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# Addiction care in Mexico: a challenge for non-specialized health professionals

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Editorial

International epidemiological studies report that substance use disorders (SUDs) and other psychiatric disorders (anxiety and depression) are among the first ten conditions that contribute to the global burden of disease. Together they account for 7.4% of the disability-adjusted life years of the total global burden, 0.5% of the total years of life lost to premature mortality, and 22.9% of the years lived with disability.<sup>1</sup> These data place SUDs as a serious public health problem in the world.

Likewise, it is known that chronic substance abuse has a negative impact in individuals because it is associated with lesions and accidents that can cause death or disability, scholar drop out, poor work performance, familiar violence, antisocial behaviors, traumatic events, other psychiatric disorders, suicidality, risky sexual behavior, sexual transmission infections and other medical consequences.<sup>2</sup>

In Mexico, information systems report periods of increase and decrease in substance use, and provide evidence that adolescents and young adults are the two age groups with more bio-psychosocial vulnerability.<sup>3</sup>

In order to respond to the addiction care demand of people with SUDs, Mexico has a public outpatient treatment infrastructure of little more than 400 units, but with limited availability of residential and hospitalization units (less than 30). As a consequence of this situation, there's a strong need for increasing and restructuring the capacity for care of the public health services which, despite the government's efforts, are still insufficient.<sup>4</sup>

In addition to public treatment services in Mexico, private services stand as an alternative for treatment, but they are very expensive and inaccessible for most of the affected individuals.<sup>4</sup> In this scenario, and in view of the limited specialized treatment services, a major community response has been going on since the 50's, offering mutual help groups (more than 20,000) such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA).<sup>4</sup>

In order to fill the gap in the residential and hospitalization services for individuals who require contention and intensive treatment, 40 years ago the Mexican community started to develop more than 2000 non-governmental organizations (NGOs), mostly based in the AA twelve-step model, aiming to respond to the perceived needs for care of their patients. Unfortunately, these initiatives are known for their limited spaces, their lack of qualified staff trained to give an optimal treatment, and for their frequent display of sanitary irregularities.<sup>5-7</sup>

On the other hand, there is evidence that individuals with SUDs that receive residential treatment in Mexico show higher co-occurrence with other psychiatric disorders and more physical, interpersonal, social, risky sexual behavior and suicidality problems when compared to individuals receiving outpatient treatments. This situation highlights the need for integrated treatment programs comprising diverse multimodal interventions such as: pharmacological treatments, psychoeducation, and counseling for SUDs, co-occurring disorders, suicide prevention and sexual health.<sup>7</sup>

The scarcity of specialized units and integrated treatment programs is not the only barrier to provide optimal care. The insufficiency of qualified professionals with knowledge, attitudes, and skills to deliver evidence-based treatments is also a great challenge. In Mexico, it is estimated that for each 100 000 habitants there are 1.5 psychiatrists, one non-specialized physician, three nurses and one psychologist.<sup>8</sup> This scenario reveals the need for having a larger force of non-specialized health professionals in order to meet the requirements for treatment addictions in our country.<sup>4</sup>

Furthermore, this problem is associated with a limited availability of undergraduate, graduate and continuing education programs oriented to provide basic knowledge and competences to non-specialized professionals (psychologists, general physicians, etc.).<sup>9</sup> Undergraduate academic

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programs should consider the possibility of bridging this gap by implementing curricula with courses covering theoretical models of addiction and co-occurring disorders, prevention and treatment for addictions, and basic psychopharmacology. Also, these programs should emphasize the development of skills in clinical interview, diagnostic assessment, as well as treatment and referral algorithms in order to optimize the utilization of available resources in the local health system and to increase the feasibility of multidisciplinary and interinstitutional collaboration.<sup>10-12</sup>

The training of non-specialized professionals would require standardized programs, supervision and certification to achieve the required quality to cover the real needs of the addiction treatment facilities.<sup>13</sup> Moreover, professionals should have the specific knowledge and skills required for assessing the addictive behavior (main substance, pattern of substance use, etc.), associated problems (medical, familiar, interpersonal, etc.) and co-occurrence with other psychiatric disorders, aiming to develop an adequate treatment plan for each individual, covering from a brief intervention to referral to specialized treatment.

The training of non-specialized health professionals for addiction treatment may boost the response capability of public institutions, increasing the coverage of services to respond to the real community care demands in our country.

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