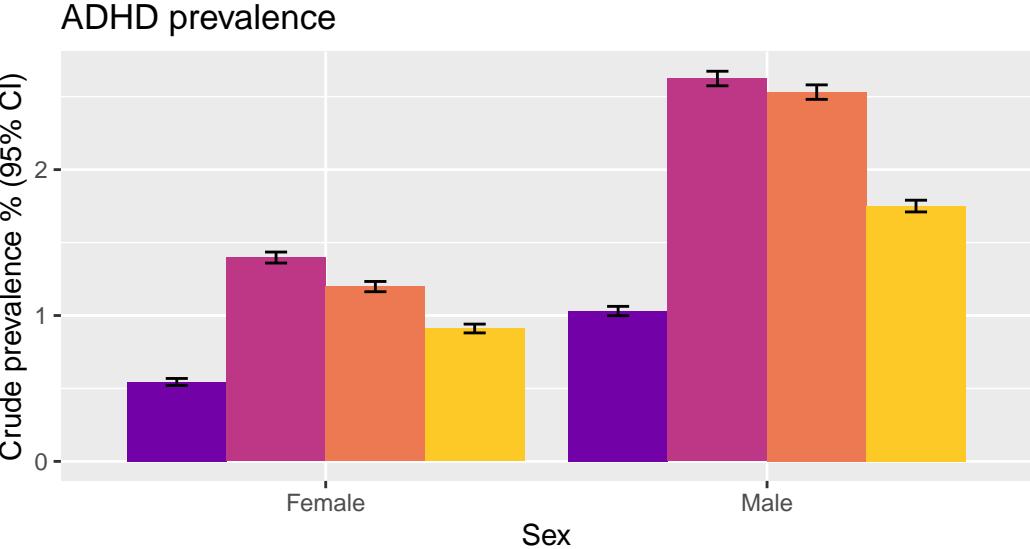


Figure 8: Crude prevalence of ADHD in school data by age band and sex. Bars show 95% normal confidence intervals.

have accessed SEED or may not have been eligible for it due to attending non-subsidised private schools. See also Supplementary Tables 23 and 24 and Supplementary Figures 43, 44.

Table 7: Crude and age- and sex-adjusted autism prevalence by ethnicity in Chile school data. Crude prevalence has 95% normal confidence intervals and adjusted prevalence has 95% gamma confidence intervals.

Ethnicity	Crude prevalence (95% CI)	Adjusted prevalence (95% CI)
Mapuche	0.36 (0.33, 0.39)	0.34 (0.31, 0.37)
Other Indigenous group	0.37 (0.20, 0.54)	0.38 (0.21, 0.75)
No Indigenous group	0.43 (0.42, 0.44)	0.42 (0.41, 0.43)

Table 8: Crude and age- and sex-adjusted ADHD prevalence by ethnicity in Chile school data. Crude prevalence has 95% normal confidence intervals and adjusted prevalence has 95% gamma confidence intervals.

Ethnicity	Crude prevalence (95% CI)	Adjusted prevalence (95% CI)
Mapuche	1.38 (1.32, 1.44)	1.33 (1.28, 1.39)
Other Indigenous group	1.12 (0.82, 1.41)	1.10 (0.83, 1.55)
No Indigenous group	1.59 (1.57, 1.61)	1.58 (1.56, 1.60)

For both autism and ADHD, adjusted prevalence was significantly lower for Mapuche students than non-Indigenous students in the Aysén, Biobío, La Araucanía, Los Lagos, Los Ríos, Magallanes and Región Metropolitana de Santiago regions, as shown in Tables 7 and 8. Autism prevalence for students belonging to other Indigenous groups fall in between and was not significantly different, and ADHD prevalence for other Indigenous groups was lower but not significantly. See also Supplementary Tables 25 and 26 and Supplementary Figures 45 and 46.

Table 9: Crude and age- and sex-adjusted autism prevalence by school's rurality in Chile school data. Crude prevalence has 95% normal confidence intervals and adjusted prevalence has 95% gamma confidence intervals.

School rurality	Crude prevalence (95% CI)	Adjusted prevalence (95% CI)
Rural	0.66 (0.63, 0.69)	0.57 (0.54, 0.61)
Urban	0.46 (0.45, 0.47)	0.46 (0.45, 0.46)

Table 10: Crude and age- and sex-adjusted ADHD prevalence by school's rurality in Chile school data. Crude prevalence has 95% normal confidence intervals and adjusted prevalence has 95% gamma confidence intervals.

School rurality	Crude prevalence (95% CI)	Adjusted prevalence (95% CI)
Rural	1.77 (1.72, 1.82)	1.67 (1.61, 1.74)
Urban	1.49 (1.48, 1.50)	1.48 (1.47, 1.50)

Autism and ADHD were both significantly more prevalent for students at rural schools than urban schools at 0.57% (0.54 - 0.61%) and 0.46% (0.45 - 0.46%) respectively for autism and 1.67% (1.61 - 1.74%) and 1.48% (1.47 - 1.50%) respectively for ADHD, as shown in Tables 9 and 10. See also Supplementary Tables 27 and 28 and Supplementary Figures 47 and 48.

These results together indicate that for autism and ADHD there were differences in prevalence across location and demographic features.

### 5.3 Clinical data

The validated clinical dataset has data on 1,570 appointments for 253 unique patients with autism aged 1-18 in 2021, of which 247 patients have lived in a commune in the SSAS catchment area during the period the data covers. Among these, most were male, live in urban areas and have Chilean but not Mapuche ethnicity. The mean age is 9.4 years. Many patients live in Villarrica commune as the validated clinical data is from Villarrica Hospital. FONASA-A, indicative of low SES, is the most common level of health insurance, and few patients have another recorded disability or have experienced foster care.

### 5.4 Machine learning with clinical data

Multiple correspondence analysis was first conducted with all features thought to be associated with autism diagnosis with no imputation. Figure 9 shows approximately 14.6% of the variance in these data were captured by the first two dimensions of MCA. Disability and foster care status were well separated by the first dimension but Figures 18 and 19 show that this separation was primarily driven by whether information was available for these features. Ethnicity, age band and commune of residence were well separated by the second dimension of MCA, as shown in Figure 9, and were somewhat separated by the first dimension. Figures 10 and 11 further show the importance of categories within the foster care, disabilities, ethnicity, age band and commune features for explaining the variance in this data. In particular, categories that explained more of the variance include not having disability or foster care status, or not having information on these, having age of 0-2 or 3-5, being foreign or Chilean, living in Toltén and having private health insurance. Examining the clustering of individual patients by the first two dimensions of MCA, Figure 12 demonstrates that patients in age bands 0-2 and 3-5 clustered well and those in older age bands did not. There was some clustering by ethnicity in Figure 13 but it was obscured by the separation of points into the two larger clusters defined by having or not having information on disability and foster care status. Figure 14 shows clear separation of Toltén and Nueva Imperial communes, however it is important to note here that these and several other

Table 11: Count and percentage of features' values in the validated clinical dataset.

Feature	Available values	Count (%)
Sex	Female	55 (22.27%)
	Male	192 (77.73%)
Age band	Age 0-2	<20
	Age 3-5	55 (22.27%)
	Age 6-8	37 (14.98%)
	Age 9-11	56 (22.67%)
	Age 12-14	45 (18.22%)
	Age 15-18	41 (16.60%)
Commune	Curarrehue	<20
	Freire	<20
	Gorbea	<20
	Loncoche	39 (15.79%)
	Nueva Imperial	<20
	Pitrufquén	<20
	Pucón	50 (20.24%)
	Temuco	<20
	Teodoro Schmidt	<20
	Toltén	<20
Private health level	Villarrica	137 (55.47%)
	FONASA - A	99 (40.08%)
	FONASA - B	67 (27.13%)
	FONASA - C	35 (14.17%)
	FONASA - D	38 (15.38%)
Ethnicity	Private Health Insurance	<20
	Mapuche	<20
	Chilean	131 (53.04%)
	Foreign	32 (12.96%)
Rurality	No ethnicity information	80 (32.39%)
	Rural	26 (10.53%)
	Urban	221 (89.47%)
Disability	Yes disability	<20
	No disability	78 (31.58%)
	No disability information	157 (63.56%)
Foster care	Yes foster care	<20
	No foster care	88 (35.63%)
	No foster care information	157 (63.56%)

communes were represented by only one patient, see Table 11. There was decent clustering of patients in Temuco and Pitrufquén communes. Figure 15 shows possible separation for patients with private health insurance and Figures 16 and 17 show little clustering by sex or rurality of residence.

### Categorical features by first two dimensions, no imputation

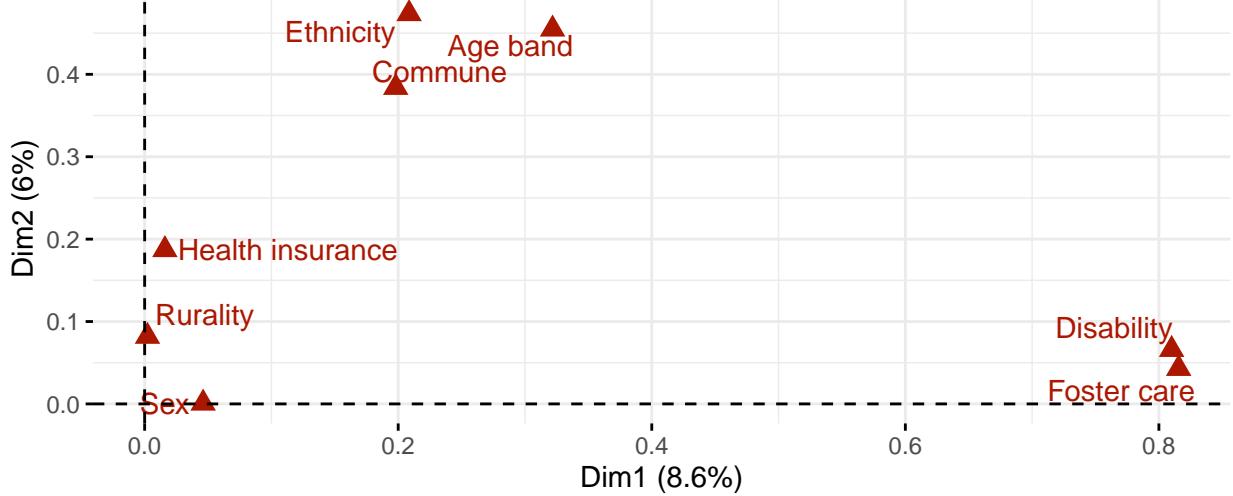


Figure 9: Categorical features by the first two dimensions of multiple correspondence analysis on autism patients in the validated clinical data using all features without imputation.

Exchanging disability and foster care status for their imputed versions led to the MCA capturing approximately 14.1% of the variance in that data with its first two dimensions, as shown in Figure 20. Disability and foster care status were no longer well separated by the first dimension and Figures 29 and 30 show that the patients who had experienced foster care did cluster well but the patients with a disability did not. In Figure 20, age band and ethnicity were now well separated by both dimensions and commune mostly by the second. With the reduced importance of disability and foster care, age bands 0-2 and 3-5, foreign, no information and Chilean ethnicity and Toltén and Nueva Imperial communes contributed most to the first two dimensions, see Figures 21 and 22. Again patients with age bands 0-2 and 3-5 clustered well and older age bands did not, as shown in Figure 23. Figure 24 shows much clearer clustering of ethnicity than before. For communes with more than one patient resident, clustering was less clear than before with only Pitrufquén well separated by these dimensions, see Figure 25. Clustering by SES, sex and rurality was weak, see Figures 26, 27 and 28.

MCA on the validated clinical data using only age band, ethnicity and commune resulted in the first two dimensions capturing 17.8% of the variance in that data, see Figure 31, and these features were fairly well represented by the first two dimensions. Again age bands 0-2 and 3-5, foreign, no information and Chilean ethnicity and Toltén and Nueva Imperial communes contributed most to the first two dimensions, see Figures 32 and 33. By patient, age bands 0-2 and 3-5 still clustered well (Figure 34), ethnicity clusters were very distinct (Figure 35), and communes showed more structure than previously (Figure 36).

### 5.5 Linkage of school and patient records

Table 12 shows that students living in SSAS were significantly different to students living in the other health services with regard to age band, SES, ethnicity, rurality and whether they accessed SEED at all, but did not differ by sex.

In the school records, 132,242 students lived in the SSAS health service catchment, of which 488 (0.37%) had autism. Among the students with autism, shown in Table 13, there were many more males than females, Temuco was the most common commune of residence and most students had a proxy SES of 1.

Aggregating the combined clinical data to patient-level data for linkage resulted in the patient dataset with

### Contribution of categories to first two dimensions, no imputation

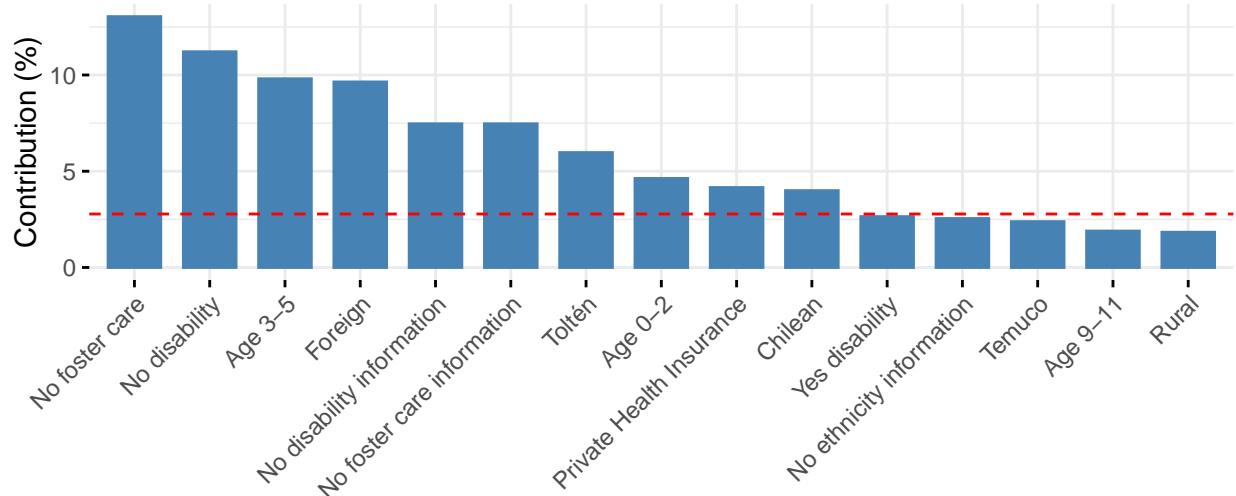


Figure 10: Contribution of the top 15 categories to the first two dimensions of multiple correspondence analysis on autism patients in the validated clinical data using all features without imputation. The red line shows the expected average if contributions were uniform.

Table 12: Percentage of features' values for each category for the students in the school data resident in SSAS and those not resident in SSAS with the p-value resulting from Chi squared tests of the difference between SSAS and non-SSAS students for each feature.

Feature	Available values	% for SSAS	% for non-SSAS	p-value
Sex	Female	48.95%	48.65%	0.0328
	Male	51.05%	51.35%	
Age band	6-8	24.08%	24.51%	0.00243
	9-11	25.11%	25.11%	
	12-14	24.69%	24.52%	
	15-18	26.13%	25.86%	
School fee	Free	84.15%	71.10%	«0.001
	\$1,000-\$10,000	0.00%	0.04%	
	\$10,001-\$25,000	0.56%	1.22%	
	\$25,001-\$50,000	2.74%	6.95%	
	\$50,001-\$100,000	6.42%	8.97%	
	\$100,001+	4.67%	10.07%	
	No information	1.46%	1.64%	
Ethnicity	Mapuche	33.58%	4.51%	«0.001
	Other Indigenous group	0.13%	1.22%	
	No Indigenous group	66.29%	94.27%	
Rurality	Rural	16.68%	7.42%	«0.001
	Urban	83.32%	92.58%	
Accesses SEED	No	83.25%	89.13%	«0.001
	Yes	16.75%	10.87%	

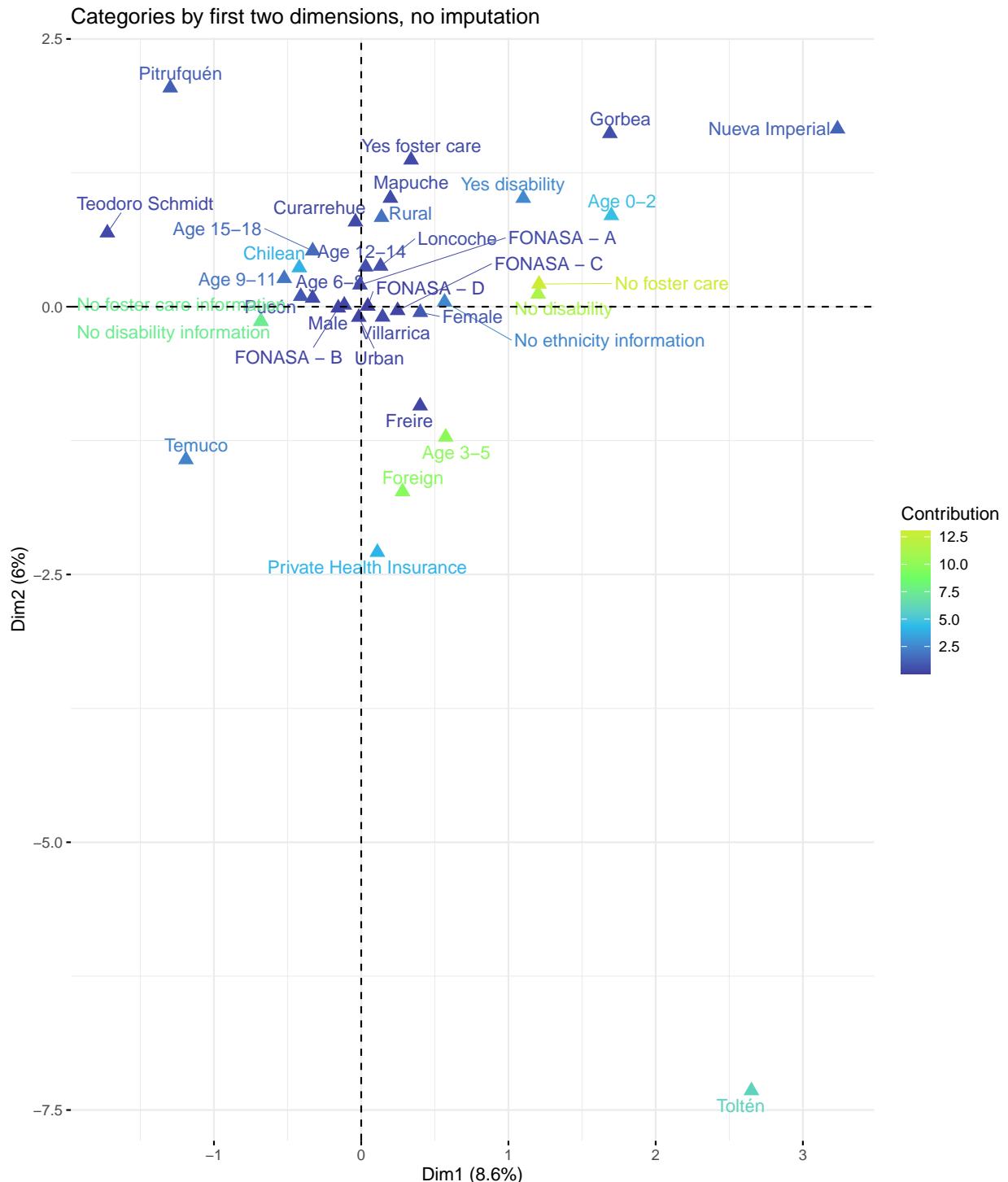


Figure 11: Available categories by the first two dimensions of multiple correspondence analysis on autism patients in the validated clinical data using all features without imputation. Brighter, more yellow colours indicate larger contribution to the first two dimensions.

**Patients by age band, no imputation**

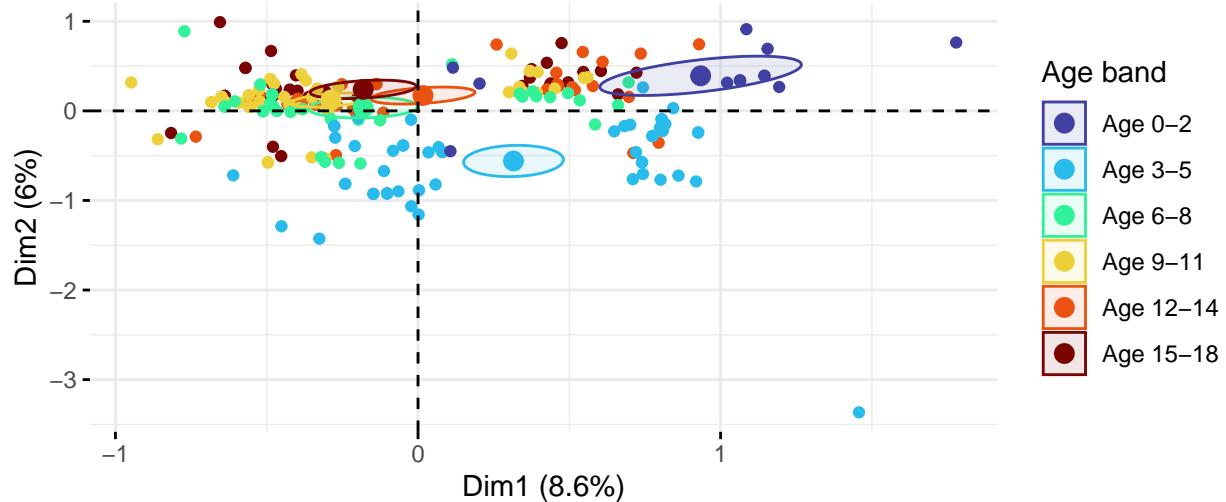


Figure 12: Patients by the first two dimensions of multiple correspondence analysis on autism patients in the validated clinical data using all features without imputation, coloured by age band.

**Patients by ethnicity, no imputation**

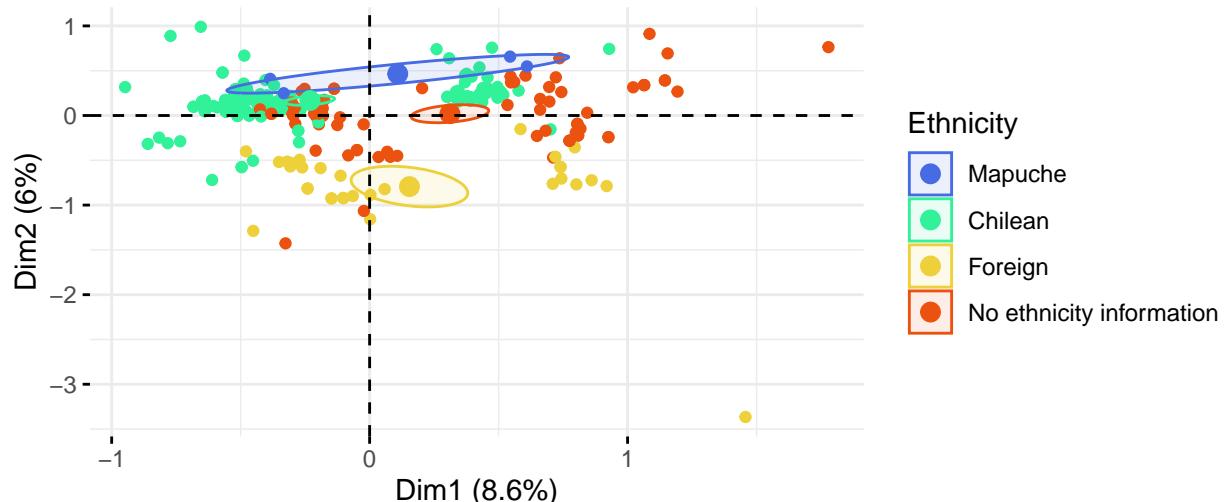


Figure 13: Patients by the first two dimensions of multiple correspondence analysis on autism patients in the validated clinical data using all features without imputation, coloured by ethnicity.

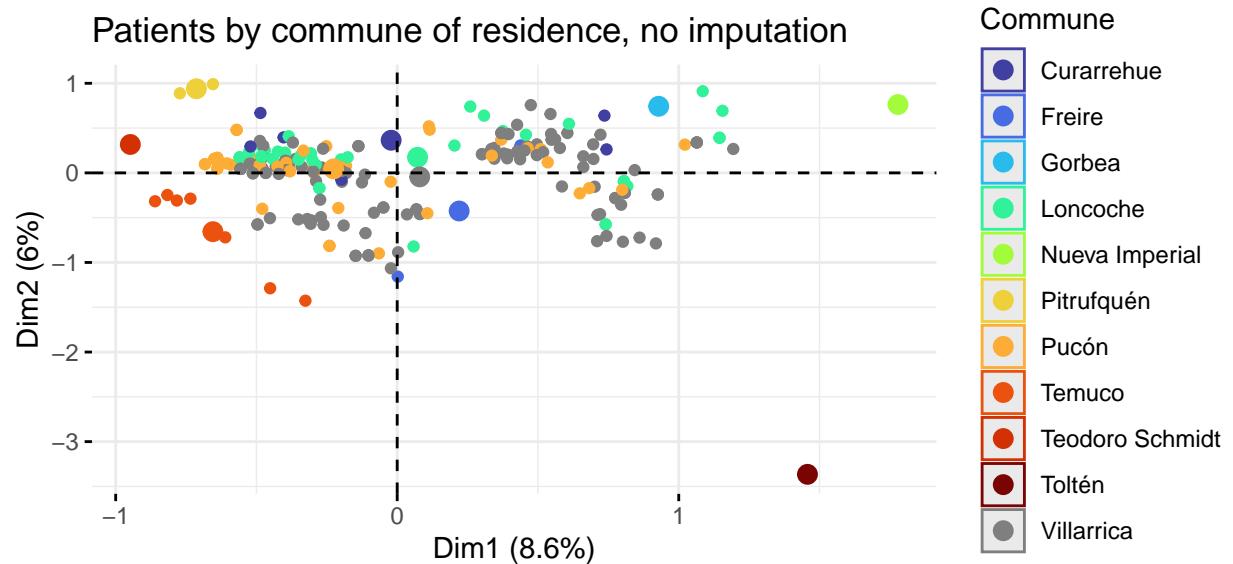


Figure 14: Patients by the first two dimensions of multiple correspondence analysis on autism patients in the validated clinical data using all features without imputation, coloured by commune of residence.

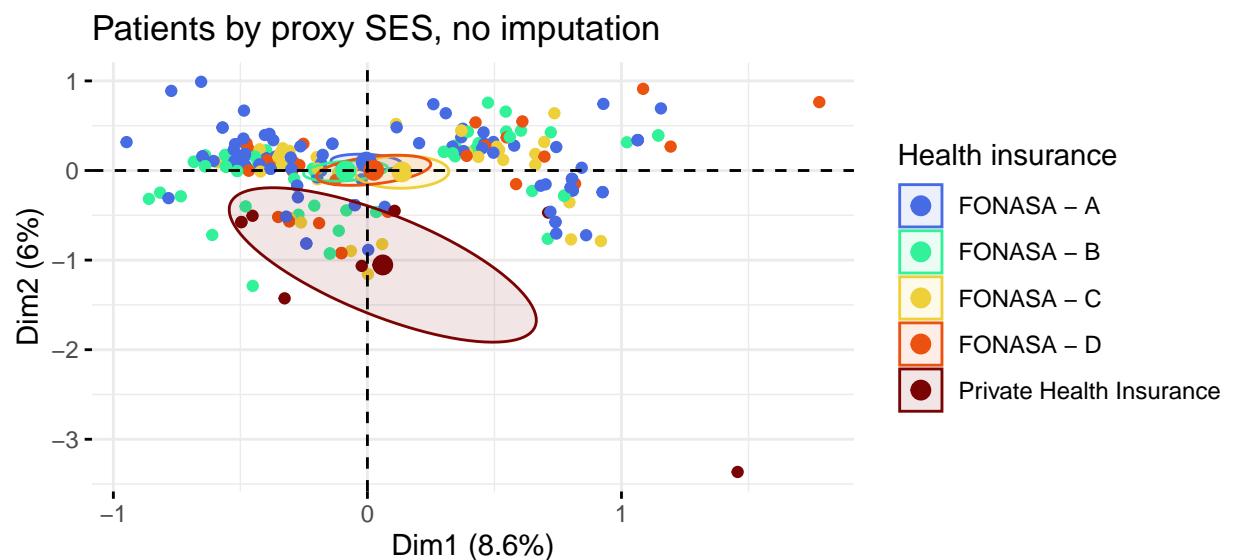


Figure 15: Patients by the first two dimensions of multiple correspondence analysis on autism patients in the validated clinical data using all features without imputation, coloured by health insurance level.

Patients by sex, no imputation

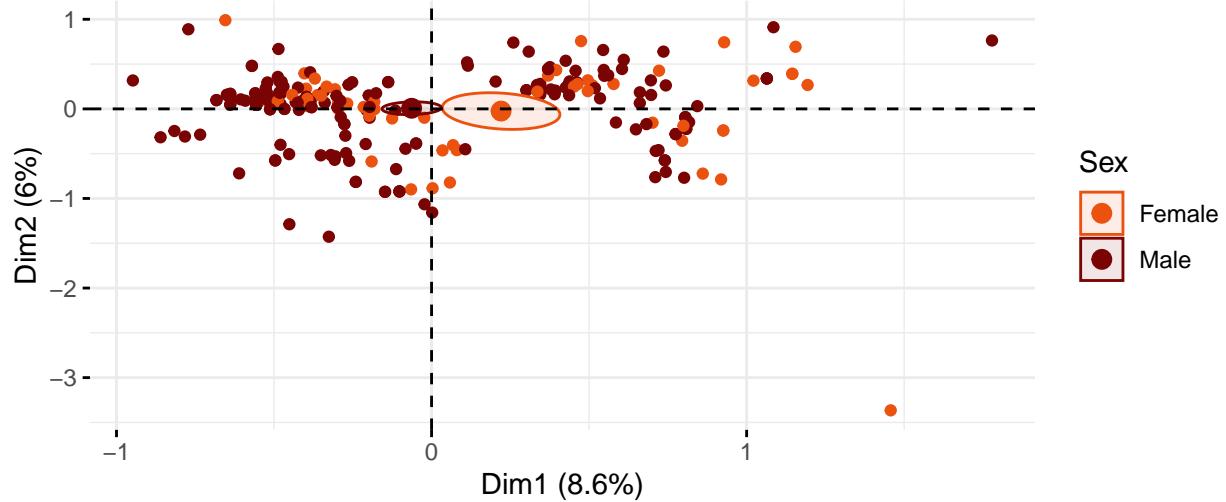


Figure 16: Patients by the first two dimensions of multiple correspondence analysis on autism patients in the validated clinical data using all features without imputation, coloured by sex.

Patients by rurality, no imputation

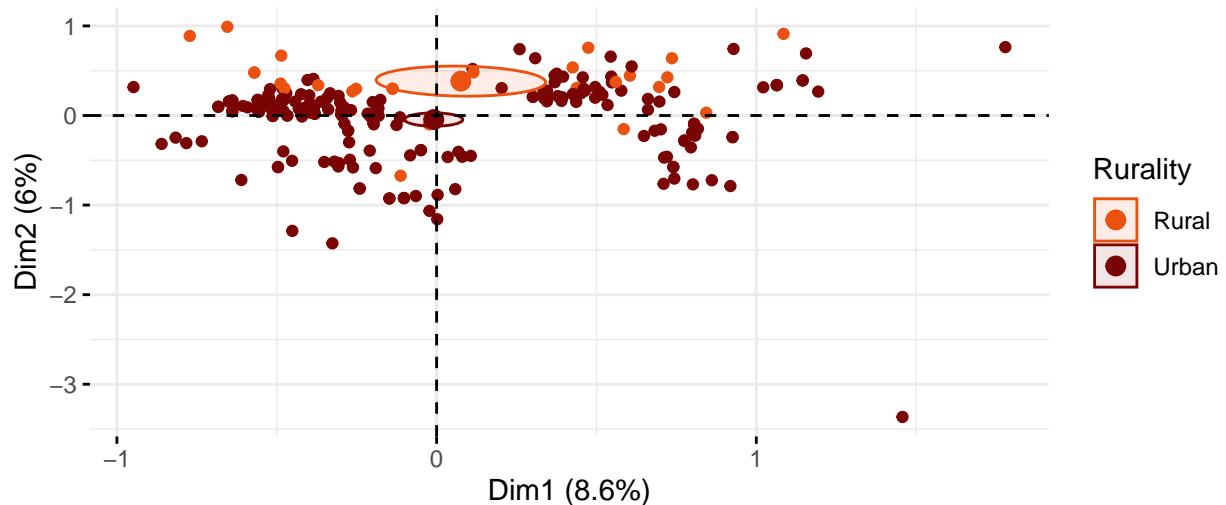


Figure 17: Patients by the first two dimensions of multiple correspondence analysis on autism patients in the validated clinical data using all features without imputation, coloured by rurality of residence.

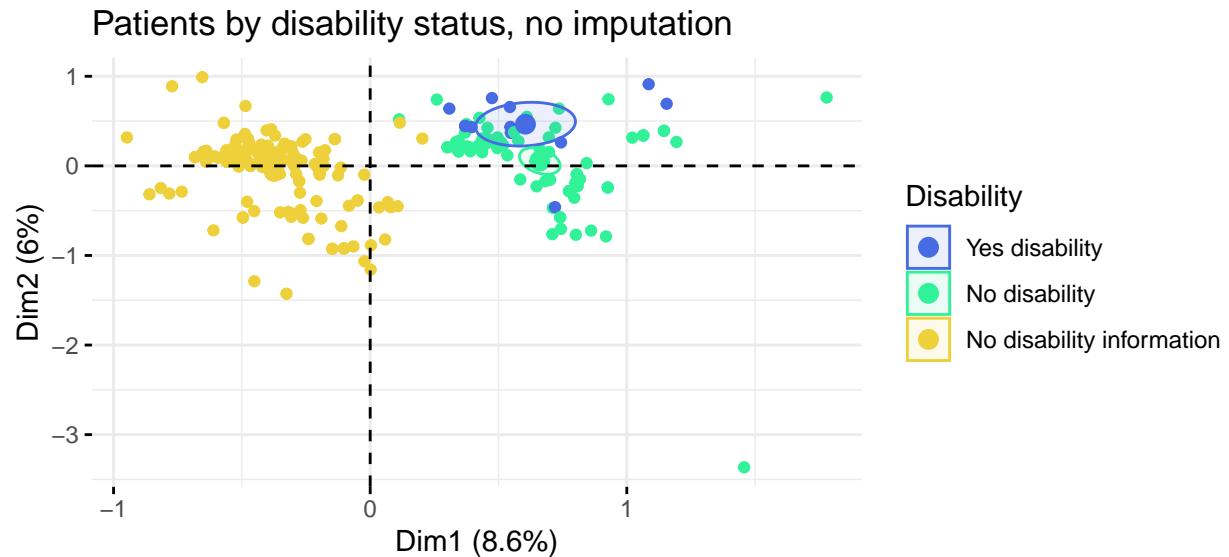


Figure 18: Patients by the first two dimensions of multiple correspondence analysis on autism patients in the validated clinical data using all features without imputation, coloured by disability status.

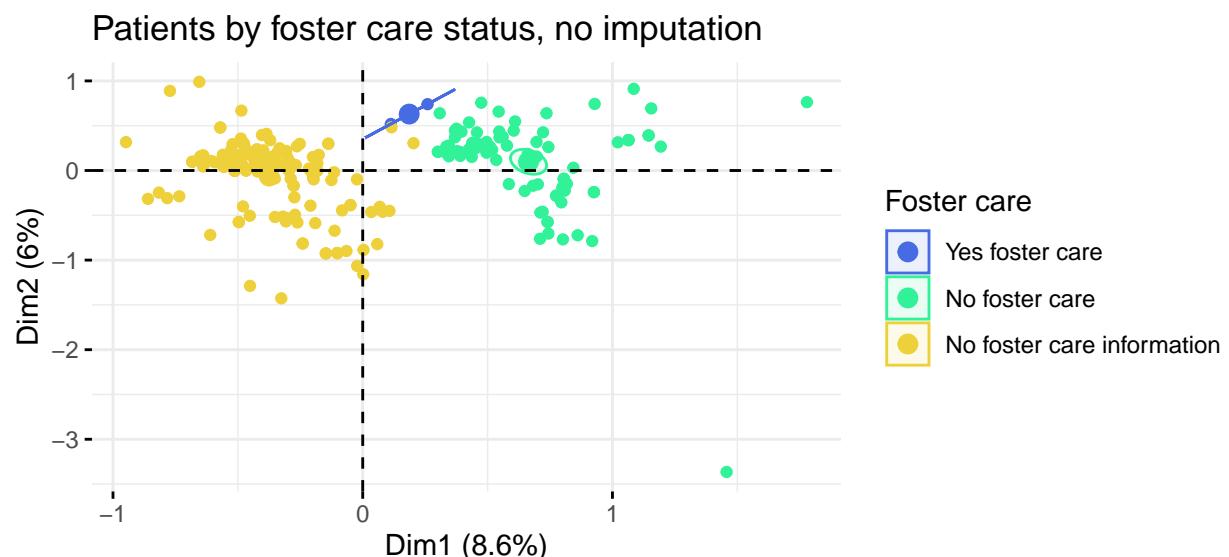


Figure 19: Patients by the first two dimensions of multiple correspondence analysis on autism patients in the validated clinical data using all features without imputation, coloured by foster care status.

### Categorical features by first two dimensions, with imputation

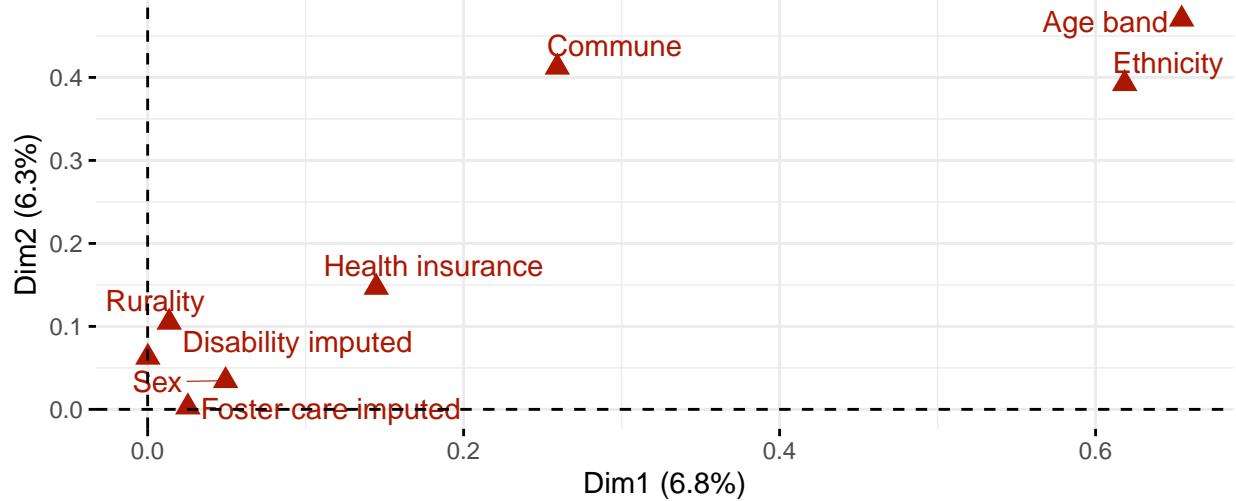


Figure 20: Categorical features by the first two dimensions of multiple correspondence analysis on autism patients in the validated clinical data using all features with imputation.

### Contribution of categories to first two dimensions, with imputation

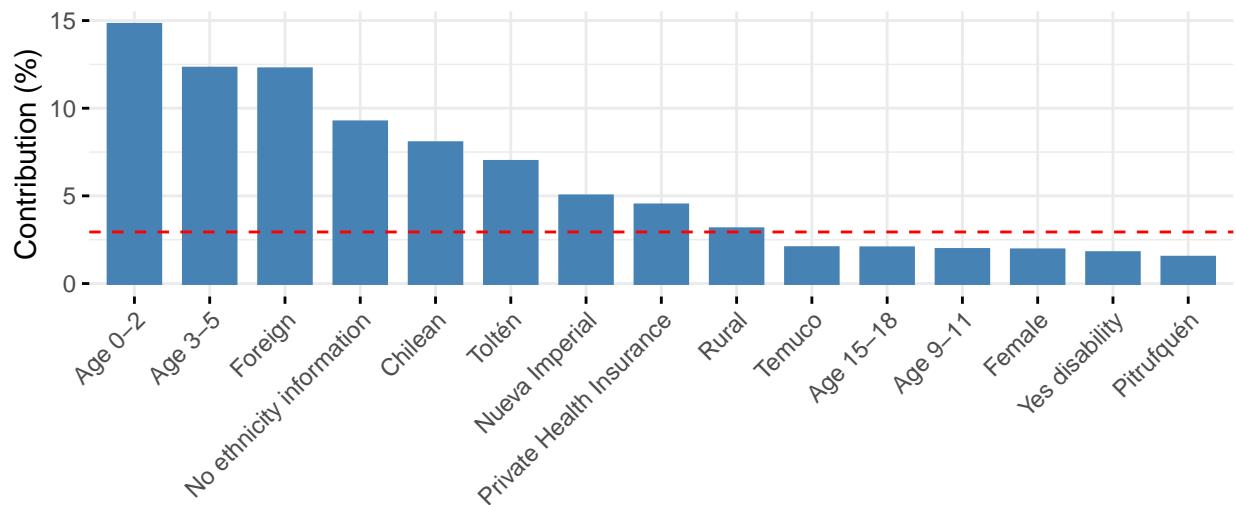


Figure 21: Contribution of the top 15 categories to the first two dimensions of multiple correspondence analysis on autism patients in the validated clinical data using all features with imputation. The red line shows the expected average if contributions were uniform.

Categories by first two dimensions, with imputation

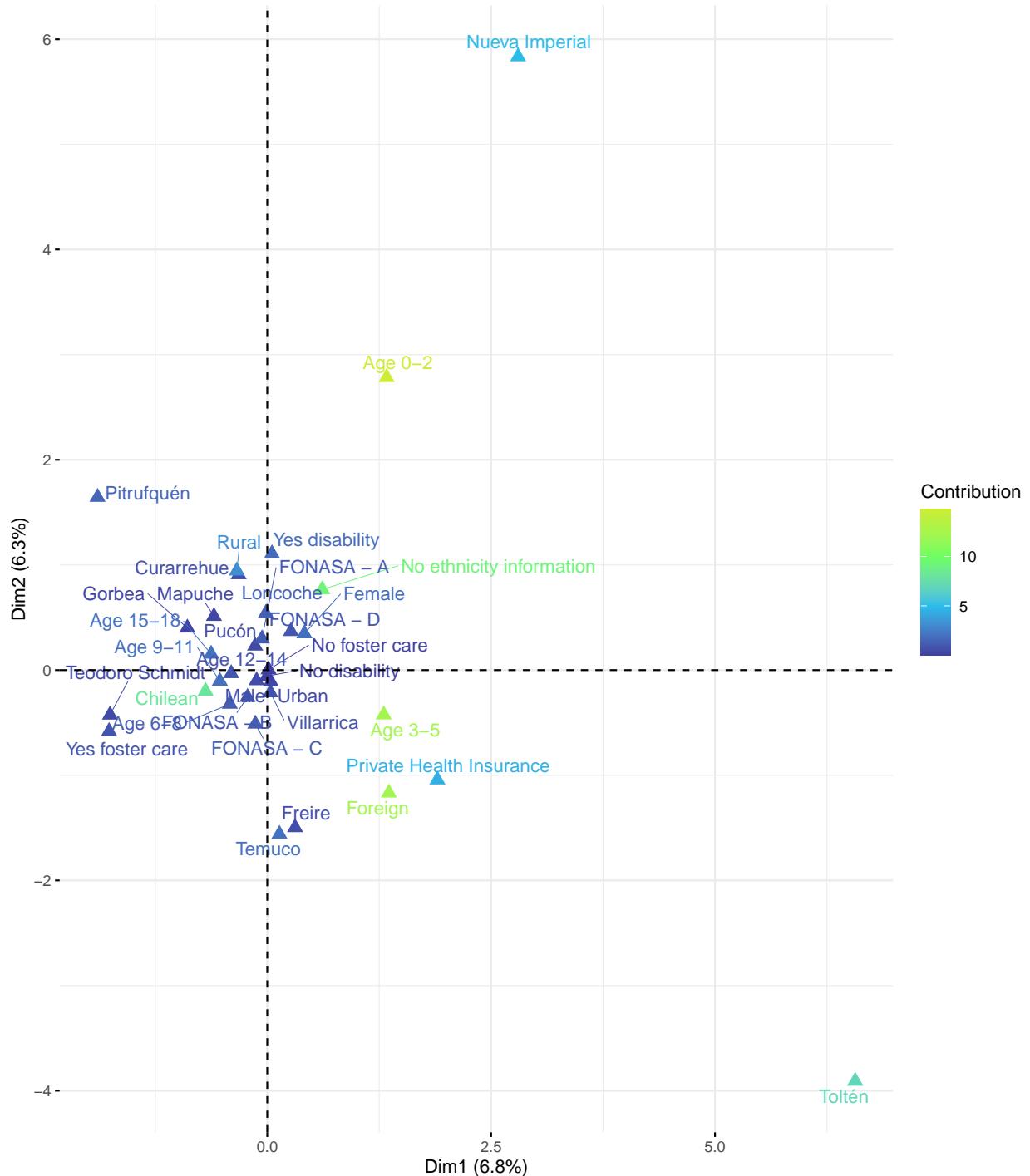


Figure 22: Available categories by the first two dimensions of multiple correspondence analysis on autism patients in the validated clinical data using all features with imputation. Brighter, more yellow colours indicate larger contribution to the first two dimensions.

**Patients by age band, with imputation**

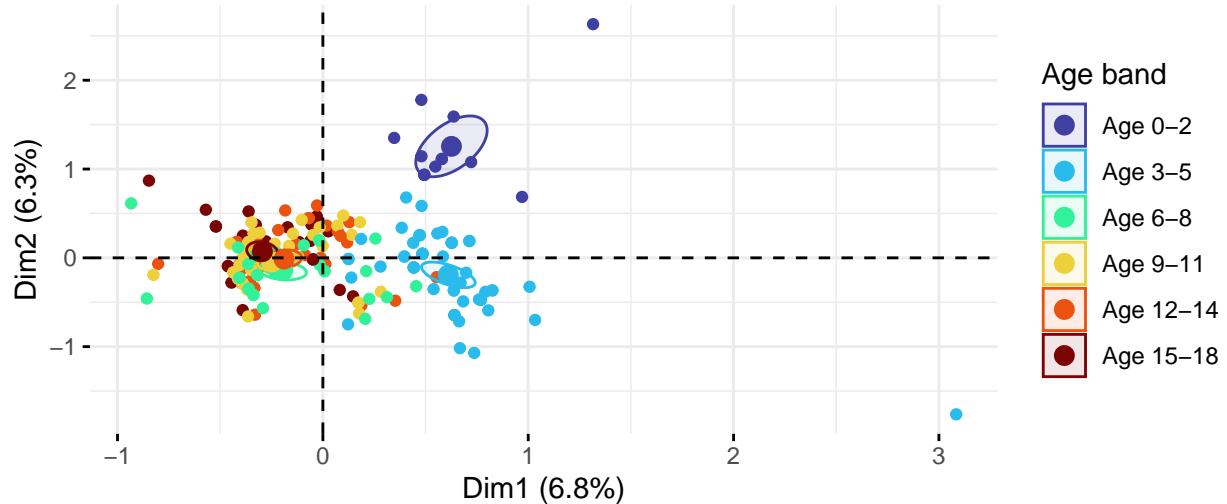


Figure 23: Patients by the first two dimensions of multiple correspondence analysis on autism patients in the validated clinical data using all features with imputation, coloured by age band.

**Patients by ethnicity, with imputation**

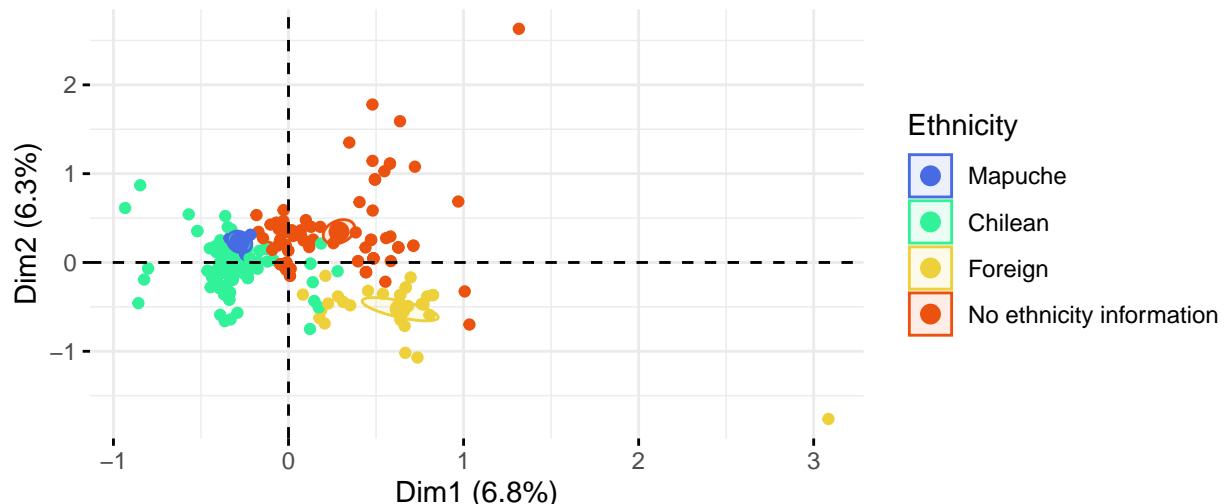


Figure 24: Patients by the first two dimensions of multiple correspondence analysis on autism patients in the validated clinical data using all features with imputation, coloured by ethnicity.

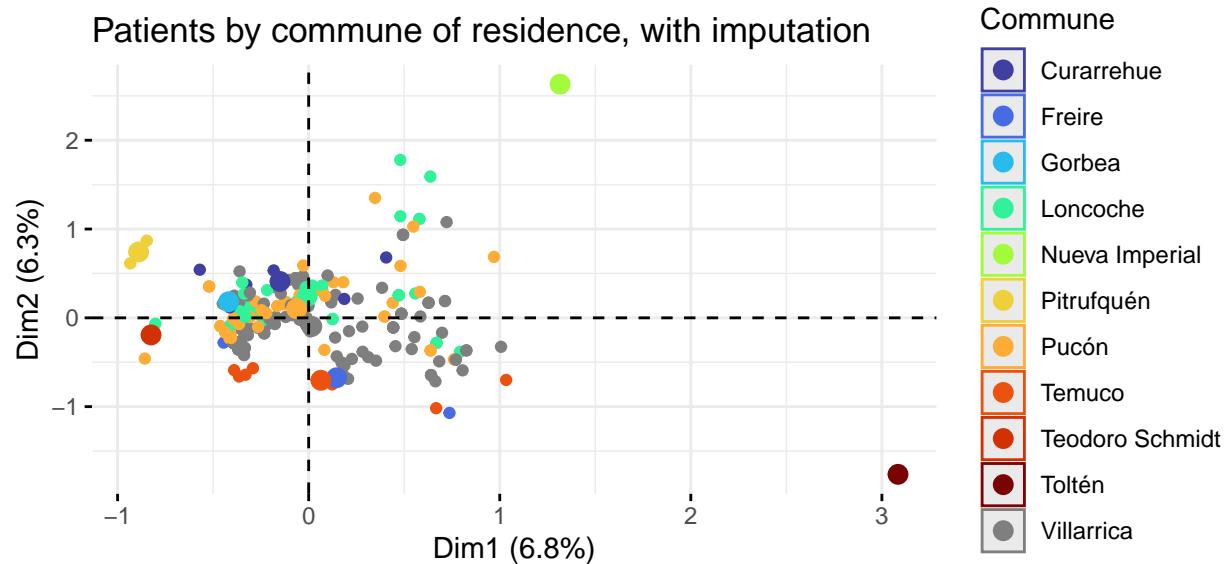


Figure 25: Patients by the first two dimensions of multiple correspondence analysis on autism patients in the validated clinical data using all features with imputation, coloured by commune of residence.

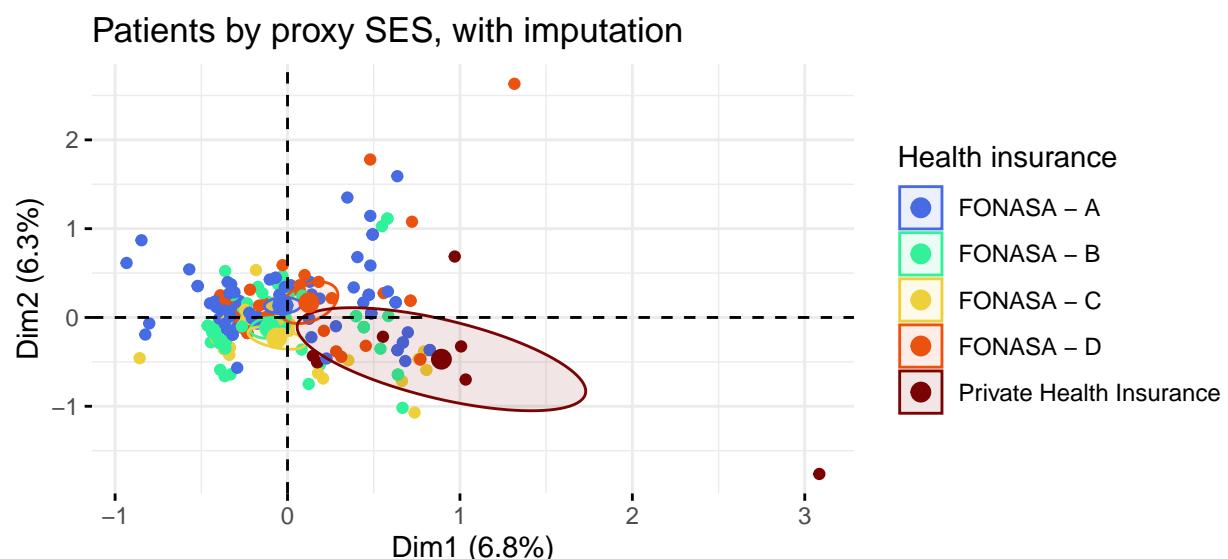


Figure 26: Patients by the first two dimensions of multiple correspondence analysis on autism patients in the validated clinical data using all features with imputation, coloured by health insurance level.

**Patients by sex, with imputation**

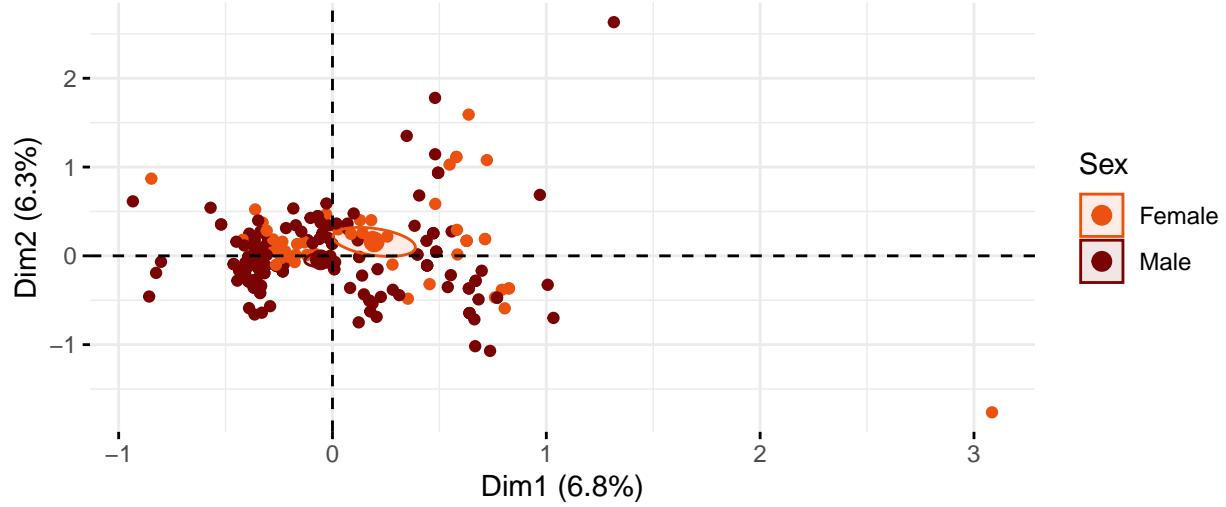


Figure 27: Patients by the first two dimensions of multiple correspondence analysis on autism patients in the validated clinical data using all features with imputation, coloured by sex.

**Patients by rurality, with imputation**

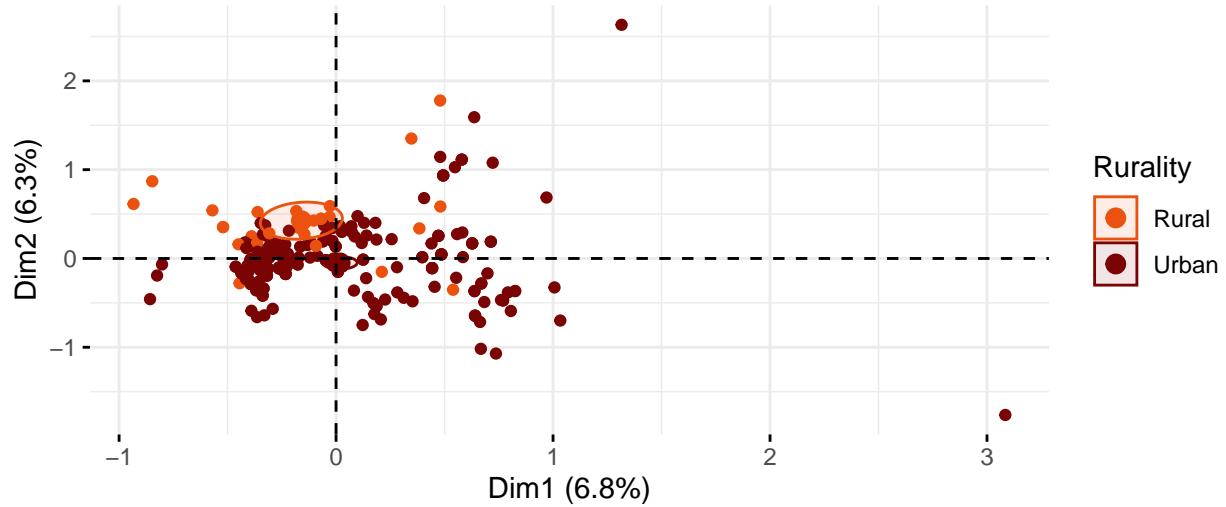


Figure 28: Patients by the first two dimensions of multiple correspondence analysis on autism patients in the validated clinical data using all features with imputation, coloured by rurality of residence.

**Patients by disability status, with imputation**

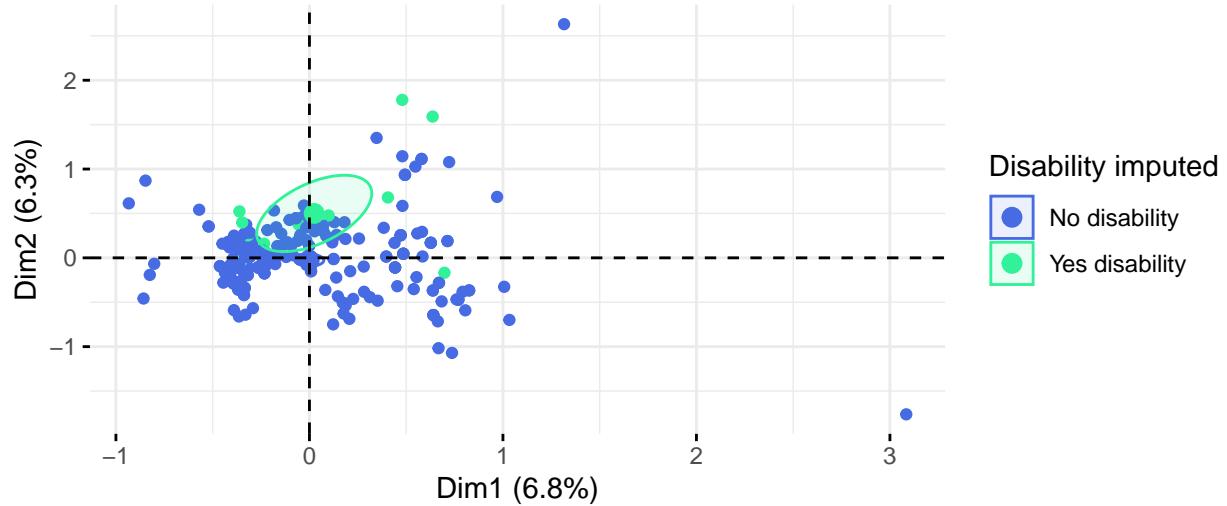


Figure 29: Patients by the first two dimensions of multiple correspondence analysis on autism patients in the validated clinical data using all features with imputation, coloured by disability status.

**Patients by foster care status, with imputation**

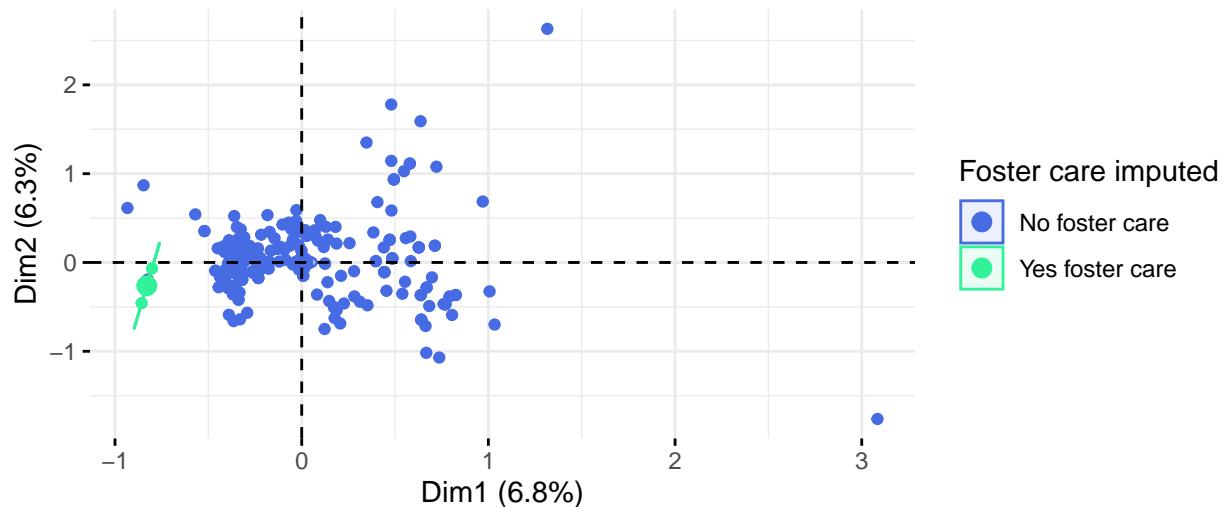


Figure 30: Patients by the first two dimensions of multiple correspondence analysis on autism patients in the validated clinical data using all features with imputation, coloured by foster care status.

### Categorical features by first two dimensions, 3 features

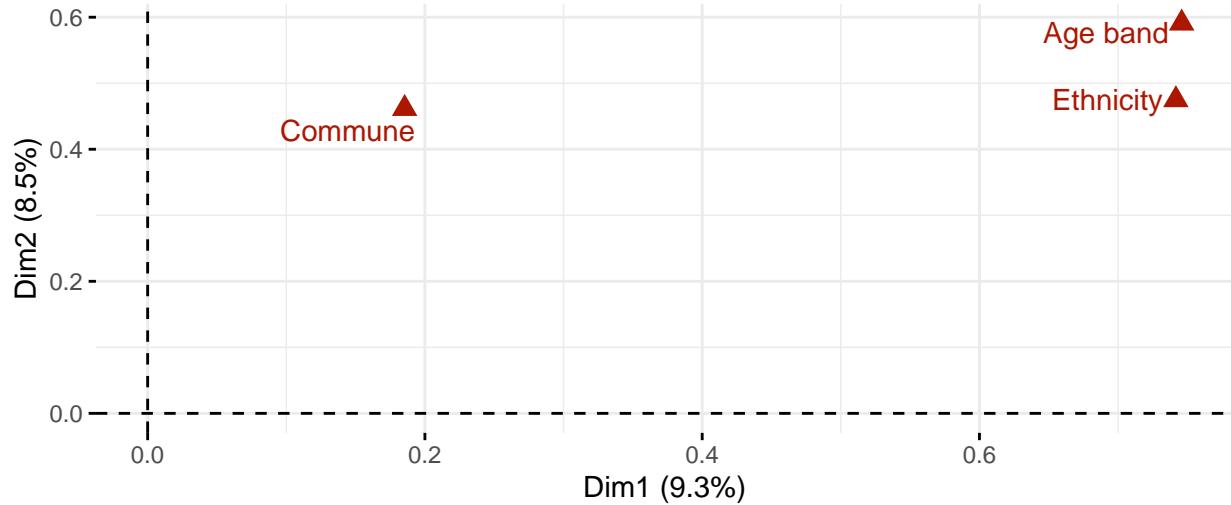


Figure 31: Categorical features by the first two dimensions of multiple correspondence analysis on autism patients in the validated clinical data using patients' age band, commune of residence and ethnicity.

### Contribution of categories to first two dimensions, 3 features

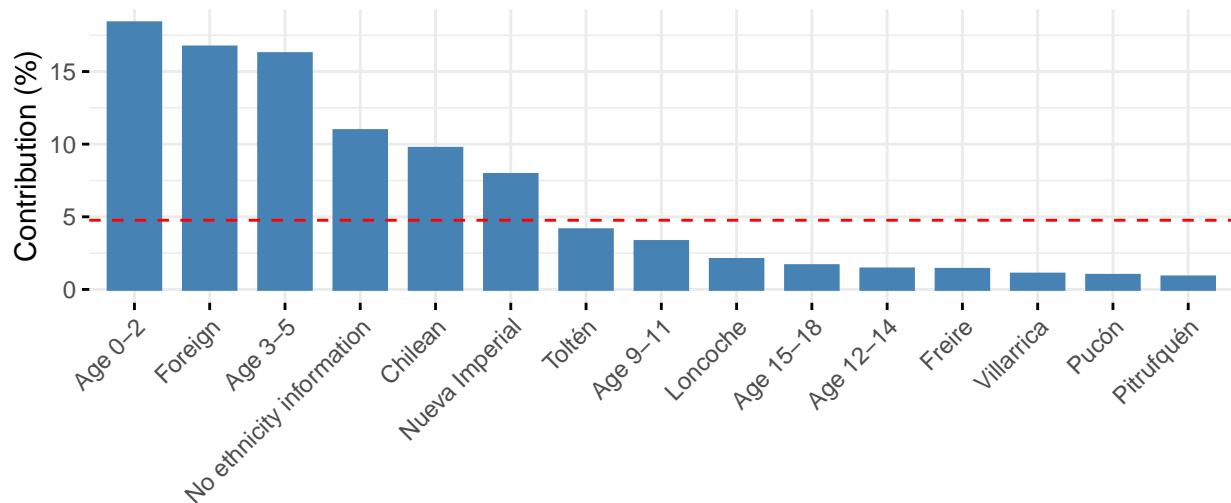


Figure 32: Contribution of the top 15 categories to the first two dimensions of multiple correspondence analysis on autism patients in the validated clinical data using patients' age band, commune and ethnicity. The red line shows the expected average if contributions were uniform.

Categories by first two dimensions, 3 features

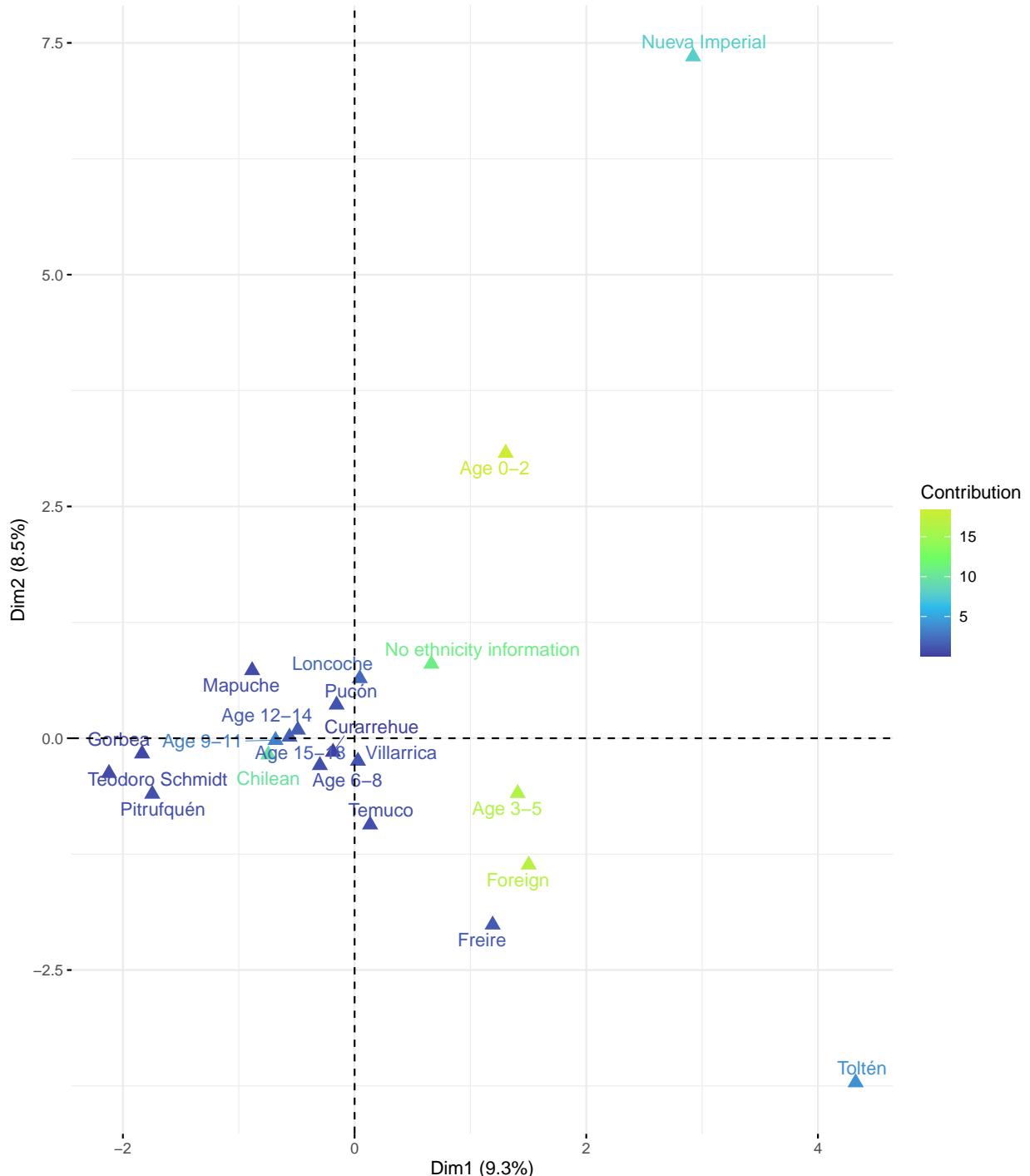


Figure 33: Available categories by the first two dimensions of multiple correspondence analysis on autism patients in the validated clinical data using patients' age band, commune and ethnicity. Brighter, more yellow colours indicate larger contribution to the first two dimensions.

Patients by age band, 3 features

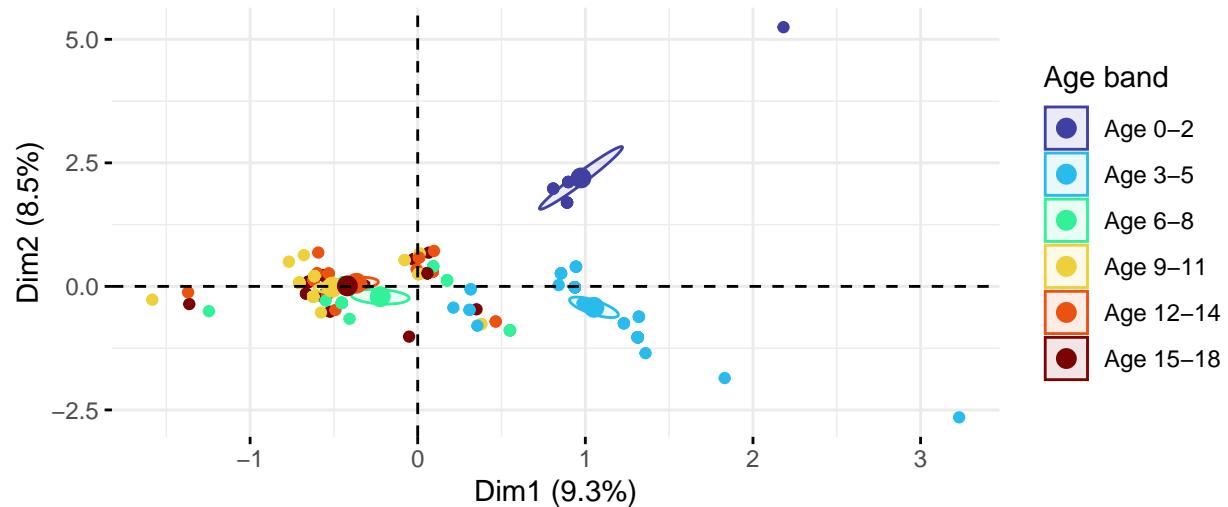


Figure 34: Patients by the first two dimensions of multiple correspondence analysis on autism patients in the validated clinical data using patients' age band, commune and ethnicity, coloured by age band.

Patients by ethnicity, 3 features

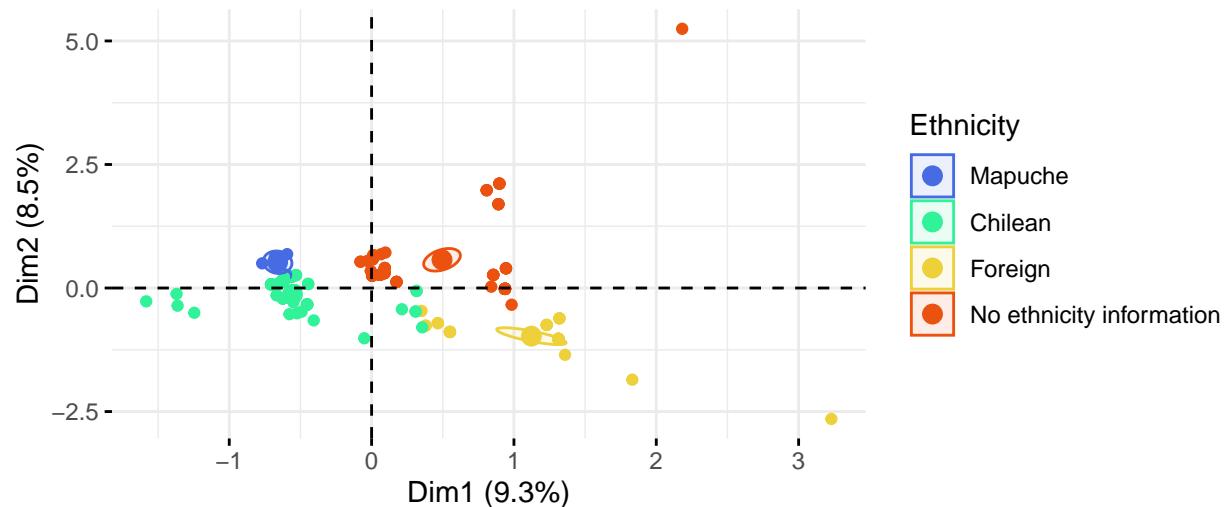


Figure 35: Patients by the first two dimensions of multiple correspondence analysis on autism patients in the validated clinical data using age band, commune and ethnicity, coloured by ethnicity.

Table 13: Count and percentage of features' values in the SSAS school dataset which comprises students with autism resident in the SSAS catchment. Proxy SES is school fee group.

Feature	Available values	Count (%)
Sex	Female	61 (12.50%)
	Male	427 (87.50%)
Age band	6-8	165 (33.81%)
	9-11	136 (27.87%)
	12-14	106 (21.72%)
	15-18	81 (16.60%)
Commune	Carahue	<20
	Cholchol	<20
	Cunco	<20
	Curarrehue	<20
	Freire	<20
	Galvarino	<20
	Gorbea	<20
	Lautaro	29 (5.94%)
	Loncoche	<20
	Melipeuco	<20
	Nueva Imperial	<20
	Padre Las Casas	35 (7.17%)
	Perquenco	<20
	Pitrufquén	<20
	Pucón	<20
	Saavedra	<20
	Temuco	236 (48.36%)
	Teodoro Schmidt	<20
	Toltén	<20
	Vilcún	<20
	Villarrica	30 (6.15%)
Proxy SES	1	417 (85.45%)
	2	48 (9.84%)
	3	<20
	NA	22 (4.51%)

Table 14: Count and percentage of features' values in the patient dataset. Proxy SES is health insurance contribution group.

Feature	Available values	Count (%)
Sex	Female	276 (20.06%)
	Male	1100 (79.94%)
Age band	6-8	413 (30.01%)
	9-11	373 (27.11%)
	12-14	301 (21.88%)
	15-18	289 (21.00%)
Commune	Carahue	44 (3.20%)
	Cholchol	<20
	Cunco	30 (2.18%)
	Curarrehue	<20
	Freire	26 (1.89%)
	Galvarino	21 (1.53%)
	Gorbea	20 (1.45%)
	Lautaro	101 (7.34%)
	Loncoche	33 (2.40%)
	Melipeuco	<20
	Nueva Imperial	78 (5.67%)
	Padre Las Casas	136 (9.88%)
	Perquenco	<20
	Pitrufquén	42 (3.05%)
	Pucón	42 (3.05%)
	Saavedra	<20
	Temuco	553 (40.19%)
	Teodoro Schmidt	<20
	Toltén	<20
	Vilcún	53 (3.85%)
	Villarrica	124 (9.01%)
Proxy SES	1	577 (41.93%)
	2	772 (56.10%)
	3	27 (1.96%)

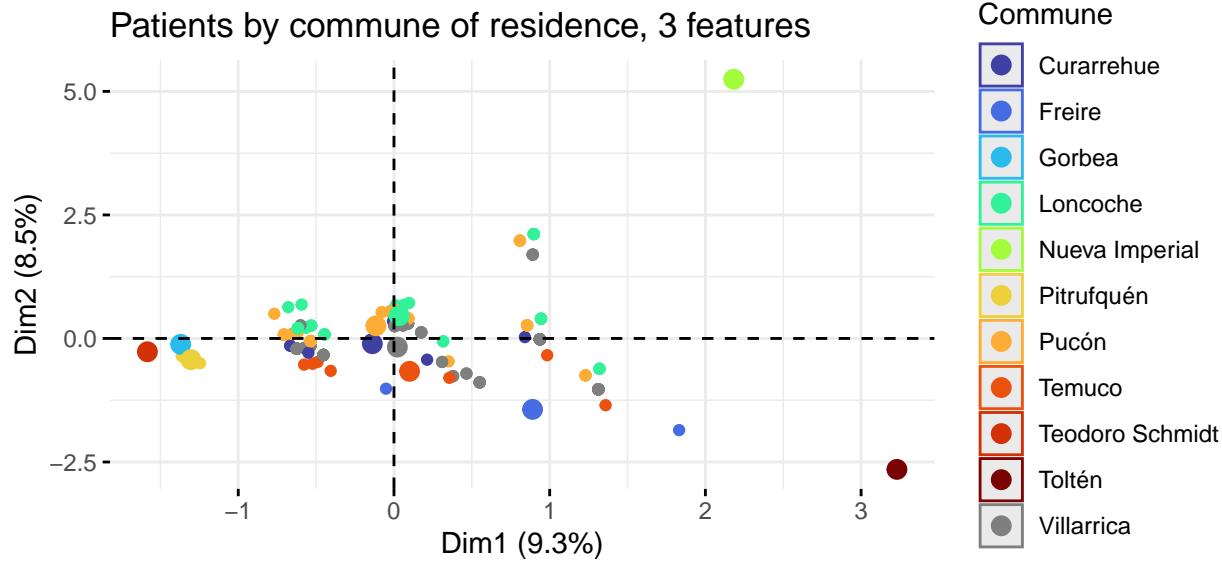


Figure 36: Patients by the first two dimensions of multiple correspondence analysis on autism patients in the validated clinical data using age band, commune and ethnicity, coloured by commune of residence.

1,376 records for 1,365 unique patients as 9 patients lived in 2 communes and 1 lived in 3 communes during the period covered by the data see Figure 4. Table 14 shows a similar pattern of category frequencies in the patient data as in the SSAS school data: males were more prevalent and Temuco was the most common commune of residence, however most patients had a proxy SES of 2 rather than 1.

### 5.5.1 Manual record linkage

Using perfect match on sex, date of birth, commune of residence and the proxies for SES, 79 perfect matches were manually found between the SSAS school and patient records. Of these, 77 unique SSAS school records were perfectly matched to SSAS patient records, and all perfect matches were for unique patients. When mismatch on SES proxy was allowed, 197 perfect matches were manually found between the SSAS school and patient records. Of these, 188 unique school records were perfectly matched to SSAS patient records and 193 SSAS patients were perfectly matched to SSAS school records.

### 5.5.2 Probabilistic record linkage

Blocking on sex and date of birth, resulted in 293 blocked pairs. Probabilistic matching on sex, date of birth, commune of residence and the proxies for SES with selection of possible matches to create a bijective set of matches resulted in 233 matches of unique SSAS school and patient records. This corresponds to 47.65% of the school records for students with autism in SSAS having a match in the SSAS patient records, 16.93% of the patient records having a match in the SSAS school records and 17.07% of the unique patients having a match in the SSAS school records. For each patient that had lived in more than one commune and therefore appeared more than once in the patient data, only one match to an SSAS school record was made, meaning the matching was bijective for SSAS school records and unique patients.

Analysis of differences between matched and unmatched records in the SSAS school data and in the patient data by sex, commune and proxy for SES are provided in the Supplementary Figures. Kolmogorov-Smirnov permutation tests found no significant difference in frequency of sexes between matched (12.88% female) and unmatched SSAS school records (12.16% female), see Supplementary Figure 49. They found a strongly significant difference in the frequency of sexes between matched (12.88% female) and unmatched patient records (21.52% female), see Supplementary Figure 50. This difference was likely due to the male to female ratios differing across the datasets: the SSAS school data of students with autism was 12.47% female, the

patient data was 20.06% female and the matches were 12.50% females. Permutation testing found that for the SSAS school data, matched (39.91% resident in Temuco) and unmatched records (56.08% resident in Temuco) differed significantly by commune, see Figure 51, and that there was no significant difference in the patient data by commune between matched (40.34% resident in Temuco) and unmatched records (40.16% resident in Temuco), see Figure 51. This appeared to be driven by the matchability of students and patients living in Temuco, the most prevalent commune. For the SSAS school data by proxy SES there was a strongly significant difference between matched (90.56% status of 1, 5.58% status of 2, 0.00% status of 3 and 3.86% with unknown status) and unmatched (80.78% status of 1, 13.73% status of 2, 0.39% status of 3 and 5.10% with unknown status) records, see Figure 53. For the patient data there was a somewhat significant difference between matched (38.2% status of 1, 58.37% status of 2, and 3.43% status of 3) and unmatched (42.69% status of 1, 55.64% status of 2 and 1.66% status of 3) records, see Figure 54. Again this likely reflected different frequencies of the SES values across datasets. Kolmogorov-Smirnov permutation testing was not conducted for date of birth as this feature contained too many categories for results to be meaningful.

## 5.6 Updated autism prevalence estimates and delta

Table 15: Age- and sex-adjusted updated autism prevalence from data linkage in SSAS by age band with 95% gamma confidence intervals.

Age band	Crude prevalence (95% CI)	Adjusted prevalence (95% CI)
6-8	1.54 (1.40, 1.67)	1.54 (1.41, 1.68)
9-11	1.34 (1.21, 1.46)	1.33 (1.21, 1.46)
12-14	1.08 (0.97, 1.19)	1.08 (0.97, 1.20)
15-18	0.96 (0.86, 1.07)	0.98 (0.87, 1.11)

After linking the school and patient data for SSAS, 1,132 patients with autism could not be matched to students. This represents the unmet need of SSAS students with autism that did not access school-based support for it. Combining these additional cases with the 488 students that did access SEED for autism gave 1,620 people with autism in SSAS. Thus the crude updated prevalence of autism in SSAS was 1.23% (1.17-1.28%) and the age- and sex-adjusted updated prevalence of autism was 1.22% (1.16-1.28%). The sample size here was 132,242, the same as the number of students resident in SSAS, because no individuals were added, only non-cases in the school data reallocated as cases based on the patient data linkage findings. For females, the adjusted updated prevalence was 0.47% (0.41-0.53%) and for males it was 1.95% (1.84-2.06%). This gave an updated male to female ratio of 4.18 after data linkage, smaller than the ratio of 7.00:1 in the SSAS school data before linkage. Updated autism prevalence was highest among individuals aged 6-8 at 1.54% (1.41-1.68%) and decreased with age, see Table 15.

Table 16: Adjusted prevalence and adjusted updated prevalence of autism by health service in Chile. Adjusted prevalence is from school data only. Adjusted updated prevalence is from linkage of school data and patient data. Prevalence for Servicio de Salud Araucanía Sur (SSAS) was calculated directly from linkage results. Prevalence for other health services was calculated by adding the adjusted prevalence delta to each health service's adjusted prevalence from the school data only. Adjusted prevalence has 95% gamma confidence intervals. The width of the adjusted updated prevalence confidence intervals is the maximum of the school data adjusted prevalence confidence intervals for each health service, and the adjusted prevalence delta confidence interval, except for SSAS which has the 95% gamma confidence intervals found earlier.

Health service	Adjusted prevalence (95% CI)	Adjusted updated prevalence (Maximal 95% CI)
Aconcagua	0.43 (0.37, 0.50)	1.28 (1.21, 1.34)
Aisén	0.75 (0.63, 0.90)	1.60 (1.47, 1.73)
Antofagasta	0.83 (0.77, 0.88)	1.67 (1.61, 1.74)
Araucanía Norte	0.30 (0.24, 0.38)	1.15 (1.08, 1.21)
Araucanía Sur	0.37 (0.34, 0.41)	1.22 (1.16, 1.28)
Arauco	0.72 (0.62, 0.82)	1.56 (1.46, 1.66)
Arica	0.61 (0.54, 0.70)	1.46 (1.38, 1.54)
Atacama	0.31 (0.27, 0.37)	1.16 (1.10, 1.22)
Biobío	0.42 (0.37, 0.47)	1.27 (1.20, 1.33)
Chiloé	0.43 (0.36, 0.52)	1.28 (1.20, 1.36)
Concepción	0.77 (0.72, 0.83)	1.62 (1.56, 1.68)
Coquimbo	0.40 (0.36, 0.43)	1.24 (1.18, 1.31)
Iquique	0.43 (0.38, 0.49)	1.28 (1.22, 1.34)
Magallanes	0.83 (0.72, 0.96)	1.68 (1.56, 1.80)
Maule	0.30 (0.28, 0.33)	1.15 (1.09, 1.21)
Metro. Central	0.42 (0.38, 0.46)	1.26 (1.20, 1.33)
Metro. Norte	0.29 (0.26, 0.31)	1.13 (1.07, 1.20)
Metro. Occidente	0.34 (0.32, 0.36)	1.19 (1.12, 1.25)
Metro. Oriente	0.30 (0.27, 0.33)	1.15 (1.08, 1.21)
Metro. Sur	0.40 (0.37, 0.43)	1.25 (1.18, 1.31)
Metro. Sur Oriente	0.36 (0.34, 0.39)	1.21 (1.15, 1.27)
O'Higgins	0.42 (0.39, 0.46)	1.27 (1.21, 1.34)
Osorno	0.43 (0.37, 0.51)	1.28 (1.21, 1.35)
Reloncaví	0.42 (0.37, 0.47)	1.26 (1.20, 1.33)
Talcahuano	0.81 (0.74, 0.90)	1.66 (1.58, 1.74)
Valdivia	0.30 (0.26, 0.35)	1.15 (1.08, 1.21)
Valparaíso	0.68 (0.62, 0.74)	1.52 (1.46, 1.59)
Viña del Mar	0.66 (0.62, 0.70)	1.51 (1.44, 1.57)
Ñuble	1.29 (1.21, 1.37)	2.13 (2.05, 2.21)

The adjusted prevalence delta for SSAS was 0.85% (0.78, 0.91%) and represents the unmet need of children with autism in SSAS that did not access SEED for it. Table 16 shows the projection of adjusted updated prevalence from the data linkage for SSAS onto the other health services. The patterns of prevalence across health services were retained and Ñuble has the highest adjusted updated prevalence at 2.13% (2.05, 2.21%). Adding the adjusted prevalence delta to the national adjusted autism prevalence found from the school data alone gave national adjusted updated autism prevalence of 1.31%. This in turn gave a posited 40,113 children aged 6-18 with autism in Chile and corresponds to an estimated unmet need of 25,903 children that did not access SEED for autism (posited count and unmet need are age- and sex-adjusted).

## 5.7 Bayesian prevalence projection

Posterior predictive distributions for common lower bound

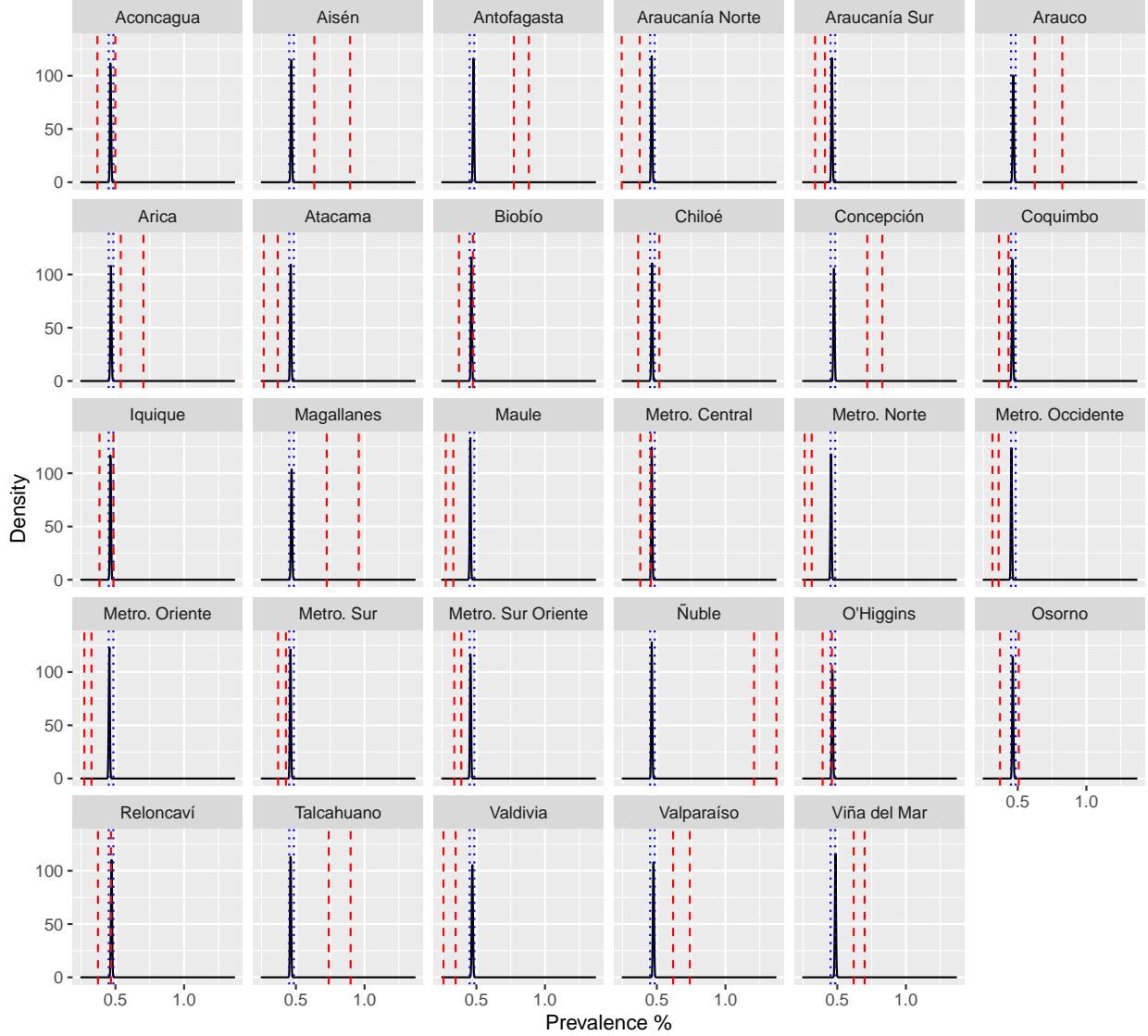


Figure 37: Posterior predictive distributions for autism prevalence using adjusted case counts from the school data with a random effect on student's health service. Modeling used a beta conjugate prior of age- and sex-adjusted national autism prevalence from school data. Red dashed lines show the adjusted sample prevalence 95% gamma confidence intervals and blue dotted lines show the posterior 95% credible interval.

Bayesian prevalence projections by health service with common national autism prevalence prior are shown in Figure 37. The differences in adjusted sample prevalence across health services are evident in the red bands and the posterior predictive distributions have been pulled towards the common prior. For regions like Ñuble which have adjusted sample prevalence in the school data higher than the national adjusted prevalence, these posterior densities are not plausible.

Bayesian prevalence projections by health service with health service specific priors are shown in Figure 38. As expected, the posterior 95% credible intervals were coincident with the adjusted sample prevalence 95% confidence intervals. The posterior prevalence peaks can be considered lower bounds for the true autism prevalence in each health service.

Posterior predictive distribution for health service specific lower bound priors

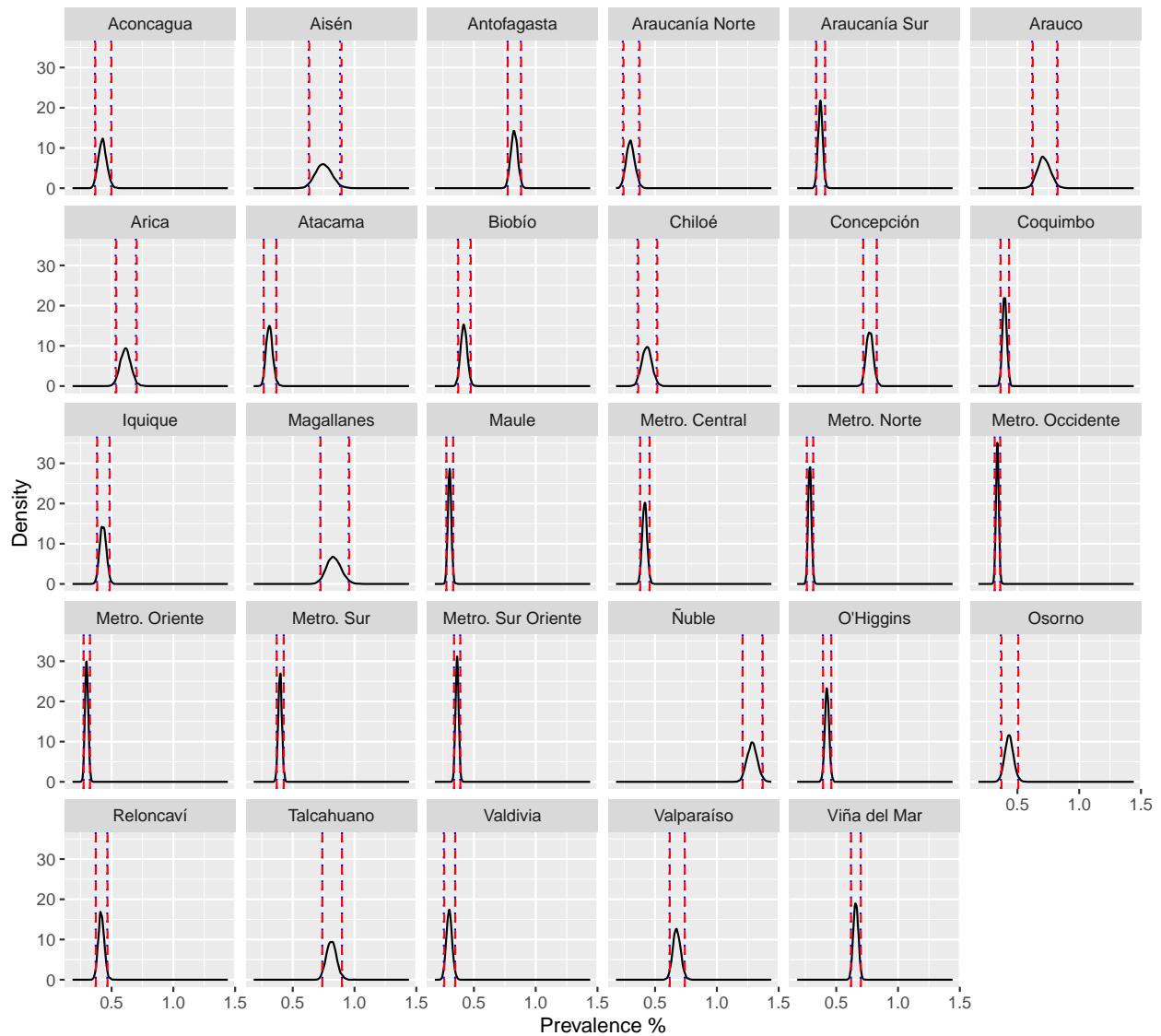


Figure 38: Posterior predictive distributions for autism prevalence using adjusted case counts from the school data with a random effect on student's health service. Modelling used beta conjugate priors of health service specific age- and sex-adjusted autism prevalence from school data. Red dashed lines show the adjusted sample prevalence 95% gamma confidence intervals and blue dotted lines show the posterior 95% credible interval.

Posterior predictive distribution for health service specific upper bound priors

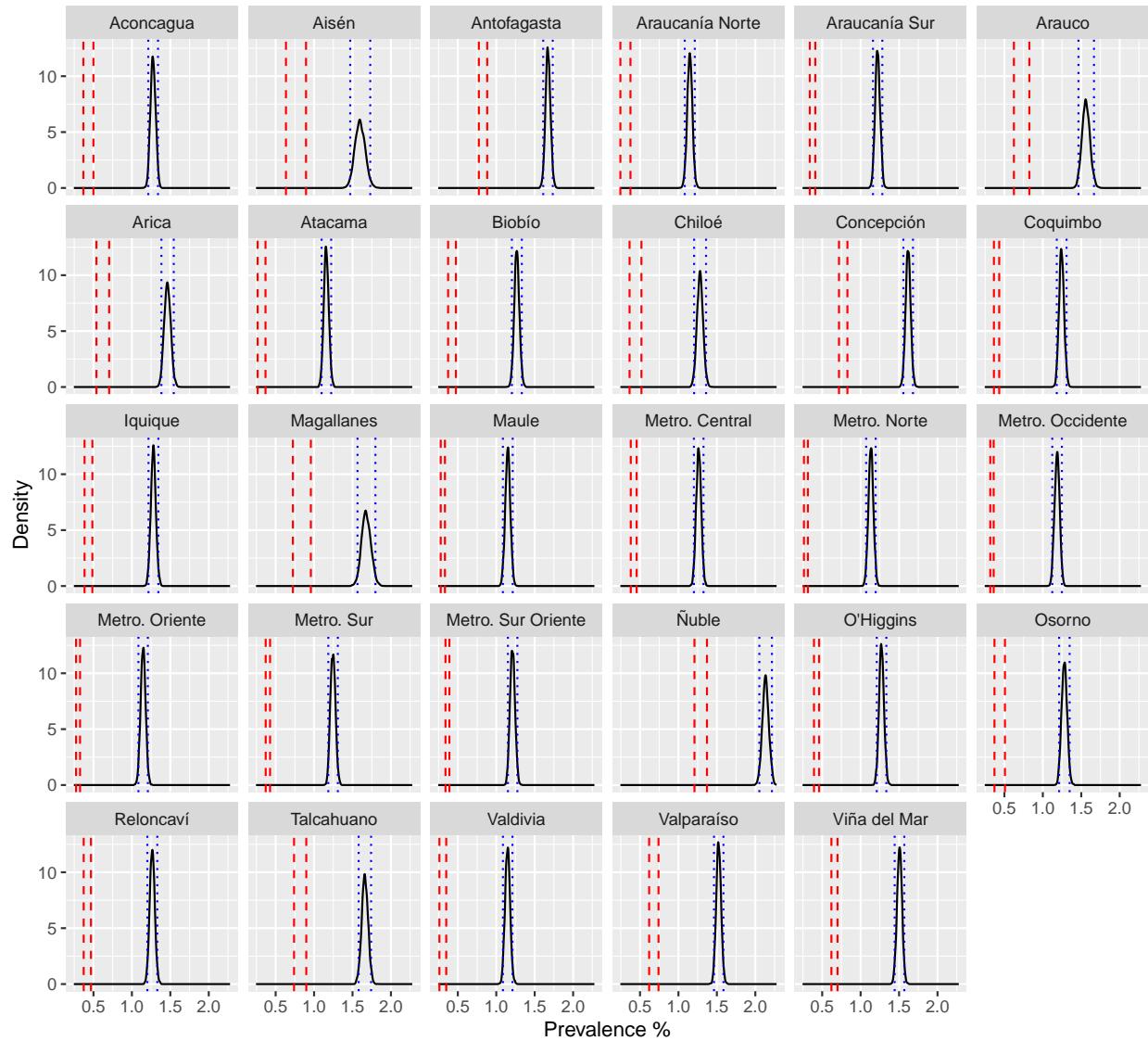


Figure 39: Posterior predictive distributions for autism prevalence using adjusted case counts from the school data with a random effect on student's health service. Modelling used beta conjugate priors of health service specific age- and sex-adjusted updated autism prevalence from data linkage. Red dashed lines show the adjusted sample prevalence 95% gamma confidence intervals and blue dotted lines show the posterior 95% credible interval.

With projected prevalence priors, the Bayesian prevalence projections shown in Figure 39 were pulled upward toward their priors by approximately delta. For regions with high sample prevalence such as Ñuble, this addition of delta resulted in posterior prevalence projections up to 1.5 percentage points higher than the national adjusted prevalence for the school data only which may not be plausible.

In Figure 40, the posterior distributions were reflective of their uniform priors with posterior credible intervals slightly within the prior bounds (Table 16). These predictive densities show a considerable departure from the adjusted sample prevalence from the school data and provide a window within which the true prevalence of recorded autism in each health service would plausibly fall.

## 6 Discussion

### 6.1 Findings

#### 6.1.1 Aim 1: Use school data and frequentist method to find a lower bound on autism and ADHD prevalence, and assess socio-demographic variation

In Chilean 6–18-year-old students, a lower bound on autism prevalence is 0.46% (0.46- 0.47%). This is higher than estimates for Venezuela of 0.17% and Ecuador of 0.11-0.21%, but lower than the estimate for Argentina of 1.03% and lower than Yáñez et al’s estimate for Chile of 1.95% (24,26–28). The observed crude prevalence of autism is highest in young students and decreases with age, and this pattern is preserved across demographic features. Yeargin-Allsop et al. also found autism prevalence decreased after age 8 and suggest changes to diagnostic criteria as a possible cause (65). Assuming true autism prevalence increases with age as individuals can be diagnosed well into adulthood, this result shows that it is easier for young children to access SEED funding in Chile. This could be the result of improved awareness of the SEED programme and policy changes in Chile to increase accessibility and participation for students with autism (14), and could also indicate that students with autism need fewer schooling interventions as they mature.

A lower bound on ADHD prevalence in Chile is 1.50% (1.48- 1.51%) which is much lower than de la Barra et al. and Vicente et al.’s prevalence values of 10.0% and 12.6% respectively (41,42). This is most likely due to the data providing at most one special needs code per student, the high rate of co-diagnosis of ADHD and autism, and autism being more likely to be recorded than ADHD in the case of co-diagnosis (38). More work focused on ADHD will be needed to quantify how far this lower bound is from the true ADHD prevalence in Chile. The crude prevalence of ADHD in Chilean students is highest for early teenagers then decreases somewhat and this pattern is preserved across demographic features. This suggests ADHD is diagnosed later than autism which is somewhat consistent with others’ work including Sainsbury et al. who note that autism is typically diagnosed at age 5 and ADHD at age 6 (66). The observed decrease in ADHD prevalence in later teenage years could indicate reduced ability to access schooling interventions with age, or reduced need for them.

This investigation appears to show autism and ADHD prevalence is very low in students with the highest socio-economic status, however this is most likely due to data artefacts as privately educated students are ineligible for SEED funding and therefore will not appear as having either condition in this data. No other clear differences in the prevalence of autism or of ADHD by socio-economic status have been found. For ADHD, this is consistent with de la Barra et al.’s findings in Chile (41).

Prevalence of autism and ADHD is lower among students of the Mapuche Indigenous group than among non-Indigenous students. For ADHD, prevalence is even lower among members of other Indigenous groups. For autism, prevalence in other Indigenous groups is lower than for non-Indigenous groups but higher than for Mapuche. This agrees with Lindblom’s findings that Indigenous children with autism in Canada’s British Columbia are underrepresented in school data (67). However it is important to note here that people Indigenous to different regions are not necessarily comparable and very little research has been done on autism and ADHD in Indigenous people in Latin America.

Autism and ADHD prevalence is higher in students at rural schools than urban schools which is somewhat surprising as urban areas generally have more resources to diagnose and provide adjustments for these

Posterior predictive distribution for health service specific uniform priors

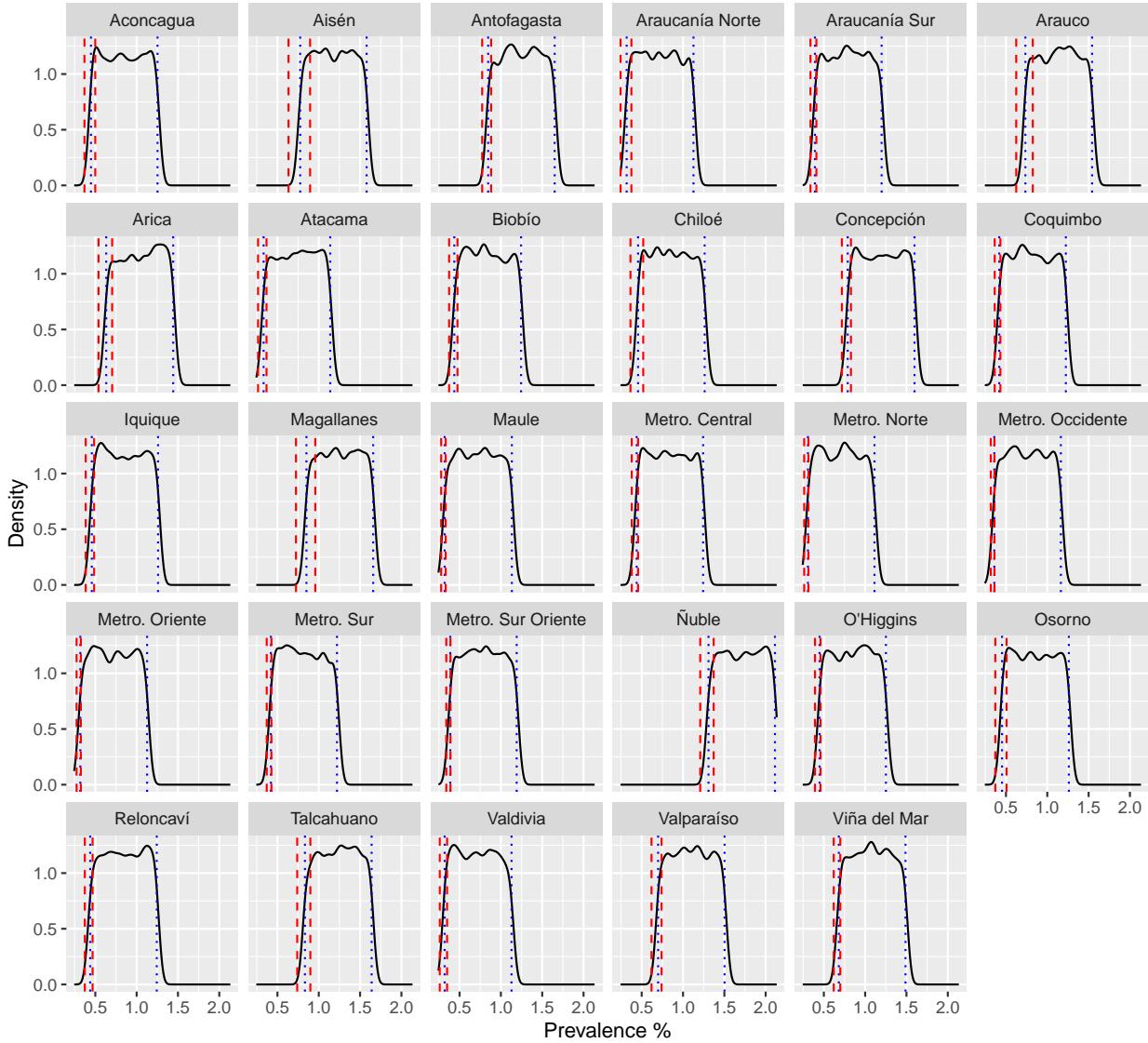


Figure 40: Posterior predictive distributions for autism prevalence using adjusted case counts from the school data with a random effect on student's health service. Modelling used uniform priors bounded below by health service specific age- and sex-adjusted autism prevalence from school data, and bounded above by health service specific age- and sex-adjusted updated autism prevalence from data linkage. Red dashed lines show the adjusted sample prevalence 95% gamma confidence intervals and blue dotted lines show the posterior 95% credible interval.

conditions, but may be the result of successful implementation of policy interventions described by Núñez and Manzano that aimed to improve healthcare for disadvantaged areas and population groups (6).

#### **6.1.2 Aim 2: Use clinical data and machine learning to identify autism diagnosis characteristics**

MCA revealed that age, ethnicity and commune of residence, and to some extent other disability status, foster care status and health insurance level, are important features for understanding the distribution of autism diagnosis. The clustering of patients based on whether information was available for other disability and foster care status shows that missingness in demographic data is important when understanding autism diagnoses. The variance explained by the available features is not large enough to draw strong conclusions about possible composite components associated with autism diagnosis, but it does indicate that further investigation with larger dataset and more demographic characteristics are likely to lead to interesting results.

#### **6.1.3 Aim 3a: Use machine learning to link school and clinical records**

Chi squared testing showed that students living in SSAS are different to students in other communes by age band, SES, ethnicity, rurality and special needs status. For the most part this is not surprising as La Araucanía region is known to be poor, rural and have a large Mapuche population (10,13,68). SSAS has a somewhat older student population than other regions and significantly fewer students access SEED funding for any condition, meaning the adjusted autism prevalence estimate for SSAS from the school data only of 0.37% is likely to be an underestimate.

Both manual and probabilistic linkage of SSAS school and patient data of individuals with autism were able to identify a reasonable number of matches. Probabilistic matching was more effective than manual matching here because matching on commune of residence was desirable but not essential, proxy SES features were known to be imprecise so requiring perfect matches would miss many correct matches, and probabilistic matching was able to identify more likely matches.

The proportions of matched and unmatched records in the SSAS school and patient datasets did differ by sex, commune of residence and proxy SES. The differences appear to be driven by differences in the frequency of these features' categories across the two datasets.

#### **6.1.4 Aim 3b: Accurately estimate autism prevalence and unmet need, project estimates across health services using Bayesian prevalence prediction**

The updated estimate for the prevalence of autism in SSAS is 1.22% (1.16 - 1.28%). It is likely to be an underestimate due to not having private sector diagnoses in the clinical data. Projected nationally, the estimated prevalence of autism in Chile is 1.31% (1.25 - 1.38). This estimate is somewhat smaller than Yáñez et al's estimate of 1.96% (0.81-4.63) in Santiago communes but well within their estimate's wide confidence interval (24). It is also lower than Roman-Urrestarazu et al.'s estimate of 1.76% (1.75%-1.77%) from similar school records for 120,000 English children (30). This suggests either that the data linkage conducted here has missed some autism cases, or that autism prevalence is lower or diagnosis less available in Chile than in England.

Using the updated prevalence estimate for SSAS, the male to female ratio is 4.18:1. This is consistent with the 4:1 ratio found by Yáñez et al (24), reasonably consistent with Roman-Urrestarazu et al.'s finding of a 4.32:1 ratio in England (30) and higher than the 3:1 ratio found by Loomes, Hull and Mandy though meta-analysis of studies in North America, Europe, East Asia, the Middle East, Australia, Aruba and Venezuela (31). This updated ratio is close to the ratio of 3.99:1 observed here in the patient data alone. It is much lower than the ratio for the whole school dataset of 6.00:1 which was itself lower than the 7.00:1 ratio observed for the SSAS school data before linkage. Taken together, this suggests females with autism are underrepresented in the school data and particularly underrepresented in the SSAS subset of the school data, which could indicate that there are barriers to females accessing SEED for autism.

Projecting the adjusted prevalence delta across all regions resulted in updated estimates for all health services that are comparable to Yáñez et al's estimate (24). Ñuble's standard adjusted prevalence estimate is considerably higher than for other communes which may indicate that Ñuble uses a different approach for

autism SEED funding assessment and this figure may be more indicative of Chile's true autism prevalence. Using the same adjusted prevalence delta for all regions may not have been appropriate given the regions differ considerably in prevalence observed from the school data. Additionally, SSAS is in the bottom third of adjusted prevalence estimates, meaning it is likely to have a larger difference between adjusted prevalence from the school data and true prevalence. If we can assume the adjusted updated prevalence for SSAS is the true autism prevalence of Chile then the delta to reach this will be larger for SSAS than for regions with higher original adjusted prevalence from the school data. Therefore using SSAS's delta in higher prevalence regions will produce overestimates. Ñuble's adjusted updated prevalence is 2.13% which is possible but there is a phenotypic upper bound on true autism prevalence and it is more likely that a larger proportion of people with autism in Ñuble are accessing SEED than in other regions, or that many students in Ñuble have been misdiagnosed with autism.

This investigation found an unmet need of 1,132 students in SSAS that did not access SEED for their autism in 2021. It also projected an unmet need of 25,903 students across Chile. This unmet need is likely an overestimate as it includes students with an autism diagnosis at non-subsidised private schools that were not eligible for SEED but may have received other school-based support, students that did receive SEED but for another condition, and students that did not need or did not want school-based interventions. However it may also underestimate the number of students with autism that did not access SEED because it does not include students diagnosed with autism in the private health sector. The accuracy of this estimate of unmet need relies on the assumption that the difference between prevalence values observed for SSAS in the school data with and without supplementation with clinical data is applicable to the national prevalence which may not be the case given we have shown above that the student population of SSAS does differ from other health services and is not nationally representative. Measured over time, the unmet need estimate could be used to assess the effectiveness of PIE interventions to integrate students with special needs in public schools (17).

The Bayes prevalence projection was able to circumvent issues with the applicability of the adjusted prevalence delta by modelling prevalence within plausible bounds provided by the school and clinical dataset. The theoretical approach presented by Ince et al. (46) was attempted and found to be ineffective here – the low prevalence of autism in these data caused calculation of the exact posterior predictive distribution to very quickly reach the limit of R's computational precision. Markov chain Monte Carlo sampling overcame this impediment and is demonstrably a more effective approach than Ince et al.'s (46) for prevalence estimation of low frequency conditions in large epidemiological datasets. Using uniform priors specific to the health services that spanned from the lower bounds found through frequentist methods to the possibly overestimated adjusted updated prevalence values found through linkage, the Bayesian modelling found that the true prevalence of autism in each health service is likely to be considerably higher than the prevalence observed for each using the school data alone. This analysis has determined a plausible range within which the true prevalence for each health service catchment area is quantifiably likely to fall.

## 6.2 Limitations

This investigation is limited by the quality of available data. Firstly, the school data is limited by having only one special needs code available per student as it is based on their SEED status and not all their extant special needs diagnoses. This limitation prompted the use of clinical data to supplement the available diagnoses, however these data are also somewhat limited as validated diagnoses and demographic information were only available for some patients. Additionally, it only includes patients treated in the public health system and the number of patients with autism that are treated privately is unknown. Autism prevalence estimates using clinical data may therefore be underestimates.

During MCA, the other disability and foster care status features were very unbalanced with few patients having a recorded disability and even fewer having experienced foster care. For both features, nearly two thirds of records had no information available and while reasonable imputation was used, any imputation adds bias to the results and here the bias is likely to be considerable as so many values were imputed. This means the MCA results should be taken as indicative and more research done on larger, more complete dataset to confirm them.

Linkage of school and patient data for SSAS used matching on proxy SES. In the school data, SES was

mapped from school fees paid and in the patient data it was mapped from health insurance contributions. These underlying features may not be comparable and the mapping to SES used for each was imprecise. To account for this, a high error rate was declared when allocating weights during probabilistic linkage, however some incorrect matches based on SES may have been made or correct matches been missed. Linkage also assumed that individuals did not move into or out of SSAS communes between collection of the school and patient data. This is unlikely to be true and a small number of correct matches are likely to have been missed due to individuals who moved not being included in one of the SSAS school data or the patient data being linked. Missed correct matches would cause the updated prevalence estimate for SSAS to be slightly too high and therefore projected updated estimates to also be slightly too high.

The Bayesian modelling did use information from the sample data, the full school dataset, twice during modelling, to varying extents for each prior. For all four analyses, random effects models were fit to health services. For the second prior, which used health service specific autism prevalence, this meant the sample data was directly used twice which generally would not be informative but here was valuable to evidence the lower bound on the true prevalence values. For the first prior, the sample data was used indirectly to calculate the common national prevalence and was valuable to demonstrate that the prevalence values observed from the school data can only be underestimates of the true prevalence. For the third prior, using the updated prevalence values found through data linkage, the sample data was used indirectly to give the prevalence values to which delta was added, and the fourth prior combined the second and third. Although it is usually not appropriate to use sample data twice in Bayesian modelling, it was considered acceptable here as the intention was to conduct exploratory analysis to project the bounds on prevalence rather than predict the true autism prevalence across the other health services.

### 6.3 Extensions

While this investigation has progressed the understanding of autism and ADHD prevalence in Chile, it has also uncovered new avenues for exploration. If clinical data on ADHD diagnoses were available for a region of Chile, the MCA analysis, data linkage, updated prevalence and unmet need estimation, and Bayesian projection conducted here for autism could be extended to ADHD. If clinical data on autism for other health service regions were available, the delta calculation could be validated and thus more accurate autism prevalence estimates could be found.

This investigation has considered autism and ADHD in isolation from each other. However, given 59.1% of people with autism have a co-diagnosis of ADHD (40), it would be valuable to consider these conditions together. MCA of autism patient data could be used to assess contributions from ADHD and other co-diagnoses such as depression and anxiety, physical disability and intellectual disability.

This investigation used MCA to assess the contribution of feature categories among patients with autism in SSAS which required casting the age feature to categorical age bands. However age is a continuous variable and the information contained in it would be better captured using a continuous variable analysis technique such as principle component analysis. The commune feature would need to be excluded because it cannot be meaningfully encoded as a continuous or ordered categorical variable. The remaining features could be one-hot encoded to pseudo-continuous variables before performing PCA. This would allow the contribution of patient age to be better characterised but one-hot encoding would somewhat reduce the power of inferences about the other features used. Cluster-based analysis of a larger dataset containing patients with and without autism would also be valuable and would allow further identification of the characteristics associated with autism diagnosis.

During data linkage, this investigation assumed that unmatched patients in the clinical data existed in the school data but did not have an autism diagnosis in the school data. It would be valuable to test this assumption by attempting to link the patient data for SSAS to all school records for SSAS, including those students that did not have an autism diagnosis. This would allow the number of patients that did not exist in the school data to be estimated which would provide a more accurate sample size for use as the denominator in prevalence calculations.

This investigation assumed the adjusted prevalence delta found for SSAS was directly applicable to other regions which may not be the case. Further analysis using Bayesian prevalence projection could use health

Table 17: Count and prevalence of autism cases by age band in Chile school data with normal confidence intervals.

Age band	Autism cases	Prevalence % (95% CI)
6-8	5162	0.69 (0.67, 0.71)
9-11	4212	0.55 (0.53, 0.57)
12-14	3038	0.41 (0.39, 0.42)
15-18	2137	0.27 (0.26, 0.28)

Table 18: Count and prevalence of ADHD cases by age band in Chile school data with normal confidence intervals.

Age band	ADHD cases	Prevalence % (95% CI)
6-8	5936	0.79 (0.77, 0.81)
9-11	15549	2.03 (1.99, 2.06)
12-14	14099	1.88 (1.85, 1.91)
15-18	10640	1.35 (1.32, 1.37)

service specific deltas that are inversely proportional to the sample prevalence observed for each health service. This would decrease the delta for services with high observed prevalence and thus lessen the increase in the updated prevalence estimate, and would increase the updated prevalence estimate for health services with low observed prevalence. This would provide more biologically plausible prevalence estimates, however such Bayesian analysis would still be using information from the school data twice – as the sample data and to inform the health service specific prior through use of observed prevalence to scale delta.

Future work could replicate the prevalence estimation conducted here using the UK Department for Education’s National Pupil Database which is similar to the school data used here. This would provide an interesting comparison of autism and ADHD prevalence in two large countries with different population structures and ethnic profiles.

## 7 Conclusions

This investigation has furthered the understanding of autism and ADHD prevalence in Chile. Autism prevalence is at least 0.46% (0.13% in females, 0.79% in males and male to female ratio of 6.00:1) and ADHD prevalence is at least 1.5% (1.01% in females, 1.97% in males and male to female ratio of 1.94:1). Both autism and ADHD are more prevalent in non-Indigenous students and students at rural schools, and neither have a clear difference in prevalence by SES. In Servicio de Salud Araucanía Sur, age, ethnicity and commune of residence are important components for explaining the variance in data on patients with autism. School data and patient data on individuals with autism in SSAS were successfully linked. From linkage, a more accurate estimate of the prevalence of autism in this region is 1.22% (male to female ratio of 4.18:1) and the estimated prevalence in Chile is 1.31%. The unmet need of students with autism that did not receive SEED funding for support with it is 1,132 students in SSAS and a posited 25,903 across Chile. Linkage also revealed females are likely underrepresented in school autism diagnoses. Bayesian prevalence projection extended prevalence projections across health services and found plausible prevalence bounds for each health service.

## 8 Supplementary materials

Table 19: Count and prevalence of autism cases by age band in Chile school data for females and males with normal confidence intervals.

Age band	Female		Male	
	Autism cases	Prevalence % (95% CI)	Autism cases	Prevalence % (95% CI)
6-8	774	0.21 (0.20, 0.23)	4388	1.15 (1.11, 1.18)
9-11	523	0.14 (0.13, 0.15)	3689	0.94 (0.91, 0.97)
12-14	391	0.11 (0.10, 0.12)	2647	0.69 (0.66, 0.72)
15-18	290	0.08 (0.07, 0.08)	1847	0.45 (0.43, 0.47)

Table 20: Count and prevalence of ADHD cases by age band in Chile school data for females and males with normal confidence intervals.

Age band	Female		Male	
	ADHD cases	Prevalence % (95% CI)	ADHD cases	Prevalence % (95% CI)
6-8	774	0.21 (0.20, 0.23)	3944	1.03 (1.00, 1.06)
9-11	523	0.14 (0.13, 0.15)	10322	2.62 (2.57, 2.67)
12-14	391	0.11 (0.10, 0.12)	9714	2.53 (2.48, 2.58)
15-18	290	0.08 (0.07, 0.08)	7165	1.75 (1.71, 1.79)

Table 21: Count and prevalence of autism cases by health service and age band in Chile school data for females and males with normal confidence intervals.

Health service	Age band	Female		Male	
		Autism cases	Prevalence % (95% CI)	Autism cases	Prevalence % (95% CI)
Aconcagua	6-8	<20	0.25 (0.12, 0.38)	59	0.99 (0.74, 1.24)
Aisén	6-8	<20	0.40 (0.14, 0.66)	52	2.29 (1.67, 2.90)
Antofagasta	6-8	54	0.39 (0.29, 0.50)	302	2.09 (1.85, 2.32)
Araucanía Norte	6-8	<20	0.07 (0.00, 0.15)	32	0.69 (0.45, 0.93)
Araucanía Sur	6-8	26	0.17 (0.10, 0.23)	139	0.86 (0.72, 1.00)
Arauco	6-8	<20	0.29 (0.12, 0.46)	67	1.79 (1.36, 2.21)
Arica	6-8	<20	0.34 (0.18, 0.49)	94	1.63 (1.31, 1.96)
Atacama	6-8	<20	0.26 (0.14, 0.39)	53	0.75 (0.55, 0.95)
Biobío	6-8	<20	0.14 (0.06, 0.23)	92	1.06 (0.85, 1.28)
Chiloé	6-8	<20	0.06 (0.00, 0.14)	38	1.07 (0.73, 1.41)
Concepción	6-8	44	0.34 (0.24, 0.43)	252	1.87 (1.64, 2.10)
Coquimbo	6-8	36	0.21 (0.14, 0.28)	207	1.14 (0.98, 1.29)
Iquique	6-8	<20	0.18 (0.09, 0.27)	100	1.11 (0.89, 1.33)
Magallanes	6-8	<20	0.19 (0.04, 0.35)	42	1.30 (0.91, 1.70)
Maule	6-8	41	0.19 (0.13, 0.24)	193	0.84 (0.72, 0.96)
Metro. Central	6-8	22	0.16 (0.09, 0.22)	162	1.07 (0.91, 1.23)
Metro. Norte	6-8	26	0.12 (0.07, 0.17)	174	0.77 (0.65, 0.88)
Metro. Occidente	6-8	62	0.16 (0.12, 0.20)	323	0.81 (0.72, 0.90)
Metro. Oriente	6-8	31	0.14 (0.09, 0.19)	154	0.69 (0.58, 0.80)
Metro. Sur	6-8	44	0.18 (0.13, 0.24)	261	1.04 (0.91, 1.16)
Metro. Sur Oriente	6-8	41	0.15 (0.10, 0.20)	277	0.95 (0.84, 1.07)
O'Higgins	6-8	38	0.20 (0.14, 0.26)	215	1.08 (0.94, 1.22)
Osorno	6-8	<20	0.20 (0.07, 0.33)	51	1.08 (0.78, 1.37)
Reloncaví	6-8	22	0.24 (0.14, 0.34)	96	1.02 (0.82, 1.23)
Talcahuano	6-8	25	0.40 (0.24, 0.55)	129	1.96 (1.63, 2.30)
Valdivia	6-8	<20	0.15 (0.06, 0.23)	71	0.90 (0.69, 1.10)
Valparaíso	6-8	22	0.23 (0.13, 0.33)	156	1.57 (1.33, 1.82)
Viña del Mar	6-8	55	0.27 (0.20, 0.34)	292	1.37 (1.21, 1.52)
Ñuble	6-8	57	0.63 (0.46, 0.79)	305	3.21 (2.85, 3.56)

Table 21: Count and prevalence of autism cases by health service and age band in Chile school data for females and males with normal confidence intervals.  
*(continued)*

Health service	Age band	Female		Male	
		Autism cases	Prevalence % (95% CI)	Autism cases	Prevalence % (95% CI)
Aconcagua	9-11	<20	0.05 (0.00, 0.11)	59	0.95 (0.71, 1.20)
Aisén	9-11	<20	0.08 (0.00, 0.20)	26	1.05 (0.65, 1.45)
Antofagasta	9-11	45	0.30 (0.22, 0.39)	260	1.67 (1.47, 1.87)
Araucanía Norte	9-11	<20	0.09 (0.00, 0.18)	26	0.57 (0.35, 0.79)
Araucanía Sur	9-11	<20	0.10 (0.05, 0.15)	120	0.71 (0.58, 0.83)
Arauco	9-11	<20	0.23 (0.08, 0.38)	70	1.73 (1.33, 2.13)
Arica	9-11	<20	0.20 (0.08, 0.31)	57	0.95 (0.71, 1.20)
Atacama	9-11	<20	0.09 (0.02, 0.16)	45	0.59 (0.42, 0.76)
Biobío	9-11	<20	0.19 (0.09, 0.28)	68	0.76 (0.58, 0.94)
Chiloé	9-11	<20	0.06 (0.00, 0.13)	49	1.27 (0.92, 1.63)
Concepción	9-11	30	0.22 (0.14, 0.30)	216	1.49 (1.29, 1.69)
Coquimbo	9-11	<20	0.10 (0.05, 0.14)	145	0.78 (0.65, 0.90)
Iquique	9-11	<20	0.19 (0.09, 0.28)	80	0.86 (0.67, 1.04)
Magallanes	9-11	<20	0.17 (0.03, 0.31)	60	1.73 (1.30, 2.17)
Maule	9-11	<20	0.07 (0.04, 0.11)	140	0.60 (0.50, 0.70)
Metro. Central	9-11	<20	0.11 (0.06, 0.17)	136	0.86 (0.72, 1.00)
Metro. Norte	9-11	<20	0.07 (0.04, 0.11)	147	0.62 (0.52, 0.72)
Metro. Occidente	9-11	28	0.09 (0.05, 0.12)	234	0.67 (0.59, 0.76)
Metro. Oriente	9-11	24	0.11 (0.06, 0.15)	129	0.55 (0.46, 0.65)
Metro. Sur	9-11	38	0.15 (0.10, 0.20)	238	0.90 (0.79, 1.01)
Metro. Sur Oriente	9-11	24	0.08 (0.05, 0.12)	191	0.63 (0.54, 0.72)
O'Higgins	9-11	30	0.15 (0.10, 0.21)	193	0.92 (0.79, 1.05)
Osorno	9-11	<20	0.12 (0.02, 0.22)	54	1.05 (0.77, 1.32)
Reloncaví	9-11	<20	0.09 (0.03, 0.15)	81	0.80 (0.62, 0.97)
Talcahuano	9-11	25	0.38 (0.23, 0.52)	132	1.87 (1.55, 2.18)
Valdivia	9-11	<20	0.05 (0.00, 0.10)	38	0.45 (0.31, 0.59)
Valparaíso	9-11	<20	0.16 (0.08, 0.23)	122	1.23 (1.01, 1.44)
Viña del Mar	9-11	47	0.22 (0.16, 0.28)	294	1.32 (1.17, 1.48)
Ñuble	9-11	39	0.41 (0.28, 0.54)	279	2.82 (2.50, 3.15)
Aconcagua	12-14	<20	0.11 (0.02, 0.20)	38	0.67 (0.45, 0.88)
Aisén	12-14	<20	0.24 (0.05, 0.44)	25	0.94 (0.57, 1.31)
Antofagasta	12-14	28	0.19 (0.12, 0.27)	170	1.09 (0.93, 1.25)
Araucanía Norte	12-14	<20	0.13 (0.03, 0.24)	21	0.44 (0.25, 0.63)
Araucanía Sur	12-14	<20	0.07 (0.03, 0.12)	94	0.57 (0.45, 0.68)
Arauco	12-14	<20	0.14 (0.02, 0.25)	46	1.17 (0.84, 1.51)
Arica	12-14	<20	0.19 (0.07, 0.31)	44	0.80 (0.57, 1.04)
Atacama	12-14	<20	0.04 (0.00, 0.09)	28	0.37 (0.23, 0.51)
Biobío	12-14	<20	0.06 (0.01, 0.11)	58	0.63 (0.47, 0.79)
Chiloé	12-14	<20	0.03 (0.00, 0.08)	32	0.79 (0.52, 1.06)
Concepción	12-14	28	0.22 (0.14, 0.30)	155	1.14 (0.96, 1.32)
Coquimbo	12-14	<20	0.08 (0.04, 0.13)	88	0.51 (0.40, 0.62)
Iquique	12-14	<20	0.10 (0.03, 0.17)	52	0.58 (0.42, 0.74)
Magallanes	12-14	<20	0.20 (0.05, 0.35)	55	1.55 (1.15, 1.96)
Maule	12-14	<20	0.07 (0.04, 0.11)	86	0.37 (0.29, 0.45)
Metro. Central	12-14	<20	0.03 (0.00, 0.06)	96	0.62 (0.49, 0.74)
Metro. Norte	12-14	<20	0.07 (0.03, 0.11)	78	0.35 (0.27, 0.42)
Metro. Occidente	12-14	25	0.08 (0.05, 0.11)	186	0.56 (0.48, 0.64)
Metro. Oriente	12-14	21	0.10 (0.05, 0.14)	122	0.54 (0.45, 0.64)
Metro. Sur	12-14	<20	0.07 (0.04, 0.11)	137	0.54 (0.45, 0.63)
Metro. Sur Oriente	12-14	<20	0.06 (0.03, 0.09)	172	0.57 (0.49, 0.66)
O'Higgins	12-14	21	0.11 (0.06, 0.15)	116	0.57 (0.47, 0.67)
Osorno	12-14	<20	0.12 (0.02, 0.22)	27	0.53 (0.33, 0.72)
Reloncaví	12-14	<20	0.13 (0.06, 0.21)	63	0.61 (0.46, 0.76)
Talcahuano	12-14	<20	0.17 (0.07, 0.26)	87	1.23 (0.97, 1.49)
Valdivia	12-14	<20	0.04 (0.00, 0.08)	43	0.51 (0.36, 0.66)
Valparaíso	12-14	<20	0.17 (0.09, 0.26)	107	1.11 (0.90, 1.32)
Viña del Mar	12-14	31	0.15 (0.10, 0.20)	230	1.08 (0.94, 1.22)

Table 21: Count and prevalence of autism cases by health service and age band  
in Chile school data for females and males with normal confidence intervals.  
(continued)

Health service	Age band	Female		Male	
		Autism cases	Prevalence % (95% CI)	Autism cases	Prevalence % (95% CI)
Ñuble	12-14	34	0.35 (0.23, 0.46)	191	1.87 (1.61, 2.13)
Aconcagua	15-18	<20	0.07 (0.00, 0.14)	22	0.36 (0.21, 0.51)
Aisén	15-18	<20	0.19 (0.02, 0.36)	24	0.85 (0.51, 1.19)
Antofagasta	15-18	25	0.17 (0.10, 0.23)	120	0.76 (0.62, 0.89)
Araucanía Norte	15-18	<20	0.02 (0.00, 0.06)	<20	0.34 (0.18, 0.51)
Araucanía Sur	15-18	<20	0.04 (0.01, 0.07)	74	0.42 (0.32, 0.51)
Arauco	15-18	<20	0.00 (0.00, 0.00)	21	0.50 (0.29, 0.71)
Arica	15-18	<20	0.07 (0.00, 0.14)	35	0.61 (0.41, 0.81)
Atacama	15-18	<20	0.04 (0.00, 0.09)	23	0.30 (0.18, 0.42)
Biobío	15-18	<20	0.07 (0.01, 0.12)	51	0.52 (0.38, 0.66)
Chiloé	15-18	<20	0.02 (0.00, 0.07)	<20	0.31 (0.15, 0.47)
Concepción	15-18	23	0.17 (0.10, 0.24)	111	0.76 (0.62, 0.91)
Coquimbo	15-18	<20	0.06 (0.02, 0.10)	63	0.35 (0.26, 0.43)
Iquique	15-18	<20	0.02 (0.00, 0.06)	44	0.48 (0.34, 0.62)
Magallanes	15-18	<20	0.38 (0.18, 0.57)	43	1.06 (0.74, 1.37)
Maule	15-18	<20	0.06 (0.03, 0.09)	51	0.21 (0.15, 0.27)
Metro. Central	15-18	<20	0.07 (0.03, 0.11)	67	0.40 (0.30, 0.49)
Metro. Norte	15-18	<20	0.05 (0.02, 0.08)	62	0.26 (0.19, 0.32)
Metro. Occidente	15-18	<20	0.04 (0.02, 0.07)	122	0.35 (0.29, 0.42)
Metro. Oriente	15-18	<20	0.04 (0.01, 0.06)	65	0.26 (0.20, 0.32)
Metro. Sur	15-18	<20	0.04 (0.01, 0.06)	86	0.33 (0.26, 0.40)
Metro. Sur Oriente	15-18	<20	0.05 (0.02, 0.07)	131	0.40 (0.33, 0.47)
O'Higgins	15-18	<20	0.08 (0.04, 0.12)	72	0.33 (0.25, 0.40)
Osorno	15-18	<20	0.04 (0.00, 0.09)	24	0.43 (0.26, 0.60)
Reloncaví	15-18	<20	0.02 (0.00, 0.05)	52	0.47 (0.34, 0.59)
Talcahuano	15-18	<20	0.12 (0.04, 0.19)	42	0.56 (0.39, 0.74)
Valdivia	15-18	<20	0.01 (0.00, 0.04)	35	0.39 (0.26, 0.52)
Valparaíso	15-18	<20	0.11 (0.05, 0.18)	91	0.85 (0.68, 1.02)
Viña del Mar	15-18	35	0.16 (0.11, 0.22)	172	0.73 (0.62, 0.84)
Ñuble	15-18	27	0.26 (0.16, 0.36)	113	1.02 (0.83, 1.21)

Table 22: Count and prevalence of ADHD cases by health service and age band  
in Chile school data for females and males with normal confidence intervals.

Health service	Age band	Female		Male	
		ADHD cases	Prevalence % (95% CI)	ADHD cases	Prevalence % (95% CI)
Aconcagua	6-8	56	0.99 (0.74, 1.25)	71	1.19 (0.91, 1.46)
Aisén	6-8	<20	0.54 (0.23, 0.84)	38	1.67 (1.14, 2.20)
Antofagasta	6-8	66	0.48 (0.36, 0.59)	106	0.73 (0.59, 0.87)
Araucanía Norte	6-8	24	0.57 (0.34, 0.79)	52	1.13 (0.82, 1.43)
Araucanía Sur	6-8	99	0.63 (0.51, 0.76)	206	1.27 (1.10, 1.45)
Arauco	6-8	20	0.53 (0.30, 0.76)	49	1.31 (0.94, 1.67)
Arica	6-8	<20	0.32 (0.17, 0.47)	46	0.80 (0.57, 1.03)
Atacama	6-8	<20	0.10 (0.03, 0.18)	20	0.28 (0.16, 0.41)
Biobío	6-8	79	0.95 (0.74, 1.16)	133	1.54 (1.28, 1.79)
Chiloé	6-8	28	0.85 (0.54, 1.16)	66	1.86 (1.42, 2.31)
Concepción	6-8	101	0.77 (0.62, 0.92)	162	1.20 (1.02, 1.38)
Coquimbo	6-8	105	0.61 (0.50, 0.73)	234	1.29 (1.12, 1.45)
Iquique	6-8	35	0.42 (0.28, 0.56)	96	1.07 (0.85, 1.28)
Magallanes	6-8	<20	0.55 (0.29, 0.81)	57	1.77 (1.31, 2.22)
Maule	6-8	69	0.31 (0.24, 0.39)	182	0.79 (0.68, 0.91)
Metro. Central	6-8	87	0.62 (0.49, 0.75)	173	1.14 (0.97, 1.31)
Metro. Norte	6-8	114	0.53 (0.43, 0.62)	218	0.96 (0.84, 1.09)
Metro. Occidente	6-8	167	0.43 (0.37, 0.50)	296	0.74 (0.66, 0.82)

Table 22: Count and prevalence of ADHD cases by health service and age band in Chile school data for females and males with normal confidence intervals.  
*(continued)*

Health service	Age band	Female		Male	
		ADHD cases	Prevalence % (95% CI)	ADHD cases	Prevalence % (95% CI)
Metro. Oriente	6-8	115	0.53 (0.43, 0.62)	202	0.90 (0.78, 1.03)
Metro. Sur	6-8	131	0.55 (0.45, 0.64)	240	0.95 (0.83, 1.07)
Metro. Sur Oriente	6-8	189	0.69 (0.59, 0.79)	355	1.22 (1.10, 1.35)
O'Higgins	6-8	124	0.65 (0.54, 0.77)	252	1.27 (1.11, 1.42)
Osorno	6-8	<20	0.36 (0.18, 0.53)	32	0.68 (0.44, 0.91)
Reloncaví	6-8	41	0.45 (0.31, 0.59)	76	0.81 (0.63, 0.99)
Talcahuano	6-8	62	0.99 (0.74, 1.23)	110	1.67 (1.36, 1.98)
Valdivia	6-8	41	0.54 (0.38, 0.71)	102	1.29 (1.04, 1.54)
Valparaíso	6-8	34	0.36 (0.24, 0.47)	89	0.90 (0.71, 1.08)
Viña del Mar	6-8	79	0.38 (0.30, 0.47)	171	0.80 (0.68, 0.92)
Ñuble	6-8	57	0.63 (0.46, 0.79)	110	1.16 (0.94, 1.37)
Aconcagua	9-11	144	2.45 (2.06, 2.85)	246	3.98 (3.49, 4.47)
Aisén	9-11	38	1.60 (1.10, 2.11)	94	3.79 (3.04, 4.55)
Antofagasta	9-11	143	0.97 (0.81, 1.12)	275	1.76 (1.56, 1.97)
Araucanía Norte	9-11	34	0.78 (0.52, 1.04)	130	2.85 (2.37, 3.33)
Araucanía Sur	9-11	240	1.48 (1.29, 1.66)	487	2.87 (2.62, 3.12)
Arauco	9-11	47	1.21 (0.86, 1.55)	107	2.64 (2.15, 3.13)
Arica	9-11	60	1.07 (0.80, 1.34)	118	1.97 (1.62, 2.32)
Atacama	9-11	28	0.37 (0.24, 0.51)	62	0.81 (0.61, 1.01)
Biobío	9-11	175	2.03 (1.73, 2.32)	329	3.67 (3.28, 4.06)
Chiloé	9-11	83	2.31 (1.82, 2.80)	183	4.76 (4.09, 5.43)
Concepción	9-11	333	2.41 (2.16, 2.67)	633	4.37 (4.03, 4.70)
Coquimbo	9-11	321	1.76 (1.57, 1.96)	545	2.93 (2.68, 3.17)
Iquique	9-11	108	1.25 (1.02, 1.48)	245	2.62 (2.30, 2.95)
Magallanes	9-11	83	2.39 (1.89, 2.90)	167	4.82 (4.11, 5.54)
Maule	9-11	227	1.03 (0.90, 1.17)	567	2.43 (2.24, 2.63)
Metro. Central	9-11	198	1.34 (1.15, 1.52)	430	2.72 (2.47, 2.97)
Metro. Norte	9-11	299	1.36 (1.20, 1.51)	507	2.15 (1.96, 2.33)
Metro. Occidente	9-11	372	1.14 (1.02, 1.25)	713	2.05 (1.90, 2.20)
Metro. Oriente	9-11	238	1.07 (0.94, 1.21)	478	2.05 (1.87, 2.23)
Metro. Sur	9-11	386	1.54 (1.39, 1.70)	656	2.48 (2.29, 2.67)
Metro. Sur Oriente	9-11	446	1.56 (1.41, 1.70)	813	2.70 (2.52, 2.88)
O'Higgins	9-11	318	1.60 (1.43, 1.78)	650	3.11 (2.88, 3.35)
Osorno	9-11	40	0.81 (0.56, 1.06)	95	1.84 (1.48, 2.21)
Reloncaví	9-11	80	0.83 (0.65, 1.01)	201	1.97 (1.70, 2.24)
Talcahuano	9-11	200	3.02 (2.60, 3.43)	316	4.47 (3.99, 4.95)
Valdivia	9-11	81	0.99 (0.77, 1.20)	179	2.12 (1.81, 2.42)
Valparaíso	9-11	99	1.03 (0.83, 1.23)	200	2.01 (1.74, 2.29)
Viña del Mar	9-11	231	1.09 (0.95, 1.23)	531	2.39 (2.19, 2.59)
Ñuble	9-11	175	1.83 (1.57, 2.10)	365	3.70 (3.32, 4.07)
Aconcagua	12-14	84	1.52 (1.20, 1.84)	187	3.27 (2.81, 3.74)
Aisén	12-14	39	1.58 (1.09, 2.07)	112	4.22 (3.45, 4.98)
Antofagasta	12-14	94	0.65 (0.52, 0.78)	248	1.59 (1.40, 1.79)
Araucanía Norte	12-14	44	0.97 (0.68, 1.25)	118	2.48 (2.04, 2.92)
Araucanía Sur	12-14	153	0.95 (0.80, 1.10)	389	2.34 (2.11, 2.57)
Arauco	12-14	33	0.89 (0.59, 1.19)	118	3.01 (2.48, 3.55)
Arica	12-14	35	0.67 (0.45, 0.89)	136	2.48 (2.07, 2.89)
Atacama	12-14	31	0.43 (0.28, 0.58)	59	0.78 (0.58, 0.98)
Biobío	12-14	140	1.61 (1.35, 1.87)	358	3.90 (3.50, 4.30)
Chiloé	12-14	95	2.49 (1.99, 2.98)	209	5.15 (4.47, 5.83)
Concepción	12-14	374	2.91 (2.62, 3.20)	641	4.72 (4.36, 5.08)
Coquimbo	12-14	286	1.71 (1.52, 1.91)	565	3.27 (3.01, 3.54)
Iquique	12-14	100	1.22 (0.98, 1.46)	209	2.33 (2.02, 2.65)
Magallanes	12-14	81	2.35 (1.84, 2.86)	178	5.02 (4.30, 5.74)
Maule	12-14	197	0.89 (0.77, 1.02)	544	2.36 (2.16, 2.56)
Metro. Central	12-14	171	1.16 (0.99, 1.33)	400	2.57 (2.32, 2.82)
Metro. Norte	12-14	270	1.26 (1.11, 1.41)	518	2.29 (2.10, 2.49)

Table 22: Count and prevalence of ADHD cases by health service and age band in Chile school data for females and males with normal confidence intervals.  
*(continued)*

Health service	Age band	Female		Male	
		ADHD cases	Prevalence % (95% CI)	ADHD cases	Prevalence % (95% CI)
Metro. Occidente	12-14	278	0.89 (0.78, 0.99)	597	1.80 (1.65, 1.94)
Metro. Oriente	12-14	212	0.97 (0.84, 1.10)	458	2.04 (1.85, 2.22)
Metro. Sur	12-14	283	1.17 (1.04, 1.31)	557	2.18 (2.00, 2.36)
Metro. Sur Oriente	12-14	378	1.33 (1.19, 1.46)	687	2.29 (2.13, 2.46)
O'Higgins	12-14	263	1.35 (1.19, 1.51)	633	3.11 (2.87, 3.35)
Osorno	12-14	30	0.60 (0.39, 0.82)	106	2.07 (1.68, 2.46)
Reloncaví	12-14	64	0.66 (0.50, 0.82)	156	1.52 (1.28, 1.76)
Talcahuano	12-14	173	2.60 (2.22, 2.98)	367	5.19 (4.67, 5.70)
Valdivia	12-14	52	0.64 (0.47, 0.81)	139	1.65 (1.38, 1.92)
Valparaíso	12-14	76	0.82 (0.64, 1.00)	218	2.25 (1.96, 2.55)
Viña del Mar	12-14	183	0.88 (0.75, 1.01)	432	2.02 (1.83, 2.21)
Ñuble	12-14	166	1.70 (1.44, 1.95)	375	3.67 (3.31, 4.04)
Aconcagua	15-18	58	0.99 (0.74, 1.24)	128	2.11 (1.75, 2.47)
Aisén	15-18	35	1.35 (0.91, 1.80)	76	2.70 (2.10, 3.30)
Antofagasta	15-18	72	0.48 (0.37, 0.60)	191	1.21 (1.04, 1.38)
Araucanía Norte	15-18	34	0.74 (0.49, 0.98)	53	1.07 (0.79, 1.36)
Araucanía Sur	15-18	98	0.58 (0.47, 0.70)	208	1.17 (1.01, 1.33)
Arauco	15-18	37	0.92 (0.63, 1.22)	103	2.44 (1.98, 2.91)
Arica	15-18	30	0.55 (0.35, 0.74)	66	1.14 (0.87, 1.42)
Atacama	15-18	22	0.31 (0.18, 0.43)	60	0.78 (0.58, 0.97)
Biobío	15-18	128	1.40 (1.16, 1.64)	278	2.83 (2.50, 3.16)
Chiloé	15-18	84	2.00 (1.58, 2.42)	167	3.67 (3.13, 4.22)
Concepción	15-18	373	2.74 (2.46, 3.01)	605	4.16 (3.84, 4.49)
Coquimbo	15-18	231	1.36 (1.19, 1.54)	508	2.79 (2.55, 3.03)
Iquique	15-18	72	0.85 (0.66, 1.05)	179	1.96 (1.68, 2.25)
Magallanes	15-18	80	2.15 (1.69, 2.62)	198	4.87 (4.21, 5.53)
Maule	15-18	99	0.44 (0.35, 0.52)	291	1.19 (1.05, 1.32)
Metro. Central	15-18	139	0.89 (0.74, 1.03)	272	1.61 (1.42, 1.80)
Metro. Norte	15-18	256	1.15 (1.01, 1.29)	370	1.55 (1.39, 1.70)
Metro. Occidente	15-18	189	0.59 (0.51, 0.67)	418	1.21 (1.09, 1.32)
Metro. Oriente	15-18	187	0.79 (0.68, 0.90)	342	1.37 (1.22, 1.51)
Metro. Sur	15-18	203	0.83 (0.71, 0.94)	406	1.55 (1.40, 1.70)
Metro. Sur Oriente	15-18	292	0.95 (0.84, 1.06)	538	1.65 (1.51, 1.79)
O'Higgins	15-18	178	0.89 (0.76, 1.02)	366	1.67 (1.50, 1.84)
Osorno	15-18	31	0.59 (0.38, 0.80)	71	1.26 (0.97, 1.55)
Reloncaví	15-18	45	0.44 (0.31, 0.56)	152	1.36 (1.15, 1.58)
Talcahuano	15-18	162	2.33 (1.98, 2.69)	289	3.89 (3.45, 4.33)
Valdivia	15-18	32	0.38 (0.25, 0.51)	87	0.96 (0.76, 1.16)
Valparaíso	15-18	59	0.60 (0.44, 0.75)	161	1.50 (1.27, 1.73)
Viña del Mar	15-18	105	0.49 (0.40, 0.58)	292	1.24 (1.10, 1.38)
Ñuble	15-18	144	1.40 (1.17, 1.63)	290	2.62 (2.33, 2.92)

### Autism prevalence by health service

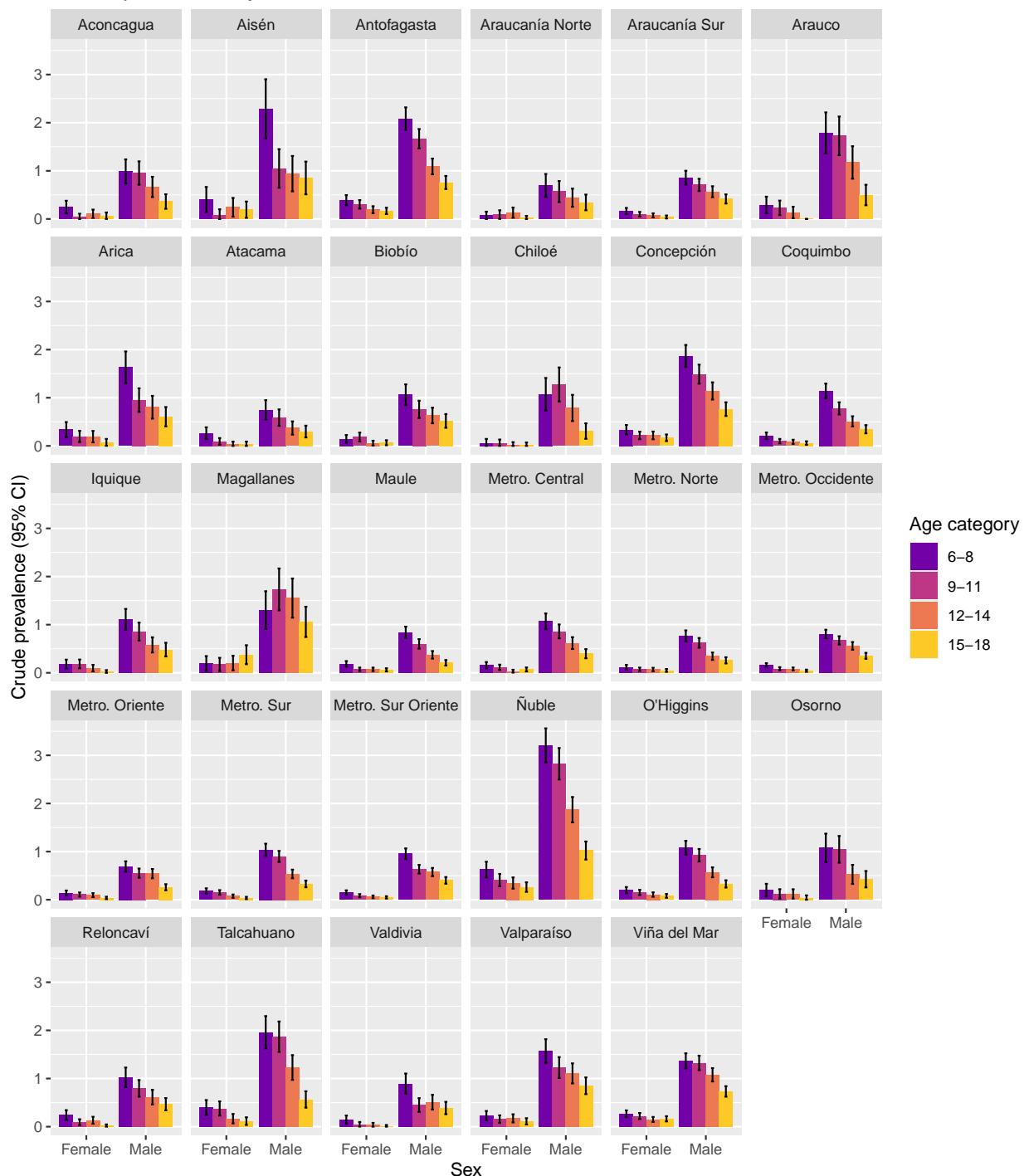


Figure 41: Crude prevalence of autism in school data by health service, age band and sex. Bars show 95% normal confidence intervals.

### ADHD prevalence by health service

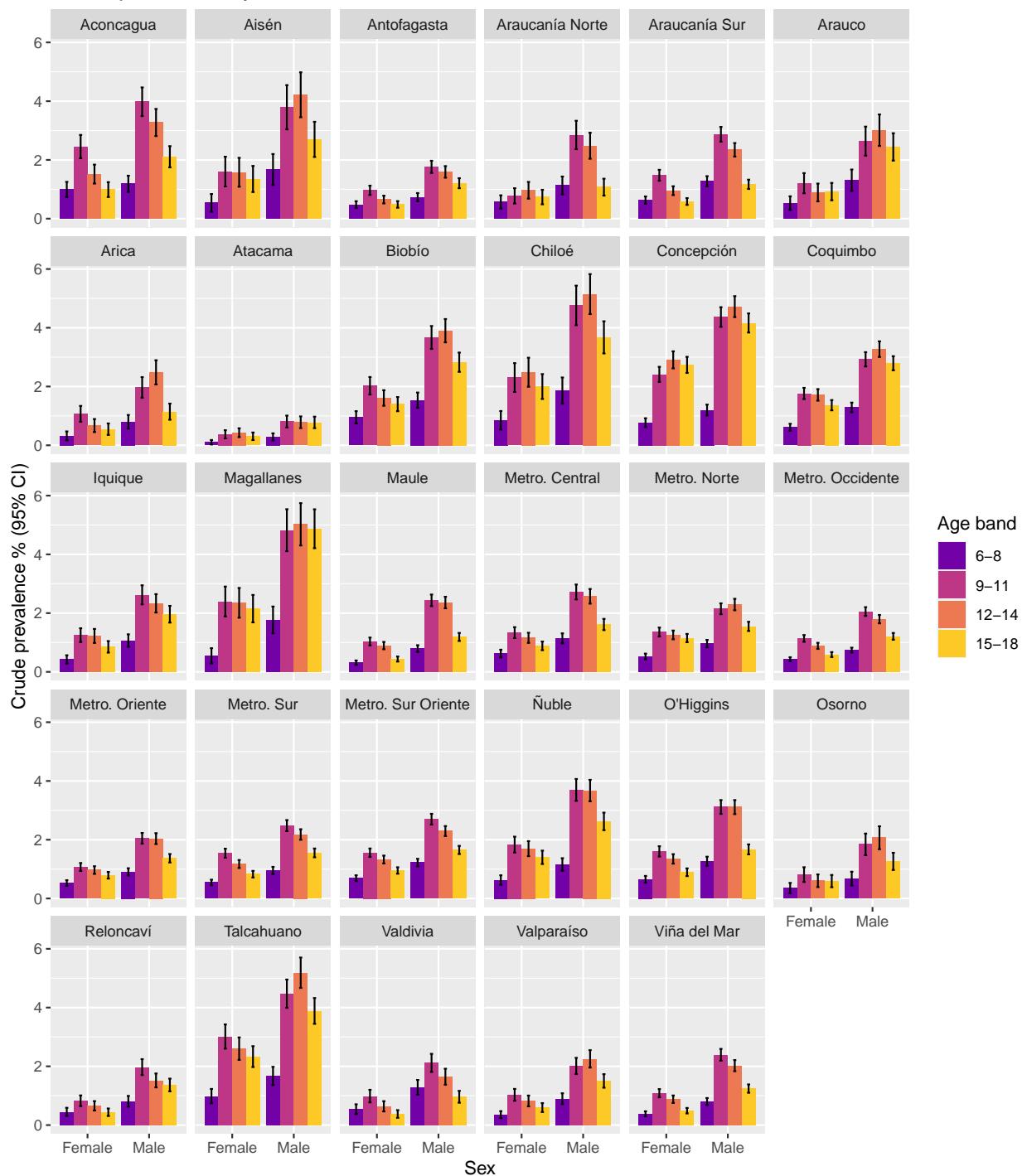


Figure 42: Crude prevalence of ADHD in school data by health service, age band and sex. Bars show 95% normal confidence intervals.

Table 23: Count and prevalence of Autism cases by school fee and age band in Chile school data for females and males with normal confidence intervals.

School fee	Age band	Female		Male	
		Autism cases	Prevalence % (95% CI)	Autism cases	Prevalence % (95% CI)
Free	6-8	655	0.25 (0.23, 0.27)	3799	1.37 (1.33, 1.42)
\$1,000-\$10,000	6-8	<20	0.00 (0.00, 0.00)	<20	1.17 (0.00, 2.78)
\$10,001-\$25,000	6-8	<20	0.11 (0.01, 0.20)	20	0.44 (0.25, 0.64)
\$25,001-\$50,000	6-8	37	0.14 (0.10, 0.19)	168	0.70 (0.59, 0.80)
\$50,001-\$100,000	6-8	53	0.17 (0.13, 0.22)	296	0.94 (0.83, 1.04)
\$100,001+	6-8	<20	0.02 (0.01, 0.04)	30	0.08 (0.05, 0.11)
No information	6-8	<20	0.23 (0.12, 0.35)	73	0.92 (0.71, 1.13)
Free	9-11	434	0.16 (0.15, 0.18)	3147	1.10 (1.06, 1.14)
\$1,000-\$10,000	9-11	<20	0.00 (0.00, 0.00)	<20	1.59 (0.00, 3.77)
\$10,001-\$25,000	9-11	<20	0.02 (0.00, 0.06)	23	0.52 (0.31, 0.73)
\$25,001-\$50,000	9-11	26	0.10 (0.06, 0.14)	152	0.61 (0.52, 0.71)
\$50,001-\$100,000	9-11	45	0.14 (0.10, 0.18)	255	0.77 (0.67, 0.86)
\$100,001+	9-11	<20	0.02 (0.00, 0.03)	35	0.09 (0.06, 0.12)
No information	9-11	<20	0.19 (0.08, 0.30)	75	1.11 (0.86, 1.36)
Free	12-14	332	0.13 (0.11, 0.14)	2246	0.81 (0.77, 0.84)
\$1,000-\$10,000	12-14	<20	0.00 (0.00, 0.00)	<20	3.67 (0.14, 7.20)
\$10,001-\$25,000	12-14	<20	0.04 (0.00, 0.10)	<20	0.21 (0.07, 0.34)
\$25,001-\$50,000	12-14	21	0.08 (0.04, 0.11)	126	0.53 (0.44, 0.63)
\$50,001-\$100,000	12-14	25	0.08 (0.05, 0.11)	195	0.56 (0.48, 0.64)
\$100,001+	12-14	<20	0.01 (0.00, 0.02)	31	0.09 (0.06, 0.12)
No information	12-14	<20	0.14 (0.04, 0.25)	36	0.60 (0.41, 0.80)
Free	15-18	236	0.09 (0.08, 0.10)	1547	0.53 (0.50, 0.55)
\$1,000-\$10,000	15-18	<20	0.00 (0.00, 0.00)	<20	0.00 (0.00, 0.00)
\$10,001-\$25,000	15-18	<20	0.06 (0.00, 0.13)	<20	0.23 (0.09, 0.37)
\$25,001-\$50,000	15-18	<20	0.05 (0.03, 0.08)	82	0.31 (0.24, 0.38)
\$50,001-\$100,000	15-18	29	0.08 (0.05, 0.11)	153	0.40 (0.33, 0.46)
\$100,001+	15-18	<20	0.01 (0.00, 0.01)	25	0.06 (0.04, 0.09)
No information	15-18	<20	0.08 (0.00, 0.16)	30	0.44 (0.29, 0.60)

Table 24: Count and prevalence of ADHD cases by school fee and age band in Chile school data for females and males with normal confidence intervals.

School fee	Age band	Female		Male	
		ADHD cases	Prevalence % (95% CI)	ADHD cases	Prevalence % (95% CI)
Free	6-8	1543	0.59 (0.56, 0.62)	3117	1.13 (1.09, 1.17)
\$1,000-\$10,000	6-8	<20	0.00 (0.00, 0.00)	<20	0.58 (0.00, 1.73)
\$10,001-\$25,000	6-8	32	0.70 (0.46, 0.94)	32	0.71 (0.46, 0.95)
\$25,001-\$50,000	6-8	167	0.65 (0.55, 0.75)	267	1.11 (0.97, 1.24)
\$50,001-\$100,000	6-8	200	0.65 (0.56, 0.74)	437	1.38 (1.26, 1.51)
\$100,001+	6-8	20	0.05 (0.03, 0.07)	32	0.08 (0.06, 0.11)
No information	6-8	30	0.44 (0.28, 0.59)	58	0.73 (0.54, 0.92)
Free	9-11	4061	1.52 (1.47, 1.57)	8323	2.91 (2.85, 2.97)
\$1,000-\$10,000	9-11	<20	0.00 (0.00, 0.00)	<20	0.00 (0.00, 0.00)
\$10,001-\$25,000	9-11	47	1.01 (0.72, 1.29)	102	2.29 (1.85, 2.73)
\$25,001-\$50,000	9-11	417	1.58 (1.43, 1.73)	616	2.49 (2.29, 2.68)
\$50,001-\$100,000	9-11	567	1.76 (1.62, 1.91)	1024	3.08 (2.89, 3.26)
\$100,001+	9-11	62	0.17 (0.12, 0.21)	112	0.30 (0.24, 0.35)
No information	9-11	73	1.26 (0.97, 1.54)	145	2.15 (1.80, 2.50)
Free	12-14	3342	1.28 (1.24, 1.33)	7634	2.74 (2.68, 2.80)
\$1,000-\$10,000	12-14	<20	0.00 (0.00, 0.00)	<20	0.00 (0.00, 0.00)
\$10,001-\$25,000	12-14	48	1.02 (0.74, 1.31)	79	1.80 (1.41, 2.20)
\$25,001-\$50,000	12-14	364	1.36 (1.22, 1.50)	638	2.70 (2.49, 2.90)
\$50,001-\$100,000	12-14	509	1.55 (1.42, 1.68)	1083	3.12 (2.94, 3.30)
\$100,001+	12-14	72	0.20 (0.15, 0.24)	147	0.41 (0.34, 0.47)
No information	12-14	50	1.03 (0.74, 1.31)	133	2.23 (1.85, 2.60)
Free	15-18	2579	0.97 (0.93, 1.00)	5529	1.88 (1.83, 1.93)
\$1,000-\$10,000	15-18	<20	0.00 (0.00, 0.00)	<20	0.39 (0.00, 1.14)
\$10,001-\$25,000	15-18	21	0.43 (0.25, 0.62)	25	0.57 (0.35, 0.80)
\$25,001-\$50,000	15-18	343	1.17 (1.04, 1.29)	482	1.84 (1.67, 2.00)
\$50,001-\$100,000	15-18	416	1.12 (1.01, 1.22)	898	2.33 (2.18, 2.48)
\$100,001+	15-18	79	0.21 (0.16, 0.26)	151	0.39 (0.33, 0.45)
No information	15-18	37	0.73 (0.50, 0.97)	79	1.17 (0.91, 1.43)

Table 25: Count and prevalence of Autism cases by ethnicity and age band in Chile school data for females and males with normal confidence intervals. Regions with high Mapuche populations only.

Ethnicity	Age band	Female		Male	
		Autism cases	Prevalence % (95% CI)	Autism cases	Prevalence % (95% CI)
Mapuche	6-8	29	0.15 (0.10, 0.20)	186	0.93 (0.80, 1.07)
Other Indigenous group	6-8	<20	0.00 (0.00, 0.00)	<20	0.77 (0.16, 1.39)
No Indigenous group	6-8	377	0.18 (0.16, 0.20)	2220	1.02 (0.98, 1.06)
Mapuche	9-11	<20	0.05 (0.02, 0.09)	155	0.72 (0.61, 0.84)
Other Indigenous group	9-11	<20	0.17 (0.00, 0.50)	<20	1.36 (0.42, 2.30)
No Indigenous group	9-11	264	0.13 (0.11, 0.14)	1852	0.84 (0.80, 0.87)
Mapuche	12-14	<20	0.06 (0.03, 0.09)	110	0.52 (0.42, 0.62)
Other Indigenous group	12-14	<20	0.00 (0.00, 0.00)	<20	0.34 (0.00, 0.81)
No Indigenous group	12-14	192	0.09 (0.08, 0.11)	1385	0.64 (0.61, 0.67)
Mapuche	15-18	<20	0.02 (0.00, 0.03)	71	0.35 (0.27, 0.43)
Other Indigenous group	15-18	<20	0.00 (0.00, 0.00)	<20	0.19 (0.00, 0.56)
No Indigenous group	15-18	136	0.06 (0.05, 0.07)	969	0.41 (0.39, 0.44)

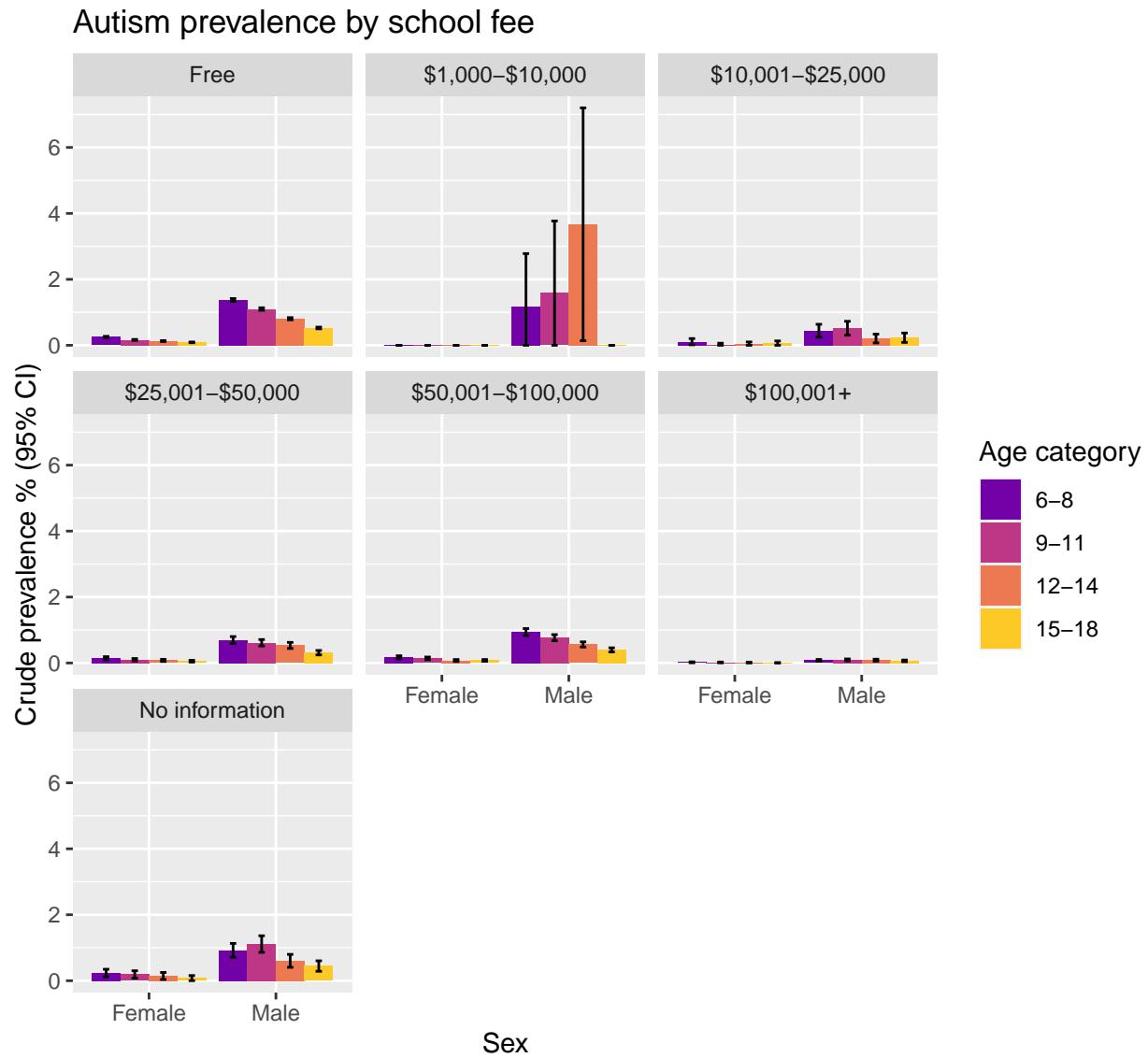


Figure 43: Crude prevalence of autism in school data by student's monthly school fee (Peso), age band and sex. Bars show 95% normal confidence intervals.

## ADHD prevalence by school fee

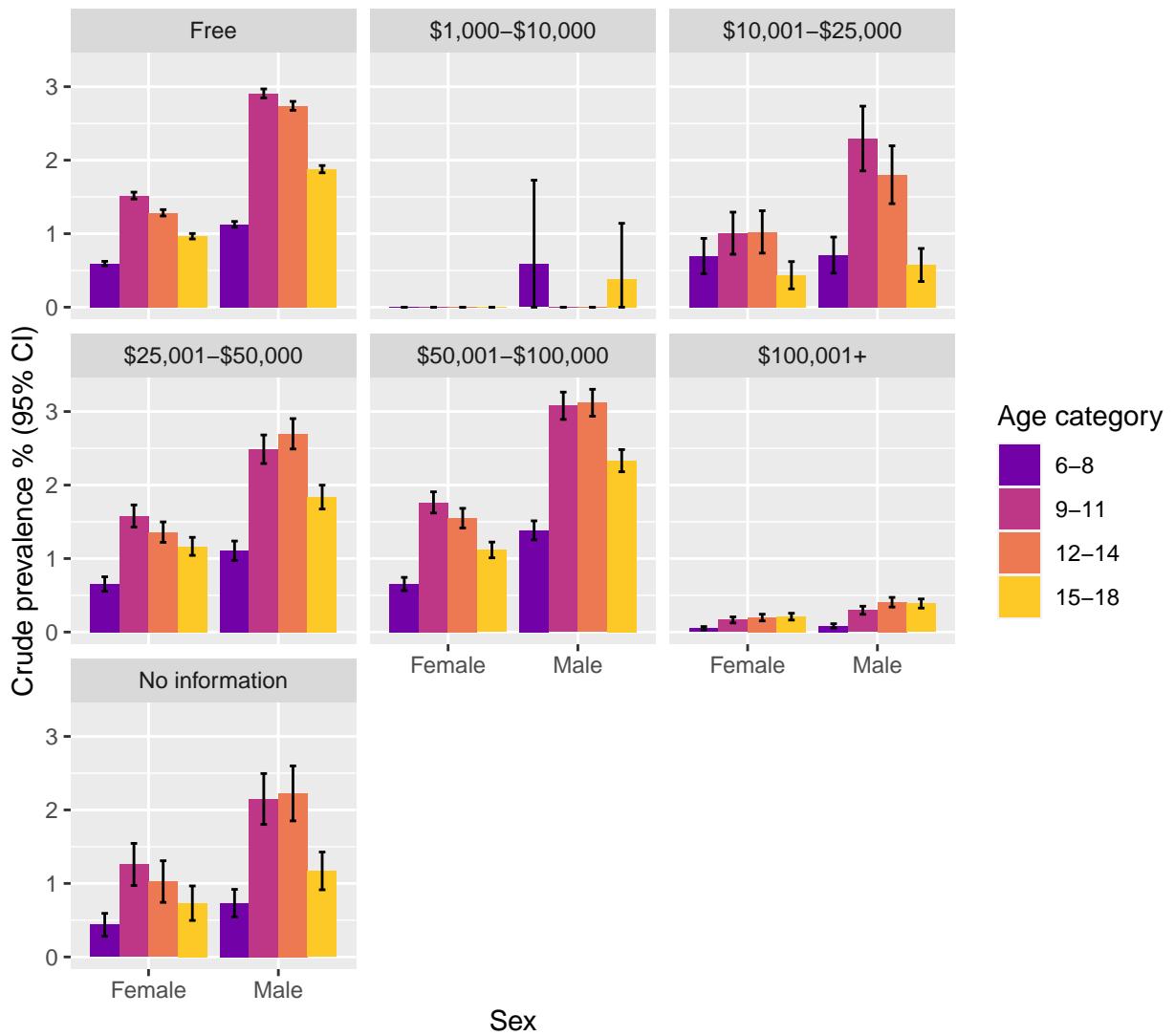


Figure 44: Crude prevalence of ADHD in school data by student's monthly school fee (Peso), age band and sex. Bars show 95% normal confidence intervals.

Table 26: Count and prevalence of ADHD cases by ethnicity and age band in Chile school data for females and males with normal confidence intervals. Regions with high Mapuche populations only.

Ethnicity	Age band	Female		Male	
		ADHD cases	Prevalence % (95% CI)	ADHD cases	Prevalence % (95% CI)
Mapuche	6-8	113	0.58 (0.48, 0.69)	218	1.09 (0.95, 1.24)
Other Indigenous group	6-8	<20	0.39 (0.00, 0.84)	<20	0.90 (0.24, 1.57)
No Indigenous group	6-8	1227	0.59 (0.56, 0.62)	2342	1.07 (1.03, 1.12)
Mapuche	9-11	253	1.24 (1.08, 1.39)	557	2.59 (2.38, 2.81)
Other Indigenous group	9-11	<20	1.19 (0.31, 2.06)	<20	1.87 (0.78, 2.97)
No Indigenous group	9-11	3113	1.48 (1.43, 1.53)	5950	2.68 (2.62, 2.75)
Mapuche	12-14	206	1.00 (0.87, 1.14)	479	2.26 (2.06, 2.46)
Other Indigenous group	12-14	<20	0.72 (0.02, 1.42)	<20	2.54 (1.27, 3.81)
No Indigenous group	12-14	2660	1.29 (1.24, 1.34)	5614	2.59 (2.52, 2.66)
Mapuche	15-18	131	0.70 (0.58, 0.81)	278	1.38 (1.22, 1.54)
Other Indigenous group	15-18	<20	1.14 (0.23, 2.05)	<20	0.38 (0.00, 0.90)
No Indigenous group	15-18	2268	1.03 (0.99, 1.08)	4353	1.86 (1.80, 1.91)

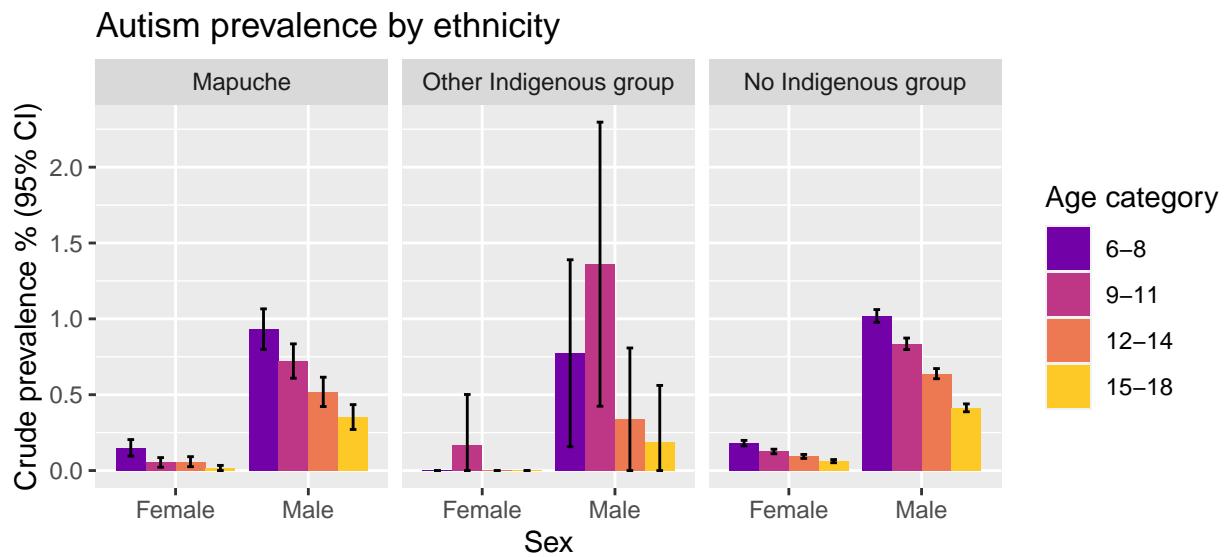


Figure 45: Crude prevalence of autism in school data by ethnicity, age band and sex. Bars show 95% normal confidence intervals. Regions with high Mapuche populations only.

## ADHD prevalence by ethnicity

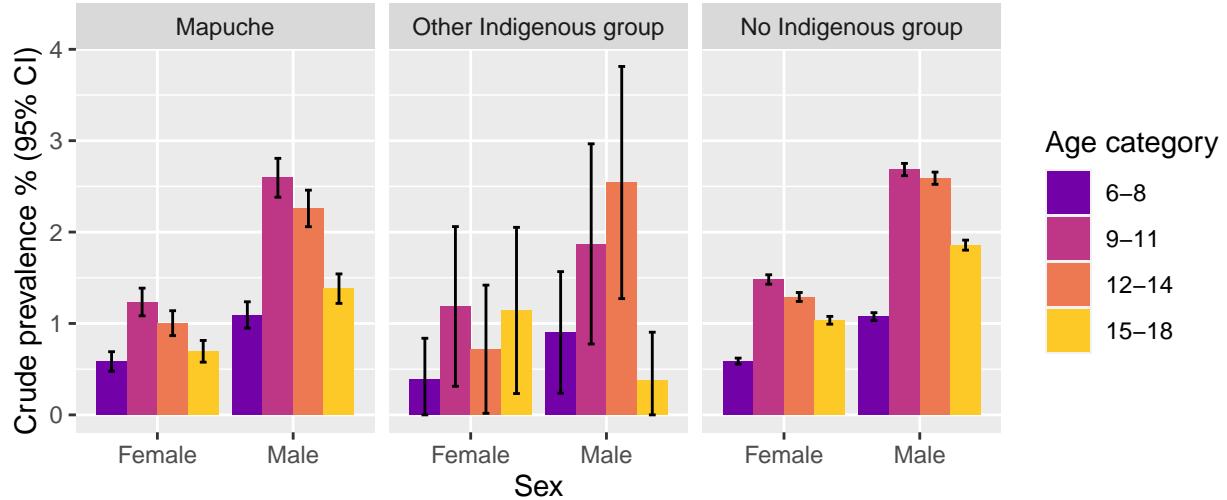


Figure 46: Crude prevalence of ADHD in school data by ethnicity, age band and sex. Bars show 95% normal confidence intervals. Regions with high Mapuche populations only.

Table 27: Count and prevalence of Autism cases by school's rurality and age band in Chile school data for females and males with normal confidence intervals.

School rurality	Age band	Female		Male	
		Autism cases	Prevalence % (95% CI)	Autism cases	Prevalence % (95% CI)
Rural	6-8	93	0.26 (0.21, 0.31)	519	1.33 (1.22, 1.45)
Urban	6-8	681	0.21 (0.19, 0.22)	3869	1.13 (1.09, 1.16)
Rural	9-11	61	0.16 (0.12, 0.20)	472	1.14 (1.03, 1.24)
Urban	9-11	462	0.14 (0.12, 0.15)	3217	0.91 (0.88, 0.95)
Rural	12-14	44	0.16 (0.12, 0.21)	291	0.93 (0.82, 1.03)
Urban	12-14	347	0.10 (0.09, 0.11)	2356	0.67 (0.64, 0.70)
Rural	15-18	<20	0.08 (0.03, 0.13)	92	0.61 (0.49, 0.73)
Urban	15-18	281	0.08 (0.07, 0.08)	1755	0.45 (0.42, 0.47)

Table 28: Count and prevalence of ADHD cases by school's rurality and age band in Chile school data for females and males with normal confidence intervals.

School rurality	Age band	Female		Male	
		ADHD cases	Prevalence % (95% CI)	ADHD cases	Prevalence % (95% CI)
Rural	6-8	221	0.62 (0.53, 0.70)	503	1.29 (1.18, 1.40)
Urban	6-8	1771	0.54 (0.51, 0.56)	3441	1.00 (0.97, 1.03)
Rural	9-11	532	1.41 (1.29, 1.53)	1304	3.14 (2.97, 3.31)
Urban	9-11	4695	1.40 (1.36, 1.44)	9018	2.56 (2.51, 2.62)
Rural	12-14	323	1.21 (1.08, 1.34)	946	3.02 (2.83, 3.21)
Urban	12-14	4062	1.20 (1.16, 1.23)	8768	2.49 (2.44, 2.54)
Rural	15-18	112	0.97 (0.79, 1.15)	287	1.90 (1.68, 2.12)
Urban	15-18	3363	0.91 (0.88, 0.94)	6878	1.74 (1.70, 1.79)

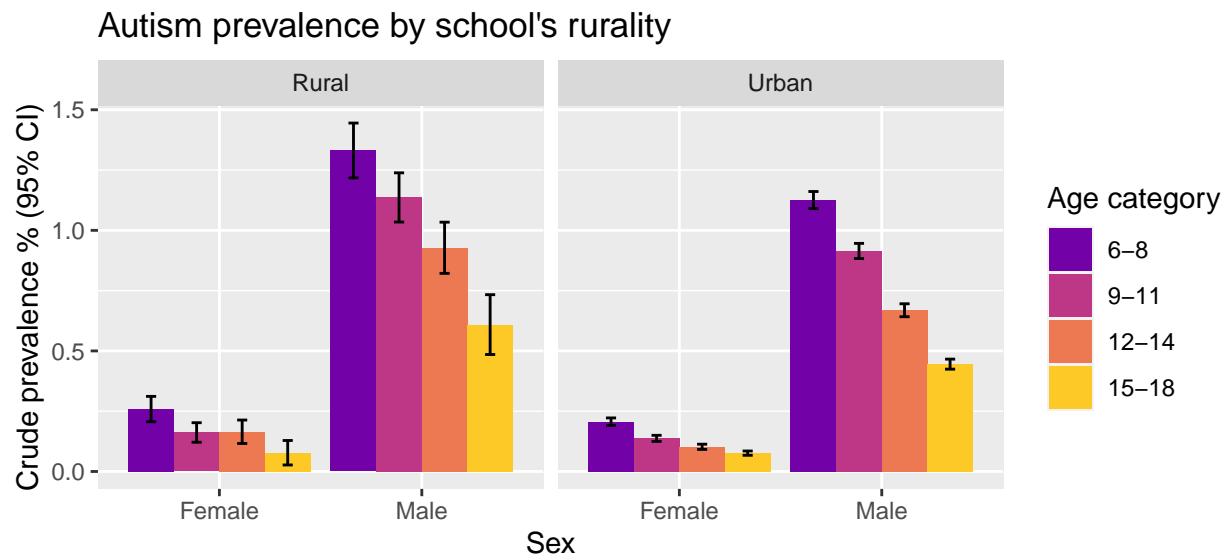


Figure 47: Crude prevalence of autism in school data by school's rurality, age band and sex. Bars show 95% normal confidence intervals.

## ADHD prevalence by school's rurality

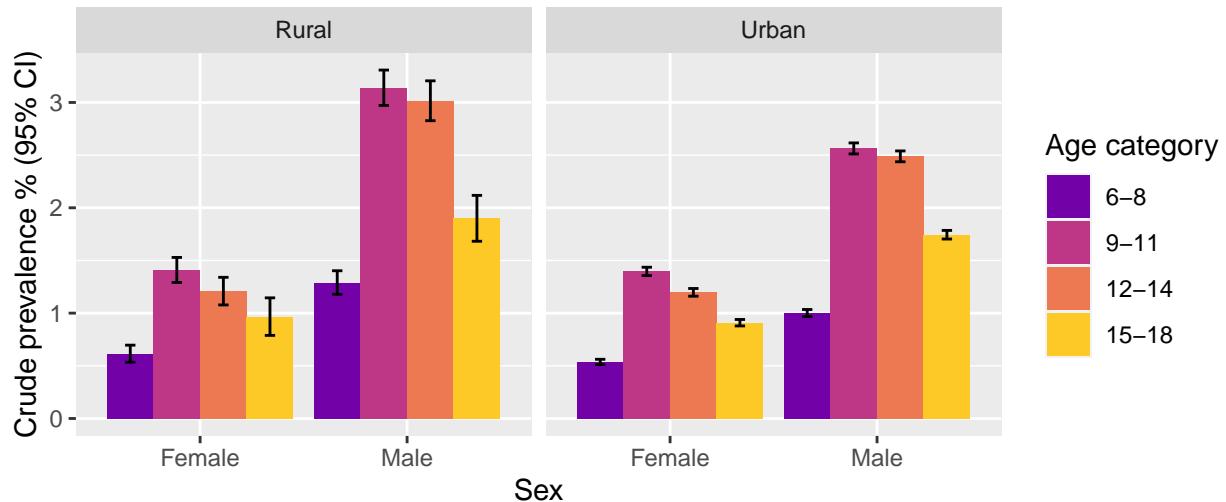
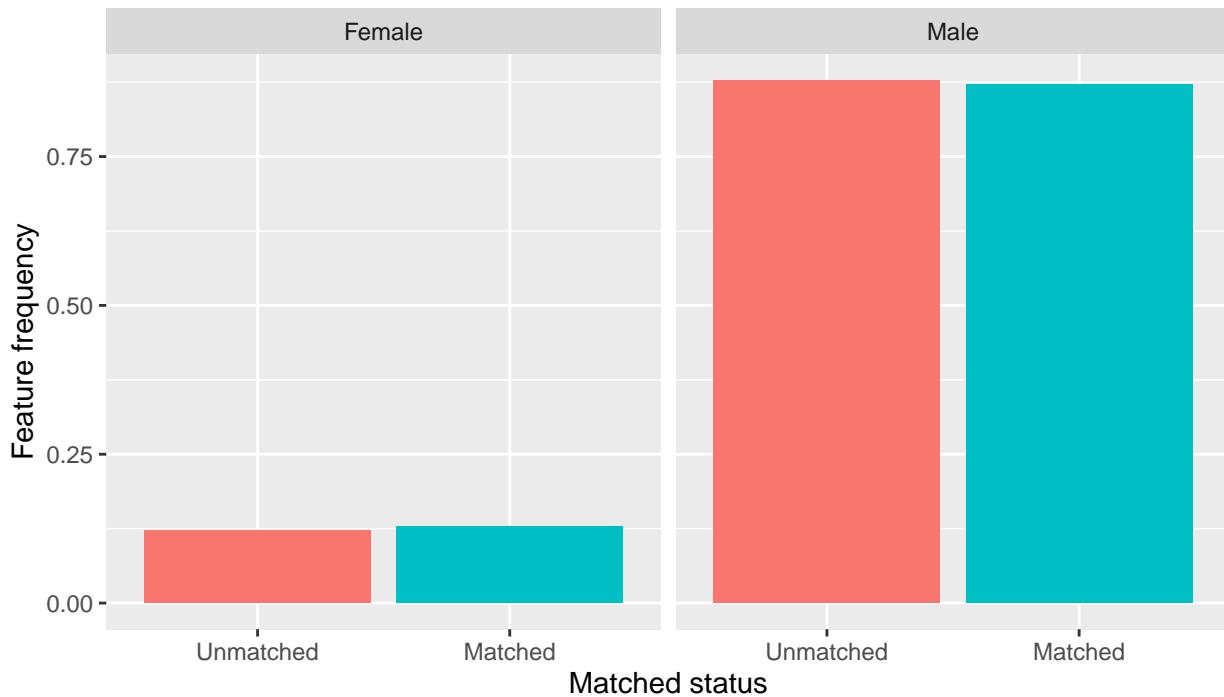


Figure 48: Crude prevalence of ADHD in school data by school's rurality, age band and sex. Bars show 95% normal confidence intervals.

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### Matched status of SSAS school records by sex



### Kolmogorov–Smirnov permutation test on matched status of SSAS school records

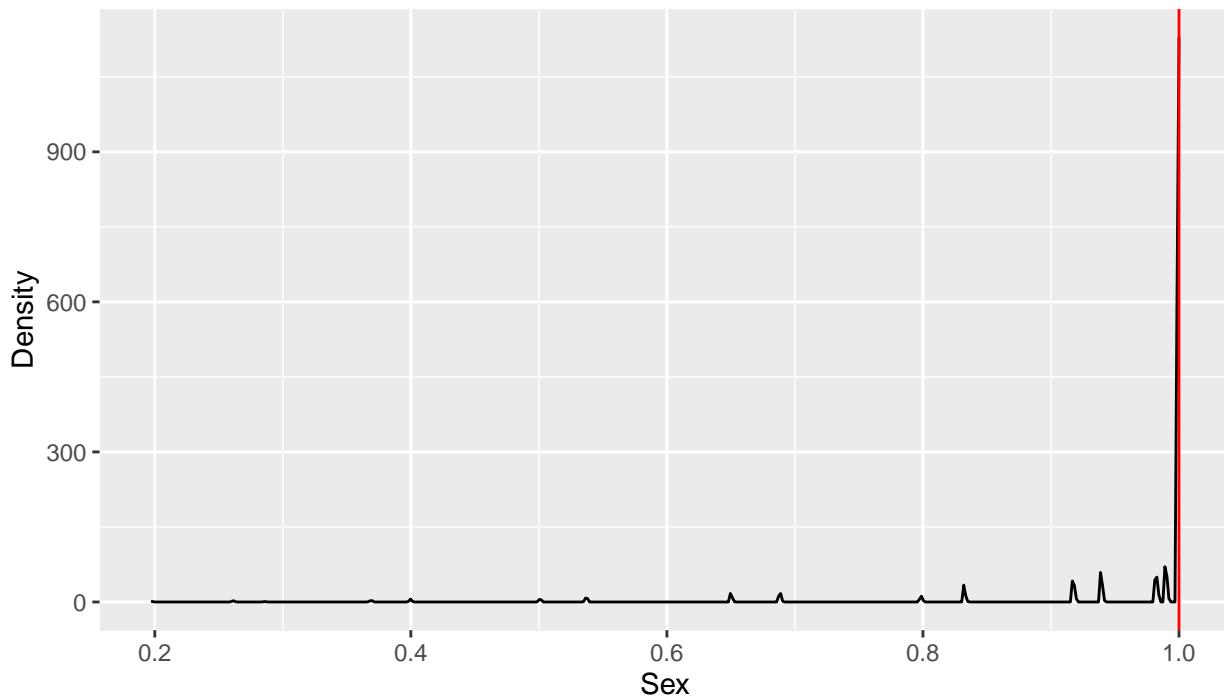
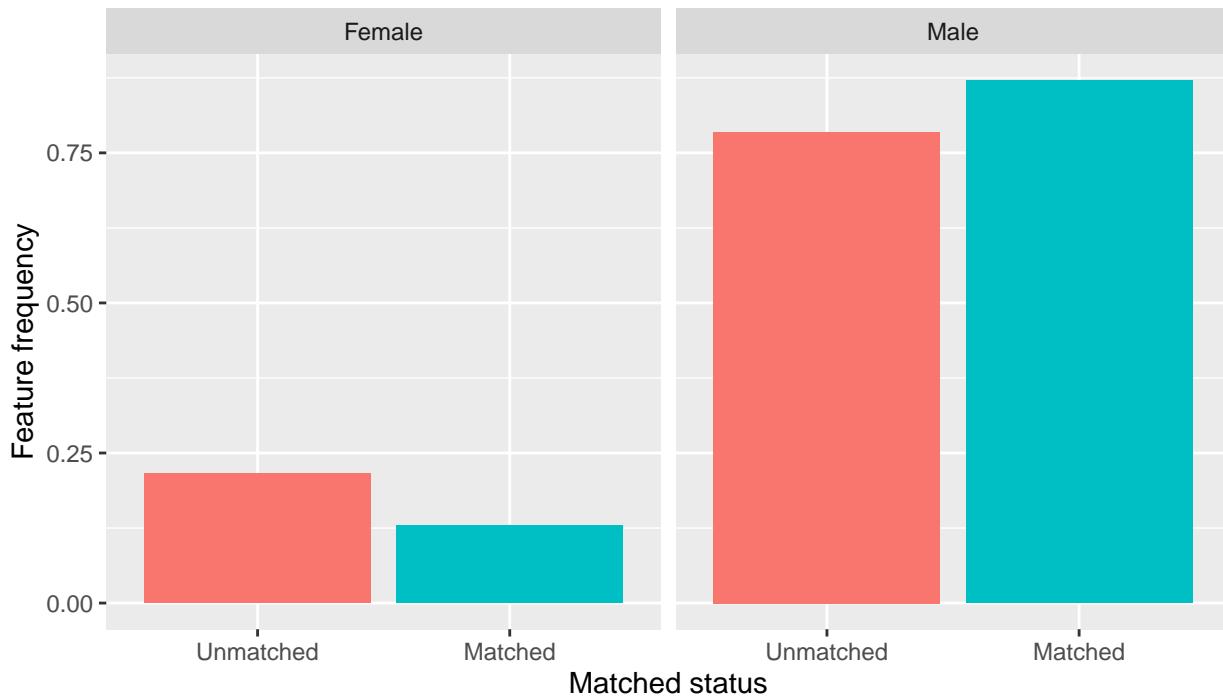


Figure 49: a) Difference in frequency of sexes among school records that matched to patient records and school records that did not match. b) Density of Kolmogorov-Smirnov p-values for 2000 permutations of matched status for school records by sex with observed p-value shown in red.

### Matched status of SSAS patient records by sex



### Kolmogorov–Smirnov permutation test on matched status of patient records

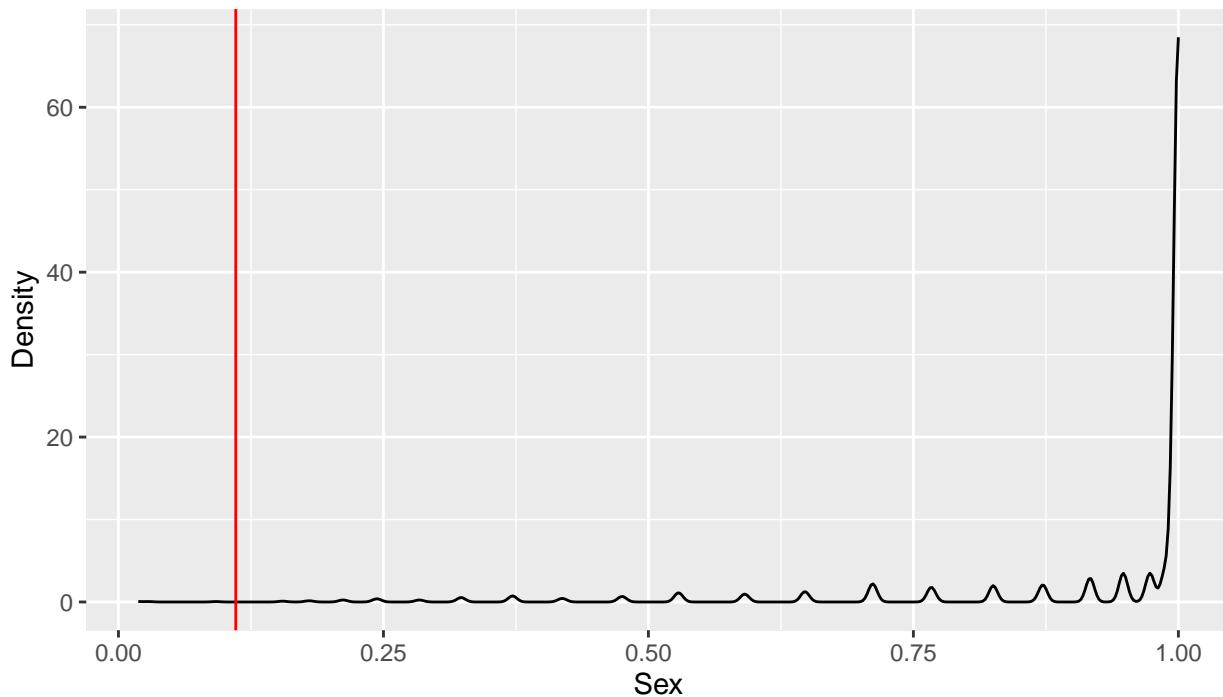


Figure 50: a) Difference in frequency of sexes among patient records that matched to school records and patient records that did not match. b) Density of Kolmogorov-Smirnov p-values for 2000 permutations of matched status for patient records by sex with observed p-value shown in red.

### Matched status of SSAS school records by commune



Kolmogorov–Smirnov permutation test on matched status of SSAS school re

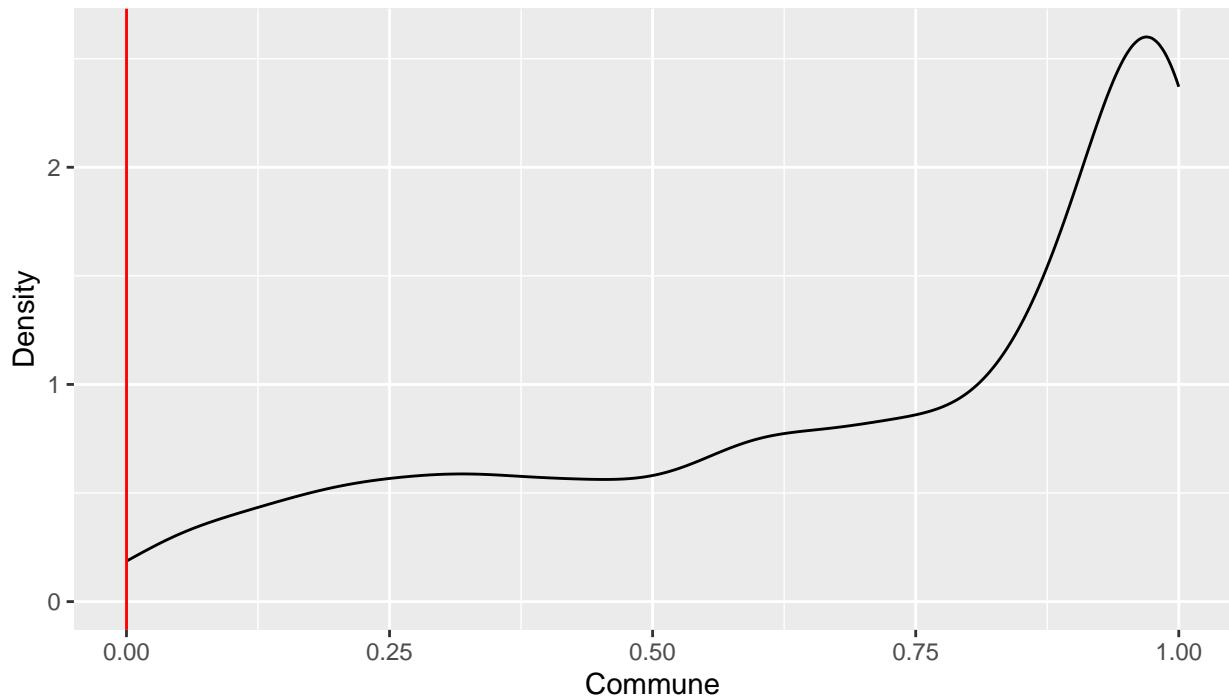
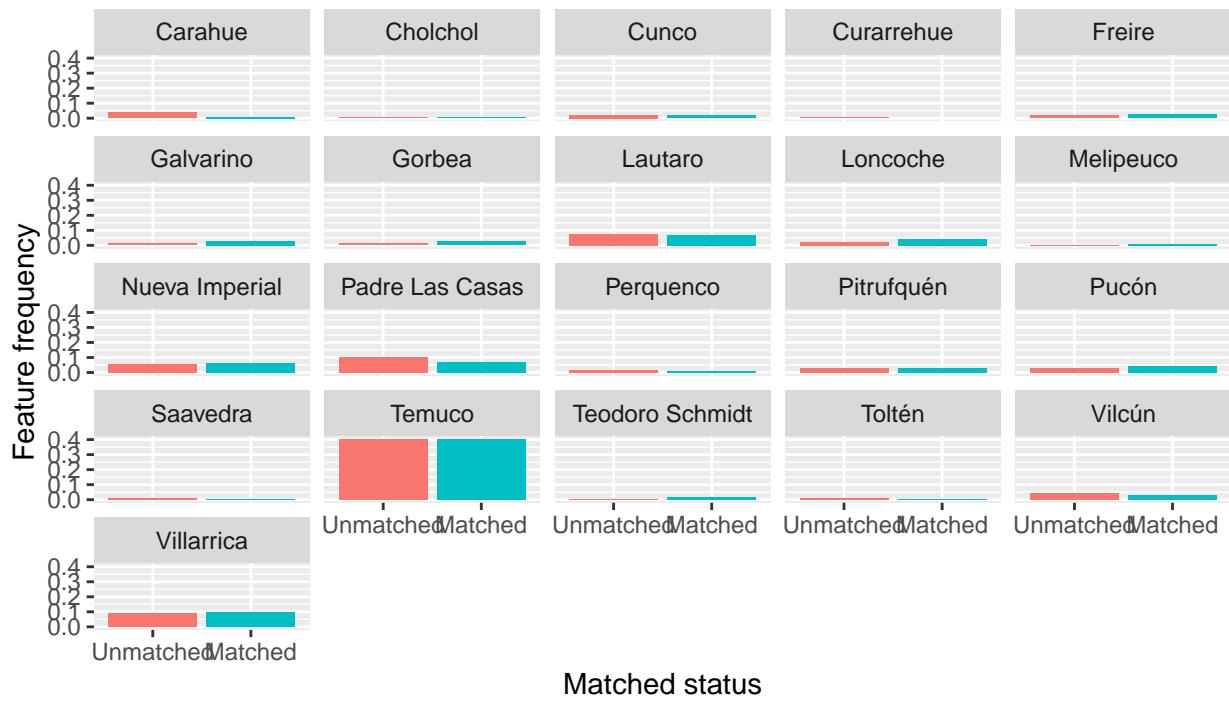


Figure 51: a) Difference in frequency of communes of residence among school records that matched to patient records and school records that did not match. b) Density of Kolmogorov-Smirnov p-values for 2000 permutations of matched status for school records by commune of residence with observed p-value shown in red.

### Matched status of SSAS patient records by commune



### Kolmogorov–Smirnov permutation test on matched status of patient records

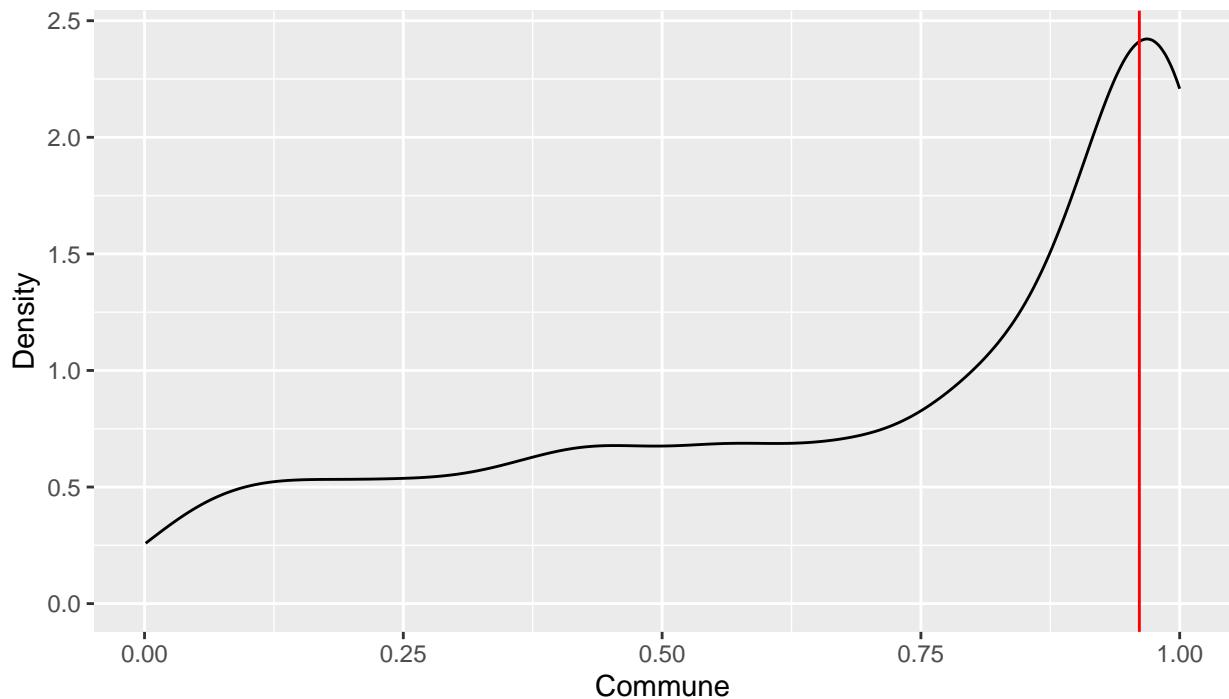
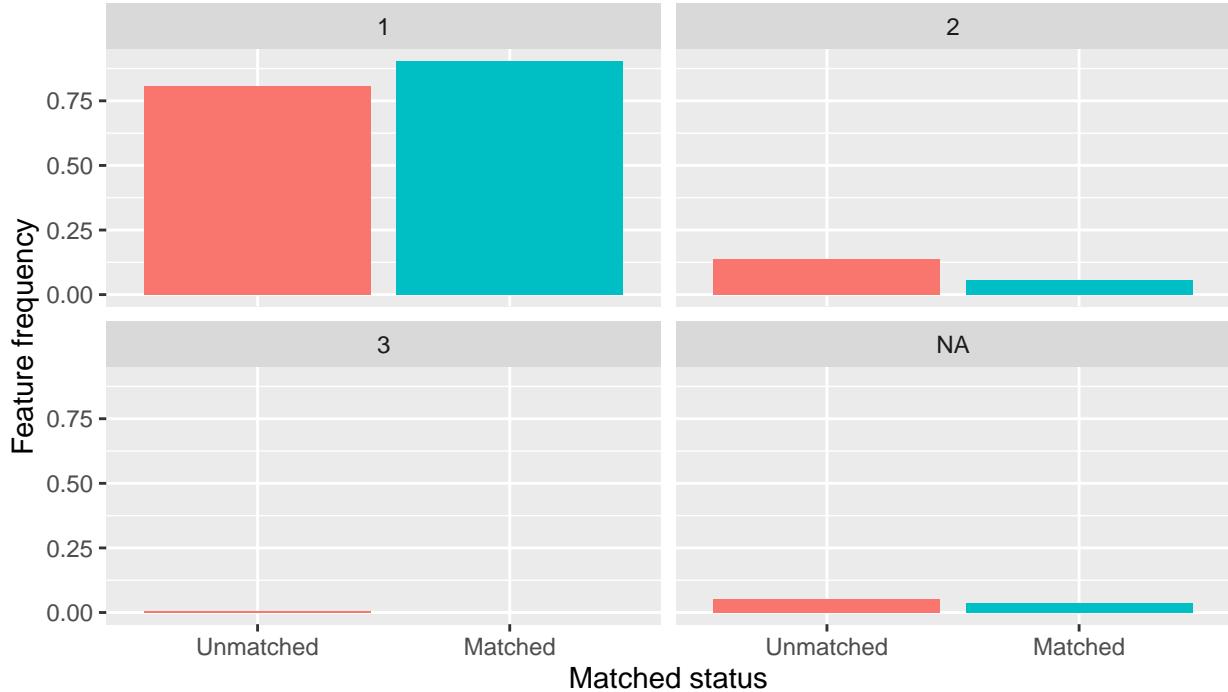


Figure 52: a) Difference in frequency of commune of residence among patient records that matched to school records and patient records that did not match. b) Density of Kolmogorov-Smirnov p-values for 2000 permutations of matched status for patient records by commune of residence with observed p-value shown in red.

### Matched status of SSAS school records by SES



### Kolmogorov–Smirnov permutation test on matched status of SSAS school

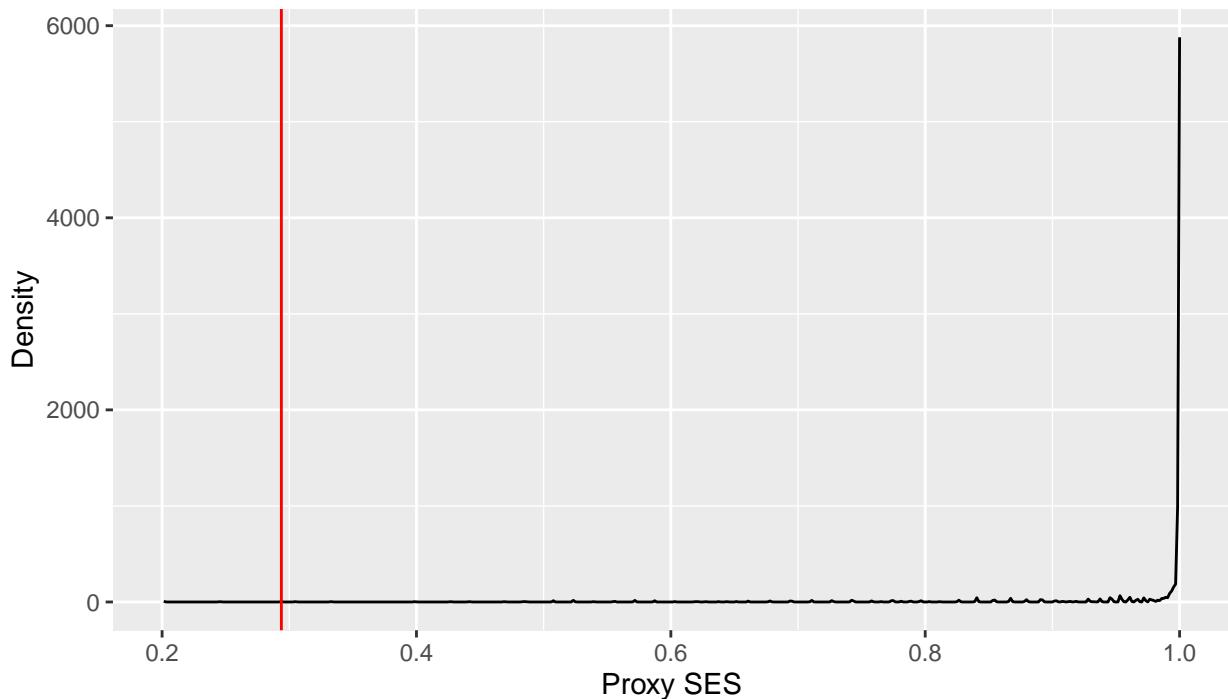
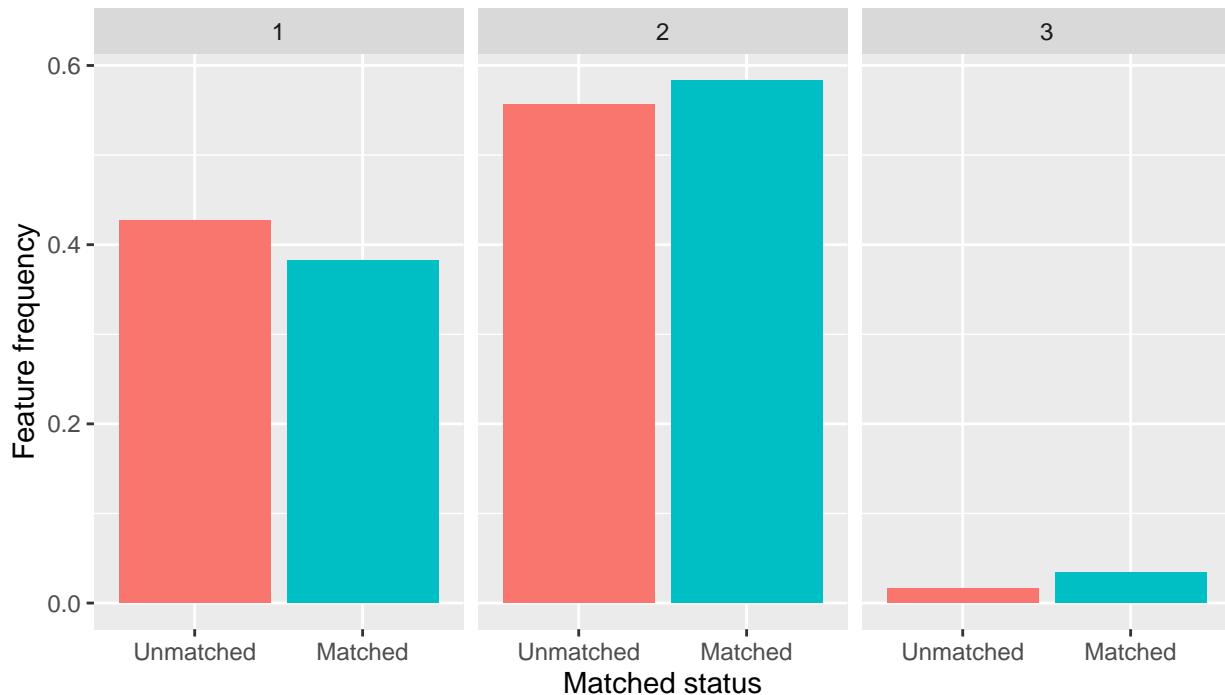


Figure 53: a) Difference in frequency of proxy SES among school records that matched to patient records and school records that did not match. b) Density of Kolmogorov-Smirnov p-values for 2000 permutations of matched status for school records by proxy SES with observed p-value shown in red.

### Matched status of SSAS patient records by SES



### Kolmogorov–Smirnov permutation test on matched status of patient records

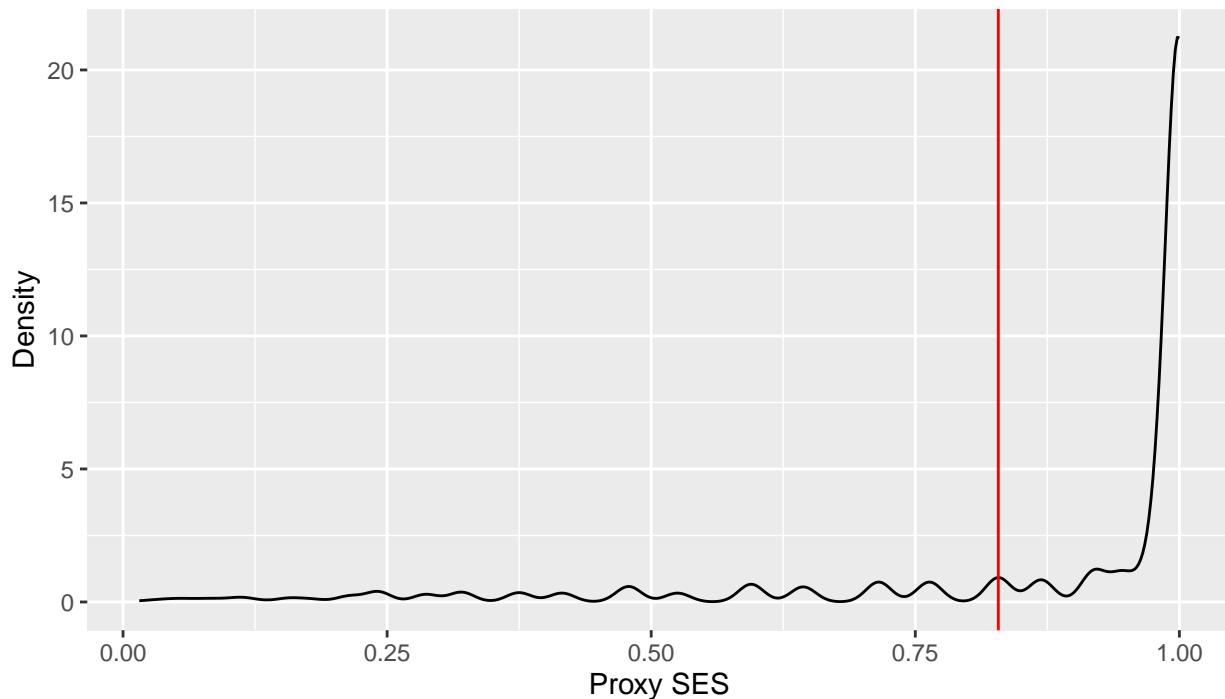


Figure 54: a) Difference in frequency of proxy SES among patient records that matched to school records and patient records that did not match. b) Density of Kolmogorov-Smirnov p-values for 2000 permutations of matched status for patient records by proxy SES with observed p-value shown in red.

18];10. Available from: <https://www.frontiersin.org/articles/10.3389/fpubh.2022.983513> 16. Ministerio de Educación. Educación Especial. [cited 2023 Jun 28]. Incremento de la Subvención Especial Diferencial. Available from: <https://especial.mineduc.cl/incremento-subvencion-educacion-especial/incremento-la-subvencion-especial-diferencial/> 17. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders [Internet]. 5th ed. Arlington, VA; 2013 [cited 2023 Jul 15]. Available from: <https://dsm.psychiatryonline.org/doi/book/10.1176/appi.books.9780890425596> 18. World Health Organisation. International Statistical Classification of Diseases and Related Health Problems (10th Revision) [Internet]. 2019. Available from: <https://icd.who.int/browse10/2019/en#/F84> 19. Lai MC, Lombardo MV, Baron-Cohen S. Autism. *The Lancet*. 2014 Mar 8;383(9920):896–910. 20. Paula CS, Cukier S, Cunha GR, Irarrázaval M, Montiel-Nava C, García R, et al. 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## **10 Appendix A | R code**

## **11 Appendix B | Research Protocol**

See overleaf.